COMPREHENSIVE ASSESSMENT REQUIREMENTS FOR MEDICARE-APPROVED HHAS

PATIENT CLASSIFICATION/PAYER	Does OASIS Apply?	Comprehensive Assessment Only Excluding OASIS[1]	Timing of Follow-up Comprehensive Assessment
SKILLED Medicare (traditional fee-for service) Medicare (HMO/Managed Care) Medicaid (traditional fee-for-service) Medicaid (HMO/Managed Care)	Yes	NA	Day 56-60[2]
SKILLED Non-Medicare/Non-Medicaid: Workers' Compensation Title Programs Other Government Private insurance Private HMO/Managed Care Self-pay; other; unknown	No[3]	Yes	Anytime after SOC assessment up to day 60; subsequent Follow-up assessment must be within 60 days.[4]
PERSONAL CARE ONLY Medicaid (traditional fee-for service) Medicaid (HMO/Managed Care) Waiver service or home health aide services without skilled services Non-Medicaid: Workers' Compensation Title Programs Other Government Private insurance Private HMO/Managed Care Self-pay; other; unknown	No	Yes	Anytime after SOC assessment up to day 60; subsequent Follow-up assessment must be within 60 days.
OASIS EXCLUDED Patients under age 18; regardless of payer source Patients receiving pre & post partum maternity services; regardless of payer source	No[5]	Yes	Anytime after SOC assessment up to day 60; subsequent Follow-up assessment must be within 60 days.
OASIS EXCLUDED Patients receiving only chore and housekeeping services[6]	No	No	NA

[1] HHAs may develop own comprehensive assessment for each time point excluding OASIS.
[2] 42 CFR 484.55(d).
[3] HHAs may collect OASIS information for their own use.
[4] S&C Memo 04-45, published 9/9/04.
[5] HHAs expecting payment for a pediatric or maternity Medicare patient must collect payment items to provide a HIPPS code.
[6] S&C Memo 05-06, published 11/12/04

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