

CMS OASIS Q&As: CATEGORY 3 - FOLLOW-UP ASSESSMENTS

Q1. When is a recertification (follow-up) assessment due for a Medicare/Medicaid skilled care patient? [Q&A EDITED 08/07]

A1. A Medicare/Medicaid skilled-care adult patient who remains on service into a subsequent episode requires a follow-up comprehensive assessment (including OASIS items) during the last 5 days of each 60-day period (days 56-60, counting from the start of care date) until discharged.

Q2. What are the requirements for follow-up comprehensive assessment for pediatric and maternity patients where the payer is Medicaid? [Q&A EDITED 08/07]

A2. Pediatric and maternity patients have been exempt from the OASIS data collection requirements; however, the agency must still perform a follow-up comprehensive assessment at any time up to and including day 60. The timetable for the subsequent 60-day period would then be measured from the completion date of the most recently completed assessment. The agency may develop its own comprehensive assessment form for these clients. Clinicians may perform the follow-up comprehensive assessment more frequently than the last 5 days of the 60-day episode without conducting another comprehensive assessment on day 56-60 and remain in compliance with § 484.55(d).

Q3. A patient is hospitalized and comes back to the agency on day 56. Which assessment do we complete? A resumption of care (ROC) or follow-up (FU) or do we need to do both? [Q&A EDITED 10/16; 09/09]

A3. When the patient returns to the agency during the last 5 days of an episode, the ROC assessment should be completed, fulfilling both the ROC and recertification requirements. M2200, Therapy Need, should forecast therapy use for the upcoming episode. You can find the instructions (mentioned above) for handling this type of situation in the OASIS Considerations for Medicare PPS Patients document found at the QIES Technical Support website <https://www.qtso.com/hhdownload.html>

Transmittal 61, posted January 16, 2004, includes a section on special billing situations and can be found in the *Medicare Claims Processing Manual*. Go to <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf> to "Section 80 - special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your Medicare Administrative Contractor (MAC).

Q3.1. Our patient's recertification was due August 12th. The nurse completed the recertification assessment on August 8th. Later that night, August 8th, the patient fell, broke her leg and is now in the hospital on her recertification date. Do we submit the recertification assessment and continue on with paperwork including the Transfer OASIS and new Plan of Care or do we keep the Recertification paperwork and complete a Transfer OASIS, and pick back up after the discharge from the inpatient facility as a new referral? [Q&A EDITED 10/16; 06/14; ADDED to Cat. 3 01/11; CMS OCCB 10/07 Q&A #5]

A3.1. The Conditions of Participation require that a follow-up comprehensive assessment be conducted during last 5 days of every 60 day episode. In your scenario, the follow-up assessment was performed during the required timeframe, but then the patient's condition changed and required what we will assume is a qualifying transfer to an inpatient facility during the recertification assessment timeframe. If your agency

completed an RFA 7 - Transfer with Discharge, then regardless of when/if the patient returned to your agency, submission of the Recertification assessment would not be necessary. Therefore, it is acceptable to not submit the Recert assessment to the OASIS system, but rather to maintain the completed Recert assessment in the patient's clinical record, with documentation explaining the situation. It would also be acceptable to submit the Recert assessment to the OASIS system.

If your agency completed an RFA 6 - Transfer without Discharge, then if the patient were to return to your agency on Day 60 or 61, special instructions would apply to determine if the episode is to be considered continuous or not. In order for the episodes to be considered continuous, the HIPPS codes resulting from both the Recertification assessment and the Resumption of Care assessments would need to match, and both assessments would need to be submitted to the OASIS system.

If the conditions required for continuous episodes are not met, it is acceptable to not submit the Recertification assessment to the OASIS system, but rather to maintain the completed Recert assessment in the patient's clinical record, with documentation explaining the situation. In either case, collection and submission of the Transfer assessment would be required.

(More complete details related to this guidance, reference the prior CMS OASIS Q&As Category 2, Questions 53 – 55 and the Medicare Claims Processing Manual, Section 80-Special Billing Situations Involving OASIS Assessments located at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf>.

Q3.2. In the new Q&As that were posted in May 2007 it states that if an agency has done a recert and then the patient goes to the hospital and the agency does a transfer without dc, then when the patient comes back the clinician does the comprehensive assessment. Depending on the HIPPS code would depend on if they did a ROC or a SOC. But what if the agency had not done the recert and the patient went to the hospital on day 58. When the patient comes out would they do a new SOC? (Since there is no HIPPS code to match up with). [Q&A ADDED to Cat. 3 01/11; Previously CMS OCCB 07/07 Q&A #3; Also in Cat. 2 Q&A #55]

A3.2. If a patient is transferred to the hospital on day 58, before the recertification assessment was completed, and the stay in the inpatient facility met the criteria for a Transfer, the agency would complete a Transfer OASIS. When the patient returns home, if it is on 59 or 60 and they have not been discharged from the home care agency, a Resumption of Care (RFA 3) assessment would be completed, and would satisfy both the ROC and the recertification requirements. If the patient's stay extends beyond the end of the current certification period, a SOC would be completed. The agency would also need to perform a "paper" discharge from the previous episode, (no OASIS DC required).

Q4. [Q&A RETIRED 08/07; Outdated]

Q4.1. A patient is seen monthly. On a monthly visit, which falls within the last five days of the certification period, the assessing clinician discovers the patient had a qualifying hospital admission since the last monthly visit that our agency was not aware of. Do we complete a Transfer, Resumption and Recert or just the Transfer and Resumption? [Q&A ADDED 01/12; Previously CMS OCCB 10/11 Q&A #1]

A4.1. When the agency learns of a qualifying Transfer after the patient returned home, a Transfer and Resumption is required within 2 calendar days after learning of the

inpatient stay. In this situation, a Transfer is required; and, since the time frame to complete the Resumption overlaps with the timeframe to complete the Recertification, the ROC assessment should be completed, fulfilling both the ROC and Recert requirements.

Q5. Must both a recertification and a Resumption of Care (ROC) assessment be completed when a patient returns to the agency from an inpatient stay a day or two before the last 5 days of a payment episode? [Q&A EDITED 10/18]

A5. In your example (and assuming no physician-ordered ROC date is provided), if the patient were discharged from the inpatient facility on day 53, the agency would be required to complete a ROC assessment no later than day 55 and a recertification assessment within days 56-60, because the regulations require that the ROC assessment be done within 2 days of the discharge from the inpatient facility.

If the patient were discharged from the inpatient facility on day 54 or 55, the ROC assessment could be done on day 56 or 57, respectively (providing the physician was in agreement). In that case, refer to the answer to Q3 in this category.

Q5.1. As long as the RFA 4, Recertification OASIS M0090 date is within the 5 day window, can you visit on day one and complete (M0090) any of the other days if you were still gathering data? [Q&A ADDED 01/11; Previously CMS OCCB 04/10 Q&A #3]

A5.1. Per the Condition of Participation, 484.55, the agency must perform a comprehensive assessment of the Medicare patient every second calendar month beginning with the start of care. The time period for the RFA 4, Recertification, has been further clarified in a number of references, Category 3 CMS OASIS Q&As, OASIS Assessment Reference Sheet, to mean the last 5 days of every 60 days, i. e. days 56-60 of the current 60-day period.

A clinician may start the comprehensive assessment on day 56 and complete it on any day on or before day 60. Only one clinician may complete a comprehensive assessment though, so if Nurse A begins it on day 56, Nurse A must be the clinician who completes it.

Q6. Please clarify the 60-day certification period referred to in the regulations. Hasn't CMS been flexible in allowing a shorter certification period if the patient's condition changed?

A6. Collecting uniform data on patients at uniformly defined time points means that certification periods will need to be less flexibly defined. Therefore, HHAs must adhere to a 60-day certification period, based on the SOC date. The HAVEN data specifications have been developed according to this schedule, and agencies will be in compliance with the regulations if they adhere to this schedule.

Q7. Should my agency be concerned about 'counting out' 60-day intervals in order to schedule the follow-up assessment? [Q&A EDITED 06/14]

A7. To assist agencies determine the correct 60-day time frame for scheduling OASIS follow-up assessments, go to the QIES Technical Support Office website <https://www.qtso.com/hhdownload.html>, click on OASIS and download 'Scheduling OASIS Follow-up Assessment'. There you will find the current year calendar in pdf file, which will help you determine a patient's first, second and third certification periods based on the start of care date.

Q8. Is it necessary to make a visit in order to complete the follow-up reassessment? [Q&A EDITED 08/07]

A8. Yes, the follow-up comprehensive assessment must be performed in the physical presence of the patient. A telehealth interaction does not constitute an in-person visit for the purposes of completing the required comprehensive assessment.

Q9. If a clinician's visit schedule is 'off track' for a visit in the last 5 days of the 60-day certification period, can a visit be made strictly for the purposes of doing an assessment? Will this visit be reimbursed by Medicare? [Q&A EDITED 09/09]

A9. Under PPS, a visit can be made for only the purpose of performing an assessment, but it will not be considered a billable visit unless appropriate skilled services are performed. A recertification assessment not completed during the appropriate time frame raises a number of issues, including non-compliance with home health Conditions of Participation (CoP), a potential likelihood of a visit made without physician's orders, and payment related issues for Medicare PPS patients. Although it is not explicitly spelled out in the CoP, the expectation that accompanies the requirement to update the comprehensive assessment between days 56 & 60 is that the orders for the ensuing 60 days will be based on the results of that assessment. The patient's care orders essentially expire at the end of day 60, so day 61 begins a new payment episode. If the patient is a Medicare patient, you should discuss any payment-related issues with your Medicare Administrative Coordinator (MAC).

Q10. What if the patient refuses a visit during the 5-day recert window? [Q&A EDITED 09/09]

A10. Most patients are willing to receive a visit if the visit schedule and required time points have been explained to them during the episode. In addition, PPS requires a visit during the same 'window' for the agency to receive continued reimbursement for a specific Medicare patient. If the HHA is completely unable to schedule a visit during this period, the follow-up assessment should be completed as soon after this period as possible.

Although it is not explicitly spelled out in the CoP, the expectation that accompanies the requirement to update the comprehensive assessment between days 56 & 60 is that the orders for the ensuing 60 days will be based on the results of that assessment. The patient's care orders essentially expire at the end of day 60, so day 61 begins a new payment episode. The agency should be aware of potential legal issues associated with completing the assessment late, considering that the agency may not have orders for visits after the end of the 60-day period. If the patient is a Medicare patient, you should discuss any payment-related issues with Medicare Administrative Coordinator (MAC).

Q11. If an agency misses the recertification assessment window of day 56-60, yet continues to provide skilled services to the Medicare patient, is the agency required to discharge and readmit the patient? Or, could the agency conduct the RFA 4 assessment late? Will any data transmission problems be encountered? [Q&A ADDED 06/05; EDITED 9/09; Previously CMS OCCB 10/04 Q&A #1]

A11. When an agency does not complete a recertification assessment within the required 5 day window at the end of the certification period, the agency should not discharge and readmit the patient. Rather, the agency should send a clinician to perform the recertification assessment as soon as the oversight is identified. The date assessment completed (M0090) should be reported as the actual date the assessment is completed, with documentation in the clinical record of the circumstances surrounding the late completion. A warning message will result from the non-compliant assessment

date, but this will not prevent assessment transmission. No time frame has been set after which it would be too late to complete this late assessment, but the agency is encouraged to make a correction or complete a missed assessment as soon as possible after the oversight is identified. Obviously, this situation should be avoided, as it does demonstrate non-compliance with the comprehensive assessment update standard (of the Conditions of Participation). For the Medicare PPS patient, payment implications may arise from this missed assessment. Any payment implications must be discussed with the agency's Medicare Administrative Coordinator (MAC).

Q11.1. If there was a need for continuing services into the next certification period, but the clinician missed completing the recertification assessment between day 56-60 and on the first visit in the new episode it was determined the patient had reached goals and needed to be discharged, do I have to complete both the Recert and the Discharge OASIS? [Q&A ADDED 01/12; Previously CMS OCCB 07/11 Q&A #4]

A11.1. Yes, both the Recert and Discharge must be completed. When a Recertification assessment is missed it should be completed as soon as possible. In the situation described, you needed to recertify for the visit that was needed and justified by the patient's condition in the new episode of care. The recertification comprehensive assessment supports the patient's need for services, and the recertification OASIS drives the payment for that episode. If the clinician determined the patient was ready for discharge on the first visit in the new episode, the Discharge comprehensive assessment is also required. The discharge is the endpoint of the quality episode, which is not captured with a recertification assessment.

Q11.1.1. We are seeing an increasing number of patients "held" in emergency rooms as "observation" patients for periods of 24 hours up to 7 days without admission to inpatient status. A Transfer assessment is not completed on these patients since they were not admitted to the hospital as an inpatient. If this patient is released from the emergency room or from observation status in the next certification period (i.e., on Day 61 or later) and returns to home health without ever being admitted to the hospital as an inpatient, is it appropriate for the agency to complete a Follow-up or Recertification assessment or must the agency discharge the patient and readmit them to home care services? If a Recertification assessment is completed, what date should be used for the M0090 date and what documentation should the agency include in the record? [Q&A ADDED 06/14; Previously CMS Qtrly 07/13 Q&A #2]

A11.1.1. Treat this situation as a missed Recertification and complete the Recertification as soon as possible after the patient's return home. M0090 is the actual date the comprehensive assessment was completed. Clinical documentation will explain the events leading to the late Recertification.

Q11.1.2. The patient had a qualifying stay in an inpatient facility, but the Transfer OASIS and the ROC assessments were not done when the RN made a routine visit following the patient's discharge home. The patient has since been recertified and continues as a current patient. How do we proceed? [Q&A ADDED 06/14; Previously CMS Qtrly 04/14 Q&A #3]

A11.1.2. When the agency becomes aware of a qualifying stay in an inpatient facility, a Transfer OASIS and Resumption of Care (ROC) assessment must be completed within 2 days of gaining the knowledge. In your situation, assuming the Recertification assessment had been performed during the last five days of the prior certification period, the agency would still need to complete a Transfer and send a qualified clinician to the

home to perform the missing ROC assessment. You will receive a notice that the assessments have been submitted out of sequence.

Q11.2. I accidentally completed the RFA 4 – Recertification assessment early (on day 54) for my Medicare patient. I did not realize this until I was into the next certification period. Should I do a new assessment or can the early assessment be used to establish the new case mix assignment for the upcoming episode? [Q&A ADDED 01/12 to Cat. 3; Also located in Cat. 4b as Q&A #23.5; Previously CMS OCCB 07/11 Q&A #4]

A11.2. Whenever you discover that you have missed completing a recertification for a Medicare patient within the required time frame (days 56-60), you should not discharge that patient and readmit, or use an assessment that was completed prior to the required assessment window. As soon as you realize that you missed the recert window, make a visit and complete the recertification assessment. You are out of compliance and will receive a warning from HAVEN or HAVEN-like software. Efforts should be made to avoid such noncompliance by implementing processes to support compliance with required data collection time frames.

Q11.3. We missed completing a recertification assessment on a patient between days 56-60. During the first visit in the new episode, the patient was transferred to the emergency room before the Recertification comprehensive assessment could be completed. The patient had a qualifying stay in an inpatient bed. What OASIS is due when we resume care of the patient? [Q&A ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #11]

A11.3. Do not discharge the patient. A Transfer assessment (RFA 6) should be completed. If the patient returns to the HHA, a Resumption of Care (ROC) comprehensive assessment should be completed. The ROC will serve as both the Resumption of Care and the Recertification, establishing the PPS payment code for the next certification period. This demonstrates non-compliance with the Medicare comprehensive assessment update standard of the Conditions of Participation but is the only option available due to the missed recertification. Care should be taken to monitor recertification dates to avoid this situation in the future.

For questions related to coverage and billing, contact your Medicare Administrative Contractor (MAC).

Q11.4. What OASIS is required when a patient returns home on day 61, in a situation where the patient was admitted to the hospital before or during day 56-60 recert window, is in an inpatient bed longer than 24 hours, but only for diagnostic testing; No Transfer OASIS had been completed? [Q&A ADDED 12/12; Previously CMS Qtrly 10/12 Q&A #1]

A11.4. Treat this situation as a missed Recertification and complete the Recertification as soon as possible after the patient's return home.

Q12. What are the indications for an 'other follow-up' (RFA 5) assessment? [Q&A EDITED 08/07]

A12. In the preamble to the comprehensive assessment regulation, it is noted that a comprehensive assessment with OASIS data collection is required when there is a major decline or improvement in health status. Each agency must determine its own policies regarding examples of major decline or improvement in health status and ensure that the clinical staff is adhering to these policies. In the event the agency determines that an

assessment at a point in time not already required is necessary (based on its own policies), reason for assessment (RFA) #5 under M0100 would be selected.

Q13. If a resumption of care assessment is performed, does the clock 'reset' with respect to follow-up assessment, i.e., is the follow-up due 60 days after resumption of care or does it remain 60 days from the original start of care date?

A13. Unless the patient has been discharged, the due dates for follow-up assessments are calculated from the original start of care date rather than from the resumption of care date. For additional guidance on transferring patients with or without discharge and resuming care, see the OASIS Considerations for Medicare PPS Patients document found at the QIES Technical Support website <https://www.qtso.com/hhdownload.html>

Q14. Our agency has a custodial service program that provides personal care and patients remain on service for several years. How do we determine the reassessment date?

A14. Note that the certification periods and the recertification follow-up assessment window are ALWAYS calculated relative to the start of care date.

Q15. [Q&A DELETED 08/07; Question focus was Physician's Orders. Refer to State Survey Agency for guidance.]

Q16. Since OASIS is temporarily suspended for non-Medicare/non-Medicaid patients, must I complete the Follow-up assessment at day 56-60?

A16. For the non-Medicare/non-Medicaid patient, the assessment may be performed any time up to and including the 60th day. The timetable for the subsequent 60-day period would be measured from the completion date of the most recently completed assessment. Another way of stating this clarification is that clinicians may perform the comprehensive assessment more frequently than the last 5 days of the 60-day period without conducting another assessment on day 56-60 and remain in compliance with 484.55(d).

Q17. I am trying to find clarification on how to use RFA 5 for decline or improvement. When I review the OASIS time points, it lists RFA 5 as a SCIC with or without hospitalization. Does the RFA 5 only have to be done when payment is affected? If the patient improved, I would think we would be discharging, thus RFA 9. I don't understand what RFA 5 is used for. [Q&A ADDED 08/07; EDITED 04/15; Previously CMS OCCB 05/07 Q&A #6]

A17. When the patient experiences an event that meets your agency's definition of a major decline or improvement in the patient's health status, you are required to complete the RFA 5, the Other Follow-up assessment, in order to be compliant with the Medicare Conditions of Participation – Section 484.55(d). In the preamble to the comprehensive assessment regulation, 484.55, it is noted that a comprehensive assessment (with OASIS data collection, if applicable) is required when there is a major decline or improvement in health status. CMS encouraged each agency to develop its own guidelines and policies for this type of assessment and did not provide written requirements about what constitutes a significant decline or improvement.

This requirement to complete an RFA 5 for a patient experiencing a major decline or improvement in health status should not be confused with the Significant Change in Condition (SCIC) payment adjustment which was introduced in the initial Home Health Prospective Pay System (PPS) model. Regardless of the pay source or impact, current regulations require that any patient experiencing a major decline or improvement (as defined by your agency) is expected to receive a follow-up comprehensive assessment

(RFA 5 Other Follow-up). Following agency policy, if the clinician identifies that there has been a major decline or improvement, the clinician will complete the assessment and evaluate the plan of care and modify as needed.

You stated that if a patient had a major improvement, you would discharge, but that may not be true if the patient had continuing home care needs. For example, if your patient had a CVA and at SOC and subsequently experienced a significant resolution of neurological symptoms, this patient may meet the criteria for your agency's definition of a major improvement. If the patient continued to have nursing needs related to medication management, you may not discharge until those goals were met. The RFA 5 would serve as the vehicle to reassessment the patient's status after the major change in status.

Q18. Since the SCIC assessment is no longer available, what should we do when additional services must be added after the SOC has been submitted and the HHRG established? If a nursing-only patient experiences a fall several weeks into the episode resulting in the initiation of PT, what OASIS assessment should we complete to get additional payment? [Q&A ADDED 09/09; Previously CMS OCCB 04/08 Q&A #2]

A18. The Other Follow-up (RFA 5) is still expected to be completed when the patient experiences a major decline or improvement in health status, as defined by your agency policy. Information collected as part of this Follow-up assessment will be helpful in ensuring appropriate re-evaluation and revision of the patient's plan of care in the presence of major changes in patient condition. This assessment continues to be a requirement of the Conditions of Participation (CoPs), even though under PPS 2008, data from the RFA 5 assessment will in no way impact the episode payment as it may have under the previous PPS model.

Under PPS 2008, if the patient experiences a major improvement or decline in status after the SOC assessment time frame, assessments should continue to be completed per the CoPs and agency policy, and appropriate care plan changes made per physician orders. In some cases, (e.g., a status decline resulting in an increase in nursing visits for treatment of a new wound) no additional payment would be received, as the Significant Change in Condition (SCIC) payment adjustment has been eliminated with PPS 2008. In cases where the major decline or improvement in the patient's status results in more therapy visits being provided (compared with the number initially reported in M2200, Therapy Need, at the SOC), upon submission of the final claim (which will indicate the number of therapy visits provided) the claims processing system will autocorrect the payment to reflect the number of therapy visits provided and reimburse the agency accordingly, even if more therapy visits were provided during the episode than were projected at any of the OASIS data collection time points that capture M2200.

No specific action related to OASIS data collection or correction is necessary or expected in order for the agency to receive payment for the actual number of qualified therapy visits provided.

Q19. Now that the Significant Change in Condition (SCIC) payment adjustment is no longer part of home health Prospective Payment System (PPS), please clarify for us the correct documentation for SCIC's now. First, are SCIC's still required, and if so, do we use the Other Follow-Up Assessment (RFA 5) form? And since this won't affect payment, do we still need to transmit this assessment, or keep on file only? [Q&A ADDED 09/09; Previously CMS OCCB 10/08 Q&A #2]

A19. The Other Follow-up (RFA 5) is still expected to be completed when the patient experiences a major decline or improvement in health status, as defined by your agency policy. Information collected as part of this Follow-up assessment will be helpful in ensuring appropriate re-evaluation and revision of the patient's plan of care in the presence of major changes in patient condition. This assessment continues to be a requirement of the Conditions of Participation (CoPs), even though under PPS 2008, data from the RFA 5 assessment will in no way impact the episode payment as it may have under the previous PPS model.

There has been no change in the OASIS reporting regulation. You are required to submit the OASIS data, including the RFA 5 - Other Follow-up, within 30 days from M0090, Date Assessment completed.