OASIS Assessment Changes in PDGM (and COVID-19 PHE)  
MAHC, April 2020

Learning Outcomes

• Describe OASIS time points for data collection and PDGM considerations
• State the purpose and criteria for a Significant Change in Condition and Other Follow-up OASIS
• Discuss pros and cons of doing a SOC versus a ROC and impact on PDGM payment

Review of Regulations, Guidance and PDGM

Initial Assessment CoP

• Initial means FIRST visit to the patient’s residence
  • Must be conducted by RN, unless therapy only case
  • Therapy only? For Medicare, the PT or SLP may perform initial visit
• Conditions of Participation require the initial assessment to determine the patient’s eligibility for home care services and immediate care needs; and must be conducted either:
  • Within 48 hours of date of referral, OR
  • Within 48 hours of return home from inpatient facility, OR
  • On the physician-ordered SOC or ROC date
• Initial assessment vs. SOC visit dates for Timely Initiation of Care
Comprehensive Assessment CoP

- Must be completed in a timely manner
- Consistent with patient’s immediate needs
- No later than 5 days after SOC (SOC is day 0)
- May NOT be started prior to SOC (first billable visit)
- RN only, unless therapy only case
- May perform initial assessment and comprehensive assessment on same visit (usually what happens) or on different visits
- If no skilled service is delivered by the RN, the visit is not the SOC or reimbursable (will not be accepted by CMS as the SOC)

PHE Waiver

- Due to the COVID-19 Public Health Emergency, CMS has waived the Home Health Condition of Participation under 42 CFR §484.55(a) regarding the initial assessment.
- This waiver for the COVID-19 PHE allows the agency to carry out the initial assessment and determine patients’ eligibility status remotely via phone call to the patient or by medical record review instead of making an actual in-person to the patient’s home. This determination must still be done within the 48 hours following referral or return home, but does not require a home visit within that time period.
- Watch your documentation of the initial assessment via telehealth!

PHE Waiver

- The Start of Care (SOC) comprehensive assessment is the required in-person clinical assessment of the patient’s physical, functional, mental, psychosocial, and cognitive status to identify the needs of the patient and caregiver that will be addressed by the home health agency’s services. This comprehensive assessment includes the collection of OASIS data.
- This comprehensive assessment must be completed within a specific time frame after the SOC date (first reimbursable visit): prior to the COVID-19 PHE, agencies had a 5 day window to complete data collection for the SOC comprehensive assessment – under the COVID-19 PHE changes, the time frame to complete the SOC comprehensive assessment has been extended to 30 days following the SOC date.
- Must be an actual in person visit to the patient – may NOT be done remotely via telehealth means

Comprehensive assessment updated or revised

- Not less frequently than the last 5 days of every 60 day episode beginning with the SOC date (days 56-60) (Follow-Up for Recertification)
- Within 2 days of a major decline or improvement in condition (Other Follow-Up)
- Within 48 hours of patient’s return home from an inpatient facility admission of 24 hours or more for reasons other than diagnostic tests (ROC)
- At discharge, completed within 2 days (DC)
M0100 RFA 5 Other Follow-Up

- Due to a major decline or improvement in patient condition (Other Follow-Up)
  - Updates the patient’s plan of care
  - No CMS definition of a Significant Change in Condition
  - Your policy dictates when you have to do an Other FU assessment
    - Has the patient improved or deteriorated beyond your expectations?

Transfer to Inpatient Facility

RFA 6 - Transfer not DC
- Inpatient admission of 24 hours or longer
- Reasons other than diagnostic tests
- Patient expected to resume care
- Does not require a home visit
- If patient does not return, a DC OASIS is not required (a DC summary is required)

RFA 7 - Transfer with DC
- Inpatient admission of 24 hours or longer
- Reasons other than diagnostic tests
- Not expected to return to home care or does not return by the end of the episode
- Does not require a home visit

Transfer to Inpatient Facility

- What if we complete an RFA 6 Transfer to Inpatient Facility without Discharge and the patient does not return to home care agency?
  - No need to cancel and change to RFA 7 Transfer with Discharge
    - Patient will remain in data system for 6 months, a new SOC will be flagged on OASIS submission but not rejected

PDGM Payment Components

From the claim:
- Timing: Early or Late
  - 30-day payment period
- Admission source: Community or Institutional
- Clinical Grouping from Principal Diagnosis
- Comorbidity Adjustment – secondary diagnoses (up to 24)

From OASIS data:
- Functional Score: only part of payment equation from OASIS data
### Clinical Grouping from Primary Dx
- In PDGM, principal and secondary diagnoses will pull from the claim, not from OASIS.
  - Up to 25 codes accepted on claim.
  - Primary dx → determines clinical grouper.
  - Secondary dx → adds comorbidity adjustment.
- If the code is not in the Clinical Group list, it is not acceptable as a PRIMARY code, can still be secondary dx.
- Ensure that clinical documentation supports ALL diagnoses.

### OASIS Functional Items
- M1033  Risk for Hospitalization
- M1800  Grooming
- M1810/1820  Upper/Lower Body Dressing
- M1830  Bathing
- M1840  Toilet Transferring
- M1850  Bed Transferring
- M1860  Ambulation/Locomotion

Functional score derived from last OASIS transmitted, usually SOC or Follow-up for Recert but may be ROC or Other Follow-up in PDGM.

### HIPPS Code (Payment Calculation) in PDGM
- HH completes assessment and submits OASIS to iQIES.
- HH can submit any valid HIPPS on RAP.
- Submits claim at end of 30-day payment period (billing requirements met).
- iQIES will send the OASIS data for functional items only to claims system.
- Claims system will combine these items with claims data (diagnosis codes, whether it is a first period of care, and whether there’s an inpatient DC within 14 days before the ‘from’ date.
- Grouper is within the claims system and will replace any HIPPS code submitted by HHA. Claims system will check for any other admissions (both HH and inpatient).

### Requirement for Other Follow-Up
- § 484.55(d) states that a marked improvement or worsening of a patient’s condition, which changes, and was not anticipated in the patient’s plan of care would be considered a “major decline or improvement in the patient’s health status” that would warrant update and revision of the comprehensive assessment.
  - Within 2 days of knowledge of the change in condition.
  - CMS does not define criteria – up to the agency.
  - What’s your agency’s policy for a SCIC?
Other Follow-Up PDGM Considerations

- Not required to update diagnoses. If only the diagnosis is changed, no need to complete an Other Follow-up
- SCIC: Major improvement or decline in a patient’s condition that was not envisioned in the original POC.
- If a significant change in condition occurs that was not anticipated and warrants a change in the POC, complete the Other Follow-Up.
- If completed before the start of a subsequent contiguous 30-day period and results in change in the functional level, the second 30-day claim would have a change in the case-mix group.
- Do not update the current 30-day claim. Update the assessment completion date (M0090) on the second 30-day claim.

October 2019 CMS Quarterly Q&A#8

- QUESTION 8: Does CMS expect an RFA 5 - Other follow-up OASIS assessment in order to support a change in primary and/or other diagnoses on the claim for the second 30-day payment period under PDGM?
- ANSWER 8: When diagnosis codes change between one 30-day claim and the next, there is no requirement for the HHA to complete an RFA 5 - Other follow-up assessment to ensure that diagnosis coding on the claim matches to the OASIS assessment. The CoP 484.55(d) does require an RFA 05 when there has been a major improvement or decline in a patient’s condition that was not envisioned in the original Plan of Care. CMS expects agencies to have and follow agency policies that determine the criteria for when the Other Follow-up assessment is to be completed.

October 2019 CMS Quarterly Q&A#9

- QUESTION 9: Is the RFA 5 - Other follow-up being used for payment again under PDGM?
- ANSWER 9: 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.

October 2019 CMS Quarterly Q&A#10

- QUESTION 10: 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?
- ANSWER 10: 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.
**Action Item**

- What is your agency's policy for a SCIC?
- How often do you do an RFA 5 Other Follow-up?
- Do you need to reconsider the criteria to trigger a SCIC?
  - What's the purpose of doing an Other Follow Up?
  - What types of events or circumstances might result in a change in functional score?

**Potential Criteria for a SCIC**

- What about:
  - New wound?
  - Increased pain?
  - Falls?
  - Repeated hospitalizations or ED visits?
  - New diagnosis?
  - New caregiver / environment?
- Change in patient's functional ability on two or more ADLs

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**60-Day Plan of Care – two 30-Day Payment Periods**

The SOC and Recert OASIS Timepoints are the only assessments necessary, EXCEPT if there is a ROC or a significant change in the patient's condition. The SOC will determine the HIPPS on the first and second claim, except if there has been a ROC or OFU.

**Functional Score & the 30-Day Period**

- Start of care: Functional score from SOC OASIS would be used for determining the functional impairment level for both the *first and second* 30-day periods.
- The follow-up OASIS completed near the time of recertification would be used for the *third and fourth* 30-day periods of care.
- If there was a hospitalization in the first 30-day period, the ROC would be used to determine functional score in the *second* 30-day period.
- If there was an Other Follow-Up in the first 30-day period, the Other FU would be used to determine functional score in the *second* 30-day period.
60-Day Plan of Care - two 30-Day Payment Periods

If there is a ROC there may be a change on the next RAP and claim. If there is a significant change in the patient’s condition requiring an Other Follow Up assessment there may be a change on the next RAP and claim. The recert will be used for the RAP and claim for the upcoming certification period.

Institutional or Community

- Depending on whether an acute or post-acute healthcare setting was utilized in the 14 days prior to home health

  Institutional
  - Inpatient acute care hospitals
    - NOT observation stays
    - NOT ER visits
    - SNF (Skilled Nursing Facility)
    - IRF (Inpatient Rehab Facility)
    - LTCH (Long Term Care Hospital)
    - IPF (Inpatient Psych Facility)
  - Rationale for higher payment: Sicker upon admission, being discharged rapidly back to community and are more likely to be re-hospitalized, have more functional decline

14 Days

- “From” date, then count back with the day before as day one.
- “From” date is January 20
- January 19 is day 1.
- 14-day period is January 6 through January 19.
- Have there been inpatient discharges January 6 through January 19?

Count back 14 days...

“From” date, then count back with the day before as day one.
“From” date for next pay period is January 31. January 30 is day 1. 14-day period is January 17 through January 30. Have there been inpatient discharges January 17 through January 30?
**Institutional**

- Inpatient acute hospital or post-acute (SNF, LTCH, IRF, inpatient psych) discharge in the 14 days prior to home health admission (SOC)

  PLUS

- Acute care hospital stay during a previous 30-day period and a discharge date within 14 days prior to a subsequent, contiguous 30-day period of care and for which the patient was not discharged from HH and readmitted (which means RFA 6 Transfer without DC and RFA 3 ROC)

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**NOT Institutional—PAC Discharge**

- **Not institutional**: post-acute care stays, meaning SNF, IRF, LTCH, or IPF stays, that occur during a previous 30-day period of care and within 14 days of a subsequent, contiguous 30-day period of care

- CMS recommends (but does not require) the patient to be discharged and then readmitted if returns to home care

- If the patient was discharged and then readmitted to home health, the admission date and “from” date on the 30-day claim would match and the claims processing system will look for an acute or a post-acute care stay within 14 days of the home health admission date.

  - New admission = institutional
  - ROC = community

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**April 2020 CMS Quarterly Q&A #3**

- There is no change in OASIS guidance in how agencies may use M0100 RFA 6 and 7 when a home health patient is admitted for an inpatient stay. In the event that a patient had a qualifying hospital admission and was expected to return to your agency, you would complete RFA 6 – Transferred to an inpatient facility – not discharged from agency. If the patient was not expected to return to your agency after this inpatient hospital stay, you would complete RFA 7- Transfer to an inpatient facility- patient discharged from agency.

- However, if the patient requires post-acute care in a SNF, IRF, LTCH or IPF during the 30-day period of home health care, CMS expects and recommends (but does not require) the home health agency to discharge the patient by completing the RFA-7 (Transfer to an inpatient facility- patient discharged from agency) and then to readmit the patient with a new Start of Care upon return to home care. If the home health agency decides to complete an RFA-6 (Transfer to an inpatient facility- patient not discharged from agency), the home health agency will need to complete an RFA-3 (Resumption of Care) upon return to home care.

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**Examples**

1. Patient goes to ER and is admitted to acute inpatient hospital on day 17 of 30-day period. Discharged after 4 days on day 21.
   
   - **ROC**: the NEXT 30-day period will be Institutional Late, use functional score from ROC OASIS, diagnosis changes from ROC interim order
   
   - **New SOC**: begins a new initial episode of care, new certification period, requires new F2F. The initial 30-day period will be Institutional Late, use functional score from SOC OASIS. You may have a partial payment adjustment on the original 30-day payment in which the patient was hospitalized.

2. Patient goes to ER and is admitted for observation. Released 2 days later.
   
   No Transfer, no ROC or new SOC, and no change to Institutional payment.
Partial Episode Adjustments becomes Partial Payment Adjustments (PEPs→PPAs)

- Agency meets patient goals before the end of the payment period and discharges. Patient is readmitted to same agency within same 30-day payment period.
- Agency receives days of services divided by 30 as a PPA
- Example: Agency completes 3 weeks of therapy as ordered by physician and discharges on day 22 (last billable visit). Patient falls and is readmitted on day 28.
- Agency receives 22/30 payment for payment period 1.
- New SOC begins new 30-day payment period and is considered Late.

Partial Payment Adjustments (PPAs)

- Agency meets patient goals before the end of the payment period and discharges. Patient is readmitted to same agency outside of the 30-day payment period, e.g., day 2 of next 30 days.
- Agency receives entire 30 day payment for first 30-day period
- Example: Agency completes 3 weeks of therapy as ordered by physician and discharges on day 22 (last billable visit). Patient falls and is readmitted on what would have been day 2 of the next 30 days.
- Agency receives full payment for payment period 1.
- New SOC begins new 30-day payment period and is considered Late.
Examples

<table>
<thead>
<tr>
<th>Example #1 Two inpatient stays</th>
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<tbody>
<tr>
<td><strong>Has inpatient stay</strong></td>
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<tr>
<td><strong>Has SNF stay</strong></td>
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<tr>
<td><strong>Admitted to HH</strong></td>
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<tr>
<td><strong>Report occurrence code 62. Both DCs within 14 days but SNF is most recent.</strong></td>
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<tr>
<td><strong>2/14 admission is grouped as Early/Institutional</strong></td>
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</tbody>
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Example #2 ROC after Inpatient Stays

| Admitted to HH | 01/15/2020 |
| Inpatient hospital stay | 02/01/2020 – 02/04/2020 |
| SNF stay | 02/05/2020 – 02/10/2020 |
| Resumes HH | 02/11/2020 |
| Second period of care starts | 02/14/2020 |
| Report occurrence code 61; hospital stay is within 14 days |
| SNF is closest but occurrence code 62 can only be reported on admission claims |
| 02/14 period grouped as Late/Institutional |

Example #3 ROC after Inpatient Stay with DC >14 days prior

| Admitted to HH | 01/15/2020 |
| Inpatient hospital stay | 01/19/2020 – 01/22/2020 |
| Resumes HH | 01/23/2020 |
| Second period of care starts | 02/14/2020 |
| No inpatient discharge in 14 days prior to the from date on the subsequent 30-day payment period |
| Option to do SOC or ROC. |
| ROC: 02/14 period grouped as Late/Community |
| New SOC: New HH episode starts with SOC 1/23, grouped as Late/Institutional, but potential impact of PPA (partial payment adjustment) if SOC chosen |
**Example #4 DC and readmit after Other Inst Stay**
- Discharged from HH 03/20/2020 to IRF
- Discharged from IRF 03/27/2020
- Readmitted to HH 03/31/2020
- No 60-day gap so Late
- Occurrence code 62 because this an admission ("From" and "Admission" dates match on claim)
- 03/31 admission grouped as Late/Institutional

**Example #5 Other Inst Stay during HH Period**
- Admitted to HH 03/20/2020
- Has an IRF stay 03/27/2020 – 04/09/2020
- Resumes care at the HHA 04/10/2020
- Second period of care starts 04/19/2020
- ROC after PAC discharge does not get institutional admission source
- Only acute hospital discharges are grouped as institutional for continuing periods of care
- The 04/19 period would be grouped as Late/Community

**Example #6 Under Observation**
- Observation in hospital 02/01/2020 – 02/03/2020
- Admitted to HH 02/04/2020
- Occurrence code does not apply, since the patient was not admitted to the inpatient hospital
- Grouped as Early/Community

**Example #7**
- Patient admitted to home care on 1/1. He is admitted back to the hospital on 1/4 and returns to home care on 2/8. Next payment period begins on January 31. Counting back 14 days is January 17 (our DC is not within 14 days of the new payment period). What do we do?
- Was the patient an institutional payment already (was admitted to home care from hospital)?
- Yes—complete a ROC (will continue as institutional for the rest of the payment period)
- No—complete a SOC (a new admission within 14 days of a DC will be institutional, but will PEP your previous payment)
Example #8

• Patient admitted to home care on 1/1. He is admitted to the SNF on 1/4 and returns to home care on 1/8. Next payment period begins on January 31. Counting back 14 days is January 17 (our DC is not within 14 days of the new payment period). What do we do?
• Was the patient an institutional payment (hospital) already?
  • Yes—complete a ROC if hospital DC was within 14 days (will continue as institutional for the rest of the payment period. Put Occurrence code 61 on claim)
  • No—complete a SOC if PAC DC was within 14 days (will be institutional with occurrence code 62 on claim. Will PEP your previous payment period)
• No—complete a SOC (a new admission within 14 days of a DC will be institutional, but will PEP your previous payment)

Do we have to make changes at the 30-day time point?

• Claims Processing Manual: In general, a RAP and a claim will be submitted for each period of care. *Each claim must represent the actual utilization over the period.*
• An OASIS is not required to change the diagnoses on the RAP and 30-Day claim.
• The Other FU (RFA 5) is not required if the patient does not meet the agency criteria for a SCIC.
• What’s the benefit of doing an Other Follow-up?
30-day Update - Purpose
• Identify any changes in diagnoses during the current payment period (days 1-30) for the next RAP and claim (days 31-60)
• Identify any changes in focus of care or services for days 31-60, re-sequence diagnosis list if needed
• Capture any changes to the claim for current payment period (days 1-30), which will be unusual
• Identify any changes due to a ROC or SCIC (double check to make sure nothing missed)
  • ROC OASIS completed?
  • ROC order written with any diagnosis changes?
  • Have SCIC criteria been met (significant changes in functional score) and no Other Follow-up completed? (Remember: no OASIS needed for diagnosis changes only!)

30-day Update - Information
• Any new diagnoses
• Any exacerbated diagnoses/conditions
• Any resolved conditions
• Any change in focus of care for days 31-60
• Any new or discontinued medications
• Any verification of diagnoses present since the start of the current payment period that were verified late (after the RAP for days 1-30 was filed)

Updating Diagnoses at the 30 Day Mark
• New diagnoses (order required)
  • An Other Follow-Up is NOT required (see regulation, reminder: dx from claim)
  • ROC may be applicable
• Changed diagnoses (order required)
  • An Other Follow-Up is NOT required
  • ROC may be applicable
• Resolved diagnoses (no order required)
  • Remove these from the diagnosis list

30-Day Update – Diagnosis list
• The diagnoses from the home health claim are used to group a 30-day home health period of care into a clinical group and to determine if there is a comorbidity adjustment.
• If a home health patient has any changes in diagnoses (either the principal or secondary), this would be reflected on the home health claim and the case-mix weight could change accordingly.

So, do we have to change the diagnosis on the claim for the second 30-day payment period?
In general, a RAP and a claim will be submitted for each period of care. Each claim must represent the actual utilization over the period.

- Wound care is the focus for days 1-30, wound heals before day 30
- If care continues with the same provider for a second period of care, the RAP for the second period may be submitted even if the claim for the first has not yet been submitted.
- For days 31-60, focus changes to DM management

30-Day Update - Process

- How will you track this information? Does your software system have tools that will help?
- Who is going to review the record?
  - The case manager – use an ongoing tracking tool to turn this in on day 30? The clinical manager?
  - The biller – does he/she know what to look for in clinical notes?
  - The coder – does the coder really need to check every case, or just those with changes in diagnosis or meds?

CMS expects that the HHA clinical documentation would also reflect these changes and any communication and/or coordination with the certifying physician would also be documented.

30-Day Update - Process

Who is doing pre-billing audit?
How does the coder know something needs to be changed?
How does that change get communicated to the biller to put it on the claim? The next RAP?

New/changed diagnosis at mid-point of certification episode

- On Day 21 of the certification episode, the patient has increased shortness of breath, 4 lb weight gain overnight, pulse ox of 88 on room air and LE edema identified on assessment. RN contacts physician per parameters, he confirms exacerbation of acute on chronic combined systolic and diastolic heart failure and orders medication changes; RN writes interim order including diagnosis and ordered interventions. The patient does not meet the agency P&P criteria for a SCIC so no Other FU OASIS is done.
- What should the agency do at the end of the first 30-Days?
New/changed diagnosis at mid-point of certification episode

An OASIS is not required to change the diagnoses on the next RAP and 30-Day claim.
• The Other FU is not required on Day 21 if the patient does not meet the agency criteria for a SCIC.
• At the end of Day 30, assuming the POC is returned signed and all other billing requirements are met, the claim for the first 30-Day payment unit can be billed. Is the heart failure dx coded as exacerbated?
• The interim order identifies an updated diagnosis that will be placed on the RAP for the second 30-Day payment unit, which can be filed after the first visit is made on/after Day 31.

More than just a PDGM issue...

• Care coordination, collaboration on patient progress
• Evaluate quality performance
  • Compare scores to SOC/ROC
  • Update patient/caregiver goals, DC plan
• Revisions to Plan of Care needed?
  • Determination of recert vs discharge
  • Evaluation of progress toward goals
  • Importance of avoiding “early” discharge
• How to manage physicians to continue home care vs advance to outpatient services?

Putting it all together

Patient referred 3/30 to HH for exacerbation of COPD, pneumonia and possible COVID-19 exposure while in hospital. The patient comes home 3/31 with orders to quarantine for 14 days, the agency is to perform telehealth/virtual visits until the test results are back. Initial assessment is done by phone 4/1, determines patient meets eligibility requirements, agency calls patient daily first 6 days until test results return negative. SOC comprehensive assessment and skilled care provided on 4/7. SN frequency for home visits 2wk1, 1wk5 and telehealth visits 3wk1, 2wk5. Date of initial assessment? _______ SOC date? _______
What is needed on the POC in addition to frequency of visits?

Putting it all together

• Patient falls 4/12 and goes to the ER, severe hip pain, no fractures, new walker, SN gets order for PT eval. Do a SCIC?
• PT does eval 4/14, initiates treatment, patient falls again and fractures hip, admitted to acute care hospital (inpatient) for ORIF 4/18. Transfer?
• Patient discharged from hospital back home on 4/24. OASIS assessment type? Why?
• Patient’s pulmonary status is improved, lungs clear on hospital xray, MD documents pneumonia resolved. 30-day update on 5/7: what changes?
• Patient progresses with therapy, ADLs improve, then gets another cold and slows progress, 5/20 is more dependent for ADLs again, on antibiotic. SCIC?
• Admitted to ACH 5/24, goes to SNF 5/28, discharged home 6/20 with return to HH. What types of OASIS are required and on what dates?
Thank you for attending!