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 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?

A2. All pediatric, maternity, and patients receiving only personal care, chore, and housekeeping have been exempt from the OASIS data collection requirements; however, the agency must still perform a 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?

A3. Effective October 1, 2004, the rules for the simplified method of handling a SCIC following an inpatient facility stay during the last 5 days of an episode changed. When the patient returns to the agency during the last 5 days of an episode, the ROC assessment should be completed and M0825 should forecast the subsequent episode. You can find the instructions (mentioned above) for handling this type of situation at http://cms.hhs.gov/oasis/oasispps.asp, scroll down to "OASIS Considerations for Medicare PPS Patients," (revised June 2004) and click on the link to the zip file. The information you are seeking is #4.

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/104_claims/clm104c10.pdf; scroll to page 89 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 06/05]

Q4. We tried to enter a recertification assessment in HAVEN for a patient who has been on service since before PPS. HAVEN displayed the following error message: 'WARNING: Inconsistent M0090 date: RFA 04 (M0090) does not meet HCFA timing guidelines. RFA 04 must be done on an every 60-day cycle; (M0090) is no earlier than day 56 and no later than day 60 of that follow-up cycle.

A4. The Final Rule for PPS published in the Federal Register on July 3, 2000 (65 FR 41128) revised the assessment timing requirements for the scheduling of OASIS follow-up assessments. Specifically, on page 41221, the OASIS schedule was changed from
an interval requiring a follow-up assessment every two months to a 60-day assessment schedule. This revised assessment interval will cause warning messages related to timing on OASIS follow-up assessment records to appear on the validation report produced by the State when the assessment is submitted for patients with a start of care prior to October 1, 2000. The warning message results from the fact that the software will calculate due dates for follow-up assessments according to the new 60-day follow-up schedule, regardless of whether the start of care date is before or after October 1, 2000. In this situation, the warnings can be ignored with no consequence to the home health agency. The specific warning message generated by the State system (message number 262) cautions that the follow-up assessment completion date (M0090) does not meet the CMS 60-day timing guidelines. The system edit that determines whether to generate this warning message considers the 60-day follow-up assessment schedule only. It is unable to consider the two-month schedule in effect prior to October 1, 2000. For that reason, the message can be ignored. See the OASIS/PPS web page at http://www.cms.hhs.gov/oasis/oasispps.asp under 'OASIS considerations for Medicare PPS patients' and 'OASIS considerations for non-Medicare PPS patients' for additional information related to timing issues.

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 our OASIS/PPS web page at http://www.cms.hhs.gov/oasis/oasispps.asp and look for ‘Scheduling OASIS Follow-up Assessment.’ There you may click on the link to ‘OASIScalendar.zip or the link to the current year calendar in pdf file, either of 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?

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 Medicare patients.

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 window? What happens then?

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 close to 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).

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 of the assessment, 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 RHII.

[Q&A added 06/05]

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. For Medicare PPS patients, this type of assessment may result in an agency's decision to request a SCIC payment adjustment. The decision to request a SCIC payment adjustment can only be made based on the completed comprehensive assessment and the SCIC guidelines stated in the Federal Register, at the listing cited below. After the assessment is completed, the agency must determine whether or not it is appropriate to request a SCIC payment adjustment, taking into consideration all of the guidelines pertaining to SCICs. To read the relevant parts of the conditions of participation (CoP) in the Federal Register on the PPS web site (which contain the guidelines for requesting a SCIC payment adjustment), go to http://www.cms.hhs.gov/providers/hha/#oasis and click on "Home Health Agency Prospective Payment System Policy Issues and Regulations." Scroll down and click on the link, "Final Rule - Prospective Payment System published July 3, 2000." Scroll down and click on the link next to "VIII. Regulations Text." The text specific to SCIC payment adjustment begins in section 484.205(a)(3) on page 450, then section 484.205(e) on page 453, and section 484.237 on page 459. It is very important that clinical, billing, and administrative staffs understand and work together in implementing these guidelines.

Q13. If a resumption of care assessment is performed, does the clock 'reset' with respect to follow-up survey, 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 information on our OASIS/PPS page, http://www.cms.hhs.gov/oasis/oasispps.asp under OASIS Considerations for Medicare PPS patients.
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. It is our understanding that the HHA must obtain the verbal order for recertification from the physician after the follow-up comprehensive assessment is completed. This assessment must be done within five days of the recertification date. What action must the HHA take if the physician is unavailable (e.g., a long holiday weekend) to provide the required verbal order? If another physician were unwilling to provide the recertification order, should we discharge the patient at the recertification date and reopen the case when we have the required verbal order?

A15. We suggest that in planning visits from the start of care you identify, with plenty of lead-time, those recertification dates that will fall on a holiday weekend. Having done that, plan to complete those assessment visits on the first day of the five-day window. Failing that, we suggest that you explain to the covering physician your inability to continue providing care beyond the recertification date without approval, and perhaps ask her/him to agree to sign orders to continue care for a shorter period of time (e.g., 1-2 weeks, until the primary physician returns). Physician vacations or other absences have always occurred, so we encourage you to look at how your agency has dealt with these situations in the past and apply that in solving similar problems with somewhat different regulations. Many agencies will find they need to review, and possibly revise, several of their previous policies and procedures in successfully implementing efficient OASIS data collection. Refer to the OASIS User's Manual, Chapters 5, 6, and 9 for more guidance in this area which is available on our website at http://www.cms.hhs.gov/oasis/usermanu.asp.

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).