

CATEGORY 3 - FOLLOW-UP ASSESSMENTS

Q1. When is a recertification (follow-up) assessment due for a Medicare/Medicaid skilled care patient?

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. [Q&A EDITED 08/07]

Q2. What are the requirements for follow-up comprehensive assessment for pediatric and maternity patients where the payer is Medicaid?

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). [Q&A EDITED 08/07]

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?

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. M0826 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.gtso.com/download/OASISConsidForMedicarePPSPatRev.pdf>

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 <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf>; scroll to page 94 of the document to read "Section 80 - special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your RHHI. [Q&A EDITED 08/07]

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 [Q&A RETIRED 08/07; Outdated.]

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?

A5. In your example, 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.

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?

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/download/hha/oasiscal2007.pdf> and download 'Scheduling OASIS Follow-up Assessment' under OASIS. 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. [Q&A EDITED 08/07]

Q8. Is it necessary to make a visit in order to complete the follow-up reassessment?

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. [Q&A EDITED 08/07]

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?

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 Regional Home Health Intermediary (RHHI).

Q10. What if the patient refuses a visit during the 5-day recert window?

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 your Regional Home Health Intermediary (RHHI). [Q&A EDITED 08/07]

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?

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 RHHI. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #1] [Q&A EDITED 08/07]

Q12. What are the indications for an 'other follow-up' (RFA 5) assessment?

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. [Q&A EDITED 08/07]

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.gtso.com/download/OASISConsidForMedicarePPSPatRev.pdf>

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.

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. 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 reassess the patient's status after the major change in status. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #6]