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

Q1. When is a follow-up comprehensive assessment (including OASIS) due? ? [Q&A EDITED 11/24; EDITED 05/22; EDITED 08/07]

A1. All patients who remain on service into a subsequent certification period require a follow-up comprehensive assessment (including OASIS) 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 recertification(follow-up) comprehensive assessments for pediatric and maternity patients where the payer is Medicaid? [Q&A EDITED 11/24; EDITED 05/22; EDITED 08/07]

A2. Pediatric and maternity patients are exempt from the OASIS data collection requirements; however, the agency must still perform a follow-up comprehensive assessment during the last 5 days of every 60-days beginning with the start of care date.

Q3. [Q&A RETIRED 05/22]

Q3.01. With PDGM, when a patient is transferred to an inpatient facility and returns home during the last 5 days of the current 60-day certification period (days 56-60), can the agency continue to complete only the Resumption of Care (ROC) to meet the requirements for both the ROC and the recert? [Q&A EDITED 10/23; ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 10/19 Q7]

A3.01. When a patient returns home from an inpatient facility stay during the last 5 days of the current 60-day certification period (days 56-60), the agency may complete only the Resumption of Care, allowing the assessment to serve both resumption and recert functions.

Q3.1. Our patient's recertification was due August 12th. The nurse completed the recertification assessment on August 8th. Later that night, on 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 10/23; EDITED 05/22; EDITED 10/16; 06/14; ADDED to Cat. 3 01/11; CMS OCCB Q&A 10/07 Q5]

A3.1. The Conditions of Participation require that a follow-up comprehensive assessment be conducted during the last 5 days of every 60-day certification period. In your scenario, the follow-up assessment was performed during the required timeframe, but then the patient's condition changed and required what we assume is a transfer to an inpatient facility during the recertification assessment timeframe, for a qualifying inpatient stay (admitted to an inpatient facility for 24 hours or longer for reasons other than diagnostic testing). If your agency completed an RFA 7 - Transfer with Discharge, you may also submit the Recertification assessment, although this is not necessary. When the patient returns home, you would then complete a new Start of Care (SOC).

If your agency completed an RFA 6 - Transfer without Discharge, and if the patient returns to your agency in the recertification period, complete a Resumption of Care OASIS if the M0090 date is on or before day 60. Complete a SOC OASIS if the M0090 date is on or after day 61.

Q3.2. If a patient is admitted to the hospital on day 58 and the agency has not done the recert, when the patient comes out of the hospital would the agency be required to do a new Start of Care (SOC)? [Q&A EDITED 10/23; EDITED 05/22; ADDED to Cat. 3 01/11; Previously CMS OCCB Q&A 07/07 Q3;]

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 meets the criteria for a Transfer, the agency would complete a Transfer OASIS. When the patient returns home, if they have not been discharged from the home care agency, and the timeframe to complete the Resumption of Care (ROC) overlaps with the timeframe to complete the Recertification then complete the ROC. This satisfies both the ROC and the recertification requirements.

If the patient's facility stay extends beyond the end of the current certification period when the patient returns home 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]

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 of Care and Recert or just the Transfer and Resumption of Care? [Q&A EDITED 10/23; EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 10/11 Q1]

A4.1. When the agency learns of a qualifying inpatient stay after the patient returned home, a Transfer and Resumption of Care (ROC) is required within 2 calendar days after learning of the inpatient stay. In this situation, a Transfer is required; and, since the timeframe to complete the ROC 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 certification period? [Q&A EDITED 10/23; EDITED 05/22; EDITED 10/18]

A5. In your example (and assuming no physician-ordered ROC date is provided), if the patient was 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 Q3.01 in this category.

Q5.1. As long as the RFA 4, Recertification OASIS M0090 - Date Assessment Completed date is within the 5-day window, can you visit on day one of the 5-day window and complete the assessment (M0090) on any of the other days if you were still gathering data? [Q&A EDITED 11/24; EDITED 10/23; EDITED 05/22; ADDED 01/11; Previously CMS OCCB Q&A 04/10 Q3]

A5.1. Per the Condition of Participation, §484.55, the agency must perform a comprehensive assessment for the patient no less frequently than the last 5 days of every 60 days beginning with the start-of-care date. The time period for the RFA 4, Recertification, has been further

clarified in a number of references, and Category 3 CMS OASIS Q&As to mean the last 5 days of every 60 days, i.e., days 56-60 of the current 60-day certification period.

A clinician may start the comprehensive assessment on day 56 and complete it on any day on or before day 60.

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? [Q&A EDITED 05/22; REVIEWED 09/09]

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

Q7. [Q&A RETIRED 05/22]

Q8. [Q&A RETIRED 05/22]

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 a comprehensive assessment? Will this visit be reimbursed by Medicare? [Q&A EDITED 05/22; EDITED 09/09]

A9. Under Medicare PPS (PDGM), a visit can be made for only the purpose of performing a comprehensive assessment including OASIS, but it will not be considered a billable visit unless appropriate skilled services are performed.

Q10. What if the patient refuses a visit during the 5-day recert window? [Q&A EDITED 05/22; 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. 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.

Q11. If an agency misses the recertification assessment window of day 56-60, yet continues to provide skilled services to the 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 EDITED 11/24; EDITED 05/22; ADDED 06/05; EDITED 9/09; Previously CMS OCCB Q&A 10/04 Q1]

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 timeframe 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. 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 (PDGM) 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 certification period 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 EDITED 11/24; EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 07/11 Q4]

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 after the oversight is identified. In the situation described, you needed to recertify for the visit that was needed and justified by the patient's condition in the new 60-day certification period. The recertification comprehensive assessment supports the patient's need for services, and for the Medicare patient, the recertification OASIS drives the payment for that period. If the clinician determined the patient was ready for discharge on the first visit in the new certification period, 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 a 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 M0090 - Date Assessment Completed and what documentation should the agency include in the record? [Q&A EDITED 10/23; EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 07/13 Q2]

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 - Date Assessment Completed is the last date that information used to complete the comprehensive assessment and determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed. Clinical documentation will explain the events leading to the late Recertification.

Q11.1.2. The home health 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 EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 04/14 Q3]

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 an error message 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 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 period? [Q&A EDITED 11/24; EDITED 05/22; ADDED 01/12 to Cat. 3; Previously CMS OCCB Q&A 07/11 Q4]

A11.2. Whenever you discover that you have missed completing a recertification assessment within the required timeframe (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, conduct a recertification comprehensive assessment including OASIS. You will receive a warning message when submitting the assessment.

Q11.3. We missed completing a recertification assessment on a patient between days 56-60. During the first visit in the new certification period, 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 EDITED 11/24; EDITED 10/23; EDITED 05/22; ADDED 12/12; Previously CMS Qtrly Q&A 04/12 Q11]

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 and for the Medicare PPS (PDGM) patient it will establish the PPS payment code for the next 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.

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 (no recert completed), is in an inpatient bed longer than 24 hours, but only for diagnostic testing; no Transfer OASIS had been completed? [Q&A EDITED 05/22; ADDED 12/12; Previously CMS Qtrly Q&A 10/12 Q1]

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

Q11.5. We had a patient who was readmitted back to the hospital. They were discharged back home on 5/12 and the certification period ended on 5/14. The patient refused to have the agency come into the home during this time to do a resumption/recertification. We plan to go out today 5/15 or tomorrow 5/16, depending on what the patient will allow. Should we do a ROC/Recert or a new start of care (SOC)? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 07/19 Q2]

A11.5. Regulations require a Resumption of Care (ROC) visit within 48 hours of the discharge from the inpatient facility or on the physician-order ROC date. In the situation described, since the timeframe to complete the ROC overlaps with the timeframe to complete the Recertification, the ROC assessment should be completed, fulfilling both the ROC and Recert requirements.

In the scenario provided, since a visit did not occur within the ROC/recert timeframe, the ROC/recert assessment should be completed as soon after this period as possible. 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 (PDGM) patient, payment implications may arise from this missed assessment. Any payment implications must be discussed with the agency's Medicare Administrative Coordinator (MAC).

Q12. What are the indications for an 'Other follow-up' (RFA 5) assessment? [Q&A EDITED 05/22; EDITED 08/07]

A12. A comprehensive assessment including OASIS 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 (ROC) assessment is performed, does the clock 'reset' with respect to follow-up assessment, i.e., is the follow-up due 60 days after ROC or does it remain 60 days from the original Start of Care date? [Q&A EDITED 10/23; EDITED 05/22; REVIEWED 09/09]

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.

Q14. [Q&A RETIRED 05/22]

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

Q16. [Q&A RETIRED 11/24]

Q17. I am trying to find clarification on how to use RFA 5 for decline or improvement. When I review the OASIS time points section of the OASIS Manual, it refers to RFA 5 as a significant change in condition. 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 EDITED 11/24; EDITED 05/22; EDITED 04/15; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q6]

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, Other Follow-up assessment, in order to be compliant with the Medicare Conditions of Participation §484.55. 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, and which no longer exists.

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 after the SOC they 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 reassess the patient's status after the major change in status.

Q18. [Q&A RETIRED 05/22]

Q19. [Q&A RETIRED 05/22]

Q20. Is the RFA 5 - Other follow-up being used for payment under PDGM? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/19 Q9]

A20.The Other follow-up assessment may be used by agencies when a patient experiences a significant change in condition that was not anticipated in the patient's plan of care and would warrant an update to the plan of care. Under PDGM, if the M0090 - Date Assessment Completed for the RFA 5 is before the start of a subsequent, contiguous 30-day period and results in a change in the functional impairment level, the second 30-day claim would be grouped into its appropriate case-mix group. HHAs must be sure to update the assessment completion date on the second 30-day claim if a follow-up assessment changes the case-mix group.

Q21. Under PDGM, if a patient experiences a significant change and we complete an RFA 5 - Other follow-up assessment that changes the functional grouping for the initial 30-day period thus resulting in a different case mix grouping, can we resubmit the original claim? [Q&A ADDED 05/22; Previously CMS Qtrly 10/19 Q10]

A21. No, similar to PPS, the case mix group cannot be adjusted within each 30-day period, but completion of an RFA 5 - Other follow-up may impact payment for a subsequent 30-day payment period. HHAs must be sure to update the assessment completion date on the second 30-day claim if a follow-up assessment changes the case-mix group to ensure the claim can be matched to the Follow-up assessment. HHAs can submit a claims adjustment if the assessment is received after the claim has been submitted and if the assessment items would change the payment grouping. Questions related to claims processing may be directed to the HHA's Medicare Administrative Contractor.