

and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

(d) *Standard: Update of the comprehensive assessment.* The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than—

(1) The last five days of every 60 days beginning with the start-of-care date, unless there is a—

(i) Beneficiary elected transfer;  
(ii) Significant change in condition;  
or

(iii) Discharge and return to the same HHA during the 60-day episode.

(2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests;

(3) At discharge.

(e) *Standard: Incorporation of OASIS data items.* The OASIS data items determined by the Secretary must be incorporated into the HHA's own assessment and must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.

[64 FR 3784, Jan. 25, 1999, as amended at 65 FR 41211, July 3, 2000; 74 FR 58134, Nov. 10, 2009]

### Subpart D [Reserved]

### Subpart E—Prospective Payment System for Home Health Agencies

SOURCE: 65 FR 41212, July 3, 2000, unless otherwise noted.

#### § 484.200 Basis and scope.

(a) *Basis.* This subpart implements section 1895 of the Act, which provides for the implementation of a prospec-

tive payment system (PPS) for HHAs for portions of cost reporting periods occurring on or after October 1, 2000.

(b) *Scope.* This subpart sets forth the framework for the HHA PPS, including the methodology used for the development of the payment rates, associated adjustments, and related rules.

#### § 484.202 Definitions.

As used in this subpart—

*Case-mix index* means a scale that measures the relative difference in resource intensity among different groups in the clinical model.

*Discipline* means one of the six home health disciplines covered under the Medicare home health benefit (skilled nursing services, home health aide services, physical therapy services, occupational therapy services, speech-language pathology services, and medical social services).

*Home health market basket index* means an index that reflects changes over time in the prices of an appropriate mix of goods and services included in home health services.

*Rural area* means, with respect to home health episodes ending on or after January 1, 2006, an area defined in § 412.64(b)(1)(ii)(C) of this chapter.

*Urban area* means, with respect to home health episodes ending on or after January 1, 2006, an area defined in § 412.64(b)(1)(ii)(A) and (B) of this chapter.

[70 FR 68142, Nov. 9, 2005]

#### § 484.205 Basis of payment.

(a) *Method of payment.* An HHA receives a national prospective 60-day episode payment of a predetermined rate for a home health service previously paid on a reasonable cost basis (except the osteoporosis drug defined in section 1861(kk) of the Act) as of August 5, 1997. The national 60-day episode payment is determined in accordance with § 484.215. The national prospective 60-day episode payment is subject to the following adjustments and additional payments:

(1) A low-utilization payment adjustment (LUPA) of a predetermined per-visit rate as specified in § 484.230.

(2) A partial episode payment (PEP) adjustment due to an intervening event