Addendum to Comprehensive Assessment

(Supporting data for Pre-Claim Review Submission Request, Q1 – Q7)

Complete each section as indicated at Start of Care and Follow-up (Recertification) OASIS

A. General Information

Beneficiary Information:

Beneficiary (First Name, Last Name) Date of Birth Beneficiary HIC number

___________________________________ ______________ __________________________

Agency Information:

Agency Name____

Address____

NPI_____________________________________ PTAN__________________________________

Contact Name___________________________________ Telephone_____________________________

Discipline Completing the Form: ☐ RN ☐PT ☐SLP ☐OT (for continuing)

Episode:

Benefit Period Requested: ☐Initial ☐Subsequent Start of Care Date: _______________________

Episode Start Date______________ Episode End Date _____________ State Services Rendered ______

Physician/Practitioner:

Physician/Practitioner Name____

Address____

NPI_____________________________________ PTAN (optional) ______________________________

HCPCS CODES: Select all that will apply for the episode under review.

☐G0162 Skilled services by an RN – M&E
☐G0493 Skilled services of an RN SO & A
☐G0495 Skilled services of an RN -Training/Ed
☐G0299 Direct skilled services of an RN
☐G0151 Services performed by a PT
☐G0157 Services performed by a LPTA
☐G0152 Services performed by a OT
☐G0158 Services performed by a COTA
☐G0153 Services performed by a SLP
☐G0161 Services performed by a SLP – maintenance
☐G0494 Skilled services of an LVN SO & A
☐G0496 Skilled services of an LVN – Training/Ed
☐G0300 Direct skilled services of an LVN
☐G0159 Services performed by a PT – maintenance
☐G0155 Services of MSW
☐G0160 Services performed by an OT – maintenance
☐G0156 Services of HHA

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Q1. Was the beneficiary admitted to your home health agency (HHA) directly from an acute or post-acute facility? ☐Yes ☐No

If "no", continue to Q2. If "yes", select the following facility:

Facility	**X**
Acute Care Facility	
Inpatient Rehabilitation Facility (IRF)	
Long-Term Care Hospital (LTCH)	
Skilled Nursing Facility (SNF)	

Q2. Was the home health certification and face-to-face (F2F) encounter performed by the same physician?
☐Yes ☐No

If "yes", proceed to Task #1. If "no", choose the provider-type that performed the F2F encounter in the table below:

Provider-Type	**X**
Physician who cared for the patient at acute or post-acute facility	
Nurse practitioner working in collaboration with this physician	
Clinical nurse specialist working in collaboration with this physician	
Certified nurse midwife under the supervision of this physician	
Physician assistant under the supervision of this physician	

☐ *Task # 1 – Q2 Upload the F2F clinical encounter note used by the certifying physician to justify the referral for Medicare home health services. This may include history and physical, progress note, discharge summary but must be from the physician's record.*

Q3. Do you have any HHA generated records that have been signed, dated, and incorporated into the certifying physician's medical records?
☐Yes ☐No

If "yes", proceed to Task #2. If "no", proceed to Task #3.

☐ *TASK # 2 – Q3 HHA generated records that have been signed, dated, and incorporated into the certifying physician's records. Include this addendum and other documents such as the agency generated face-to-face form, therapy evaluations, orders, certification/recertification summaries, etc.*

☐ *TASK # 3 – Q3 Upload the plan of care established and periodically reviewed by an authorized physician. Include the initial plan of care, plan of care for current episode, valid orders for all disciplines and any supplementation orders not on the Plan of Care.*

☐ *TASK # 4 Upload the signed and dated physician's certification of patient eligibility. This includes the physician recertification estimate of how long skilled services are required.*

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B. HOMEBOUND – Beneficiary must meet **BOTH** Criteria #1 AND Criteria #2 to meet homebound eligibility.

1. **Criteria #1: Confined to home** – **At least one** Illness/Injury and the corresponding assistive device and/or special transportation and/or other person required to leave home **OR** contraindication and corresponding ICD-10 code must be noted.

Q4. If the beneficiary has/needs assistance to leave home, complete the table below.

Illness/Injury	**Assistive Device(s) Needed to Leave Home**	**Special Transportation**	**Person to Assist Leaving Home** (who and how do they assist beneficiary)

Q5. If the beneficiary has a condition such that leaving the home is medically contraindicated, complete the table below.

Medical Contraindication (Diagnosis(es) or Condition(s))	**ICD-10 Code(s)**

Is there a medical statement from the physician providing medical restrictions? ☐ Y ☐ N

If YES, Describe the medical restrictions imposed by the physician (as documented in the order):

2. **Criteria #2: Confined to Home** – *BOTH Component 1 and Component 2 must be noted.*

a. **Q6. Component 1**: **Normal inability to leave home** – *Describe Beneficiary's normal inability to leave home including, but not limited to, beneficiary's prior ability to leave home (if different from current ability to leave home), the limitations causing the normal inability to leave home, what conditions cause those limitations, what assistance is required related to those limitations, if applicable.*

For only the OASIS items below that support HB status, insert the response exactly as it appears on the OASIS.

OASIS ITEM	**DESCRIPTION**	**RESP #**
(M1060) a	**Height** *(in inches)*	
(M1060) b	**Weigh**t *(in pounds)*	
(M1200)	**Vision** (*with corrective lenses in patient usually wears them)*	
(M1210)	**Ability to Hear** *(with hearing aid or hearing appliance if used)*	
(M1220)	**Understanding of Verbal Content** *(in patient's own language)*	
(M1230)	**Speech and Oral (Verbal) Expression of Language**	

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(M1242)	**Frequency of Pain Interfering** *(with patient's activity or movement)*	
(M1400)	When is the patient dyspneic or noticeably **Short of Breath**?	
(M1610)	**Urinary Incontinence or Urinary Catheter Present**	
(M1615)	**When** does **Urinary Incontinence** *occur***?**	
(M1700)	**Cognitive Functioning** *(day of assessment)*	
(M1710)	**When Confused (Reported or Observed Within Past 14 Days)**	
(M1720)	**When Anxious (Reported or Observed Within Past 14 Days)**	
(M1740)	**Cognitive, behavioral, and psychiatric symptoms** *(Demonstrated at least once a week)*	
(M1800)	**Grooming:** *(current ability to tend safely to personal hygiene needs)*	
(M1810)	**Current Ability to Dress Upper Body:** *(with or without dressing aids)*	
(M1820)	**Current Ability to Dress Lower Body:** *(with or without dressing aids)*	
(M1830)	**Bathing**	
(M1840)	**Toilet Transferring**	
(M1850)	**Transferring:** *(Ability to move safely from bed to chair, or ability to turn/position self in bed)*	
(M1910)	**Fall Risk Assessment**	
(GG0170C)	**Mobility:** *(Code patient's usual performance at SOC/ROC using the 6-point scale.)*	
(M1860)	**Ambulation/Locomotion**	

Comment: Describe prior ability and prior assistance required if different from current assessment.

b. **Q7.** Component 2: <u>**Considerable and taxing effort to leave home**</u>. **At least one** *Structural Impairment*, *Functional Impairment* or *Activity Restriction* must be present to support Component 2.

1) Structural Impairment: *List each of beneficiary's structural impairments and the "extent"* of the *Structural Limitation*, *Functional Limitation*, *Performance Restriction* and *Capacity Limitation*. Use the scale below to classify the ***"Extent".***

EXTENT	Presence % of time	Intensity affecting day-to-day life	Frequency over last 30 days
Mild	Less than 25%	Person can tolerate	Rarely
Moderate	Less than 50%	Interfering	Occasionally
Severe	Greater than 50%	Partially disrupting	Frequently
Complete	Greater than 95%	Totally disrupting	Daily

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Structural Impairment	Identify Structure Impaired	Extent
Structures of the Nervous System *(Brain, spinal cord, peripheral nerves, etc)*		
Eye, Ear and Related Structures *(Eyeball, retina, pinna, etc)*		
Structures Involved in Voice and Speech *(Larynx, tongue, etc)*		
Structures of the Cardiovascular System *(Heart, arteries, veins, etc.)*		
Structures of the Immunological System *(Specific blood cells, etc)*		
Structures of the Respiratory System *(Pharynx, larynx, trachea, bronchi, lungs, etc)*		
Structures of the Digestive System *(stomach, sml intestine, liver, pancreas, GB, etc)*		
Structures r/t Metabolic / Endocrine Systems *(Liver, pancreas, thyroid, pituitary, adrenal, etc)*		
Structures of the Genitourinary System *(Bladder, kidneys, genital organs, ureters, etc)*		
Structures r/t Movement *(Bones, muscles, tendons by body region)*		
Skin and Related Structures *(Skin, hair follicles, nails, etc.)*		

Comment: if additional space is needed to fully describe the <u>structural impairment,</u> enter the detail below.

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2) Functional Impairment: List the beneficiary's **specific functional impairments** and the **extent** of the impairment. For Extent scale, see 1(A) above. Check the appropriate box to indicate condition(s) that support homebound (HB) and those that support medical necessity (MN) for the episode under review.

HB	MN	Functional Impairment	Describe Functional Impairment	Extent
		Mental Functions		
		Sensory Functions and Pain		
		Voice and Speech Functions		
		Functions of the Cardiovascular System		
		Functions of Hematological and Immunological Systems		
		Functions of the Respiratory System		
		Functions of the Digestive System		
		Functions of the Metabolic and Endocrine System		
		Functions of the Genitourinary System		
		Neuromuscoloskeletal and Movement Related Function		
		Functions of the Skin and Related Structures		

Comment: if additional space is needed to fully describe the functional impairment(s) that support homebound status, add to the following table.

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3) Activity Restriction/Limitation: *List each of the beneficiary's "activity restrictions" or "limitations" and the **"extent of the performance restriction"** and **"capacity limitation"** for each restriction/limitation. "Activity" is the execution of a task or action by an individual. "Participation" is involvement in a life situation.*

- *Activity limitations are difficulties an individual may have in executing activities.*
- *Participation restrictions are problems an individual may have in involvement in life situations.*
- *The **Performance qualifier** indicates the **extent of Participation restriction** by describing the person's **actual performance** of a task or action **in his or her current environment.** The Performance qualifier measures the difficulty the respondent experiences in **doing things, assuming that they want to do them**.*
- *The **Capacity qualifier** indicates the **extent of Activity limitation** by describing the **person's ability** to execute a task or an action. The Capacity qualifier focuses on limitations that are inherent or intrinsic features of the person themselves. These limitations should be direct manifestations of the respondent's health state, **without the assistance**. By assistance we mean the help of another person, or assistance provided by an adapted or specially designed tool or vehicle, or any form of environmental modification to a room, home, workplace etc.*

SCALE: Performance and Capacity

Performance Extent of Participation Restriction	**Capacity** (*without assistance*) Extent of Activity Limitation
Mild difficulty *means a problem that is present less than 25% of the time, with an intensity a person can tolerate and which happens rarely over the last 30 days.*	
Moderate difficulty *means a problem that is present less than 50% of the time, with an intensity, which is interfering in the person's day to day life and which happens occasionally over the last 30 days.*	
Severe difficulty *means a problem that is present more than 50% of the time, with an intensity, which is partially disrupting the person's day to day life and which happens frequently over the last 30 days.*	
Complete difficulty *means a problem is present more than 95% of the time, with an intensity, which is totally disrupting the person's day to day life and which happens every day over the last 30 days.*	

Check the appropriate box to indicate the restriction(s)/limitation(s) that will be addressed by nursing or therapy services during this episode.

Nurse	Therapy	Activity Restriction/Limitation	Performance	Capacity
		Communication		
		Mobility		
		Self-Care		
		Domestic Life		
		Interpersonal Interactions and Relationships		

Comment: if additional space is needed to fully describe activity restriction(s)/limitation(s) that will be addressed by nursing services. (Note: therapy services will address these limitations in the assessments, reassessments, evaluations and re-evaluations in specific goals.)

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☐ *Task # 5 – Q4, Q5, Q6, and Q7. Attach documentation that supports both Criteria 1 and Criteria 2 for Confined to the Home. This form is designed to support homebound, and if signed by the physician, can serve as the response in Task #2 as well.*

Provide printed names, signatures and dates below.

______________________	____________________________	____________
Clinician name (printed) (Person completing the OASIS)	Clinician signature	Date

Optional physician signature if Addendum is used for Task # 2.

______________________	____________________________	____________
Physician name (printed)	Physician signature	Date

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MEDICAL NECESSITY

1. Indicate which *acute* or *post-acute care* (PAC) facility from which the beneficiary was admitted directly to your agency, or within 60 days if from another home health agency or hospice. Provide the discharge date from the acute or PAC, if known. For Follow-up OASIS, indicate the most recent dates applicable to inpatient stays occurring during the *prior* episode.

TYPE	NAME	DATES
Hospital		
Long-term Care Hospital (LTAC)		
Inpatient Rehabilitation (IRF)		
Skilled Nursing Facility (SNF)		
Nursing Facility (NF)		
Home Health Agency (HHA)		
Hospice (HOS)		

2. Indicate if the patient was seen in *ER Department* within the past two weeks prior to admission. For Follow-up OASIS, provide the ER Department dates occurring during the *prior* episode.

ER Department Visit(s)	REASON for Visit(s)	DATES

Comment: if additional space is needed to fully describe the acute/post-acute services

3. Indicate if the beneficiary had any of the following within the *past 3 weeks*; provide details in the space(s) provided (applicable for SOC/ROC and Follow-up OASIS).

Medical Necessity Component	**Specific Details** *(diagnosis, procedure, medication, etc). Include date associated with component*
A new onset of diagnosis	
An exacerbation of a diagnosis *(with tx change)*	
A new or changed medication	
A change in caregiver status	
Abnormal laboratory results	
A fall or incident requiring PT, OT, or SLP	
New or worsening wound(s)	
Other	

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Comment: if additional space is needed to fully describe the <u>medical necessity component</u>

4. Specific **<u>Skilled Nursing Services</u>** and Treatments to be performed *<u>during this episode</u>*

a) ☐ **Skilled Observation/Assessment (G0163) (describe the rationale for SO & A)**

b) ☐ **Skilled Beneficiary/Caregiver Training/Education (G0164)**

☐ Oral medications
☐ Complex medication regimen
☐ Administration of injection
☐ IV administration or care
☐ Self-admin. medical gas
☐ Self-admin. Inhalation Rx
☐ Ambulation with assistive device
☐ Transfer techniques
☐ Other: ______________________________

☐ Performance ADL
☐ Bed-bound patient
☐ Braces, splints, orthotics
☐ Prosthesis care/gait training
☐ Proper skin care
☐ Wound care
☐ Ostomy care
☐ Tracheostomy care

☐ Therapeutic diet
☐ Gastrostomy feeding
☐ Nasogastric feeding
☐ Parenteral nutrition
☐ Indwelling catheter care
☐ Self-catheterization
☐ Bowel/bladder training
☐ Diabetic management

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c) ☐ Skilled Procedure/Treatment (G0299, G0300)

☐ Foley insertion
☐ Bladder instillation
☐ Open wound care/dressing
☐ Decubitus Care
☐ Administer of IV medication
☐ Disimpaction/F.U. Enema
☐ Tracheostomy care
☐ Administer Vit. B12 injection
☐ Administer of insulin
☐ Other: ____
☐ Administer of inhalation medication
☐ Administer other IM injection
Medication:________________________
☐ Bowel program

5. **Therapy Services**: Indicate therapy service(s) to be provided during this episode. Indicate which assessments are included in this submission for each therapy service being provided.

a. ☐ Physical Therapy (attachments)

☐ Current 30-day assessment
☐ Previous 30-day assessment

b. ☐ **Occupational Therapy (attachments)**

☐ Current 30-day assessment
☐ Previous 30-day assessment

c. ☐ **Speech Language Pathology (attachments)**

☐ Current 30-day assessment
☐ Previous 30-day assessment

Comment: If using the therapy evaluation to support medical necessity then either 1) attach appropriate therapy evaluation or 2) provide the following information in the space below; *prior level of function and therapy goals.*

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Explanation of medical necessity from OASIS: Copy and paste the medical necessity statement from the OASIS, if additional support is needed, or document here. Include all services to be provided during the episode.

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For Recertification Only: Physician estimate of how much longer services will be needed:

_______________ **Weeks** _______________ **Months** _______________ **Other**

Provide printed name, signature and date below.

________________________________ ____________________________________ _______________

Clinician name (printed)
(Person completing the OASIS)

Clinician signature

Date

Optional physician signature if Addendum is used for Task # 2.

____________________________ ____________________________________ _______________

Physician name (printed)

Physician signature

Date

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