

§484.55(a) *Standard: Initial assessment visit.*

(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician- *or allowed practitioner*-ordered start of care date.

Interpretive Guidelines §484.55(a)(1)

For patients receiving only nursing services or both nursing and rehabilitation therapy services, a registered nurse must conduct the initial assessment visit. For patients receiving rehabilitation therapy services only, the initial assessment may be made by the

applicable rehabilitation skilled professional rather than the registered nurse. See §484.55(a)(2).

The initial assessment bridges the gap between when the first patient encounter occurs and when a plan of care can be implemented. “Immediate care and support needs” are those items and services that will maintain the patient’s health and safety through this interim period, i.e., until the HHA can complete the comprehensive assessment and implement the plan of care. “Immediate care and support needs” may include medication, mobility aids for safety, skilled nursing treatments, and items to address fall risks and nutritional needs.

The clinical record must demonstrate that homebound status/eligibility for the Medicare home health benefit was determined and documented during the initial visit.

An HHA that is unable to complete the initial assessment within 48 hours of referral or the patient’s return home, shall not request a different start of care date from the ordering physician to ensure compliance with the regulation or to accommodate the convenience of the agency.

In instances where the patient requests a delay in the start of care date, the HHA would need to contact the physician to request a change in the start of care date and such change would need to be documented in the medical record.