Clover Health

Policy Title	OASIS Documentation Requirements for Home Health Reviews
Policy Department	Utilization Management / Payor Operations
Effective Date	10/1/2026
Revision Date(s)	N/A

Disclaimer:

Clover Health applies CMS criteria and guidelines, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Clover Policies, and applicable Medicare and Medicaid regulations when determining coverage and medical necessity.

Purpose:

This policy establishes Clover Health's requirements for the submission and review of OASIS documentation supporting Home Health authorization requests, concurrent reviews, continued stay reviews, and retrospective post-payment billing audits.

Definitions:

OASIS: Standardized CMS assessment instrument for Home Health episodes.

Qualified Clinician: RN, PT, OT or SLP authorized to complete OASIS assessments.

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Policy:

1. General Requirements

Completed OASIS assessment(s) are required for all Home Health utilization review requests, including prior authorization, concurrent review, and retrospective post-payment audits, whether conducted as a clinical medical necessity review, a claim payment review, or both. The OASIS must be completed by a qualified clinician as defined by CMS (RN, PT, SLP, or OT as applicable), finalized in the Electronic Health Record (EHR) or home health software package, and completely aligned with the multi-disciplinary Plan of Care (POC).

2. Mandatory Submission with Utilization Management and Audit Requests

Because Clover Health does not have direct access to the federal iQIES system to verify provider data, Home Health Agencies (HHAs) must submit clinical proof of the finalized OASIS assessment(s) directly to the plan alongside their corresponding authorization or audit intake documentation.

- **Submission Format:** The HHA must provide complete copies (preferrably CDA/CCDA or electronic PDF or standard EHR system print-out/export) of the finalized initial assessment as well as subsequent assessments throughout the entire length of service through the plan's approved submission channels
- **Utilization Management (UM) Reviews:** The electronic OASIS copy must accompany the prior authorization request, when available but at most within five (5) calendars from the Start of Care (SOC), and all subsequent assessments concurrent/continued stay review requests. Clinical information must be received within five (5) calendar days of the Start of Care (SOC) date or the requested extension date.
- **Post-Payment / Retrospective Audits:** In the event of a post-payment audit or retrospective review, the HHA must include the corresponding historical electronic OASIS copies within their structured audit response submission.
- **Administrative Penalty:** Failure to include the complete electronic OASIS document(s) with the clinical submission request will result in an immediate administrative denial for UM reviews, or a full retraction of payment for post-payment audits to the extent permitted by applicable law.

- **Non-Contracted / Out-of-Network Providers:** For non-contracted or out-of-network providers, Clover will apply applicable Medicare Advantage, Original Medicare payment, state-law, and provider-payment-dispute rules, including 42 CFR § 422.214 where applicable. Noncontract providers remain responsible for applicable Original Medicare claim, OASIS, and CMS/iQIES submission requirements. Clover may request clinical and billing records reasonably necessary to determine coverage, medical necessity, payment, or audit support; however, Clover-specific contractual manual-submission penalties will not be applied to noncontract providers unless permitted by applicable law, plan terms, or other enforceable provider agreement/deemed-provider arrangement.

3. Federal iQIES Validation and Compliance

- **Dual Submission Tracking:** Submitting the OASIS copy directly to Clover Health does not exempt the HHA from its federal mandate to transmit the assessment to CMS. The HHA must successfully submit and validate the assessment via the internet Quality Improvement and Evaluation System (iQIES).
- **Notice of Admission (NOA) Timeline:** The HHA must submit a Notice of Admission (Type of Bill 032A) to Clover Health within five (5) calendar days of the SOC date to establish the care episode.

4. Claims Matching and Billing Reconciliation

- **HIPPS Code Reporting:** The Health Insurance Prospective Payment System (HIPPS) code, generated directly from the validated OASIS assessment data, must be explicitly and accurately reported under Revenue Code 0023 on all 30-day period claims (Type of Bill 0329).
- **Claims Validation:** Payment of Type of Bill 0329 is contingent upon a matching, accepted OASIS assessment(s) submitted to the plan. Claims submitted with mismatched HIPPS codes, missing or invalid NOA data, or claims lacking the required accompanying OASIS documentation will face an administrative claim denial or trigger an immediate retrospective audit.

5. Explicit Patient Exemptions

Consistent with CMS guidelines, the OASIS submission requirements outlined in this policy do not apply to patients under the following criteria:

- Patients under eighteen (18) years of age.
- Patients receiving strictly pre-partum or post-partum maternity care.
- Patients receiving exclusively unskilled care (e.g., personal care, homemaker, chore, or custodial services only).

Claim Codes:

Submission of the bill types and revenue codes listed below does not independently establish coverage or payment eligibility. Medical necessity, homebound status, skilled care requirements, and the specific electronic OASIS submission requirements outlined in this policy must be fully satisfied.

Bill Types

- 032A – Home Health Notice of Admission (NOA)
- 0329 – Home Health Final Claim (30-Day Period)
- 0327 – Home Health Adjustment Claim
- 0328 – Home Health Void / Cancellation Claim
- 032D – Home Health Cancellation of Admission:
- 0320 – Home Health Non-Payment / Informational Claim: 34X- Home Health Outpatient Services
- 3XQ - Home Health Reopening
- 3XG or 3XI - Contractor Adjustment

Revenue Codes

- **0023 – Home Health Prospective Payment System (HH PPS):** Mandatory overall episode revenue code line item. This specific billing line must carry the exact 5-character Health Insurance Prospective Payment System (HIPPS) code generated directly by the validated OASIS assessment. Missing or mismatched HIPPS data on this line item will result in claim rejection.
- **All Discipline-Specific Visit Revenue Codes (0001, 0023, 027x, 042x, 043x, 044x, 055x, 056x, 057x, 062x):** While individual visit lines (e.g.,

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Physical Therapy, Skilled Nursing, Home Health Aide) do not independently trigger an OASIS submission, payment for these revenue codes during a clinical or claim payment review is entirely contingent upon the clinical necessity established within the corresponding period's OASIS assessment. Individual visit line items found to be unsupported by the OASIS clinical scoring will be subject to retrospective payment retraction.

References

42 CFR §§484.45 - Reporting OASIS Information

42 CFR §§484.55 - Comprehensive Assessment

42 CFR §§ 484.250 – Patient Assessment Data Submission Requirements

42 CFR §§484.245 - Home Health Quality Reporting Program

42 CFR 484.60- Care Planning, Coordination of Services, and Quality of Care

CMS Medicare Benefit Policy Manual Chapter 7 (Home Health Services)

CMS Medicare Claims Processing Manual Chapter 10 (Home Health Agency Billing)

CMS Medicare Managed Care Manual (Pub. 100.16), Chapter 4- Benefits and Beneficiary Protections

CMS OASIS Guidance Manual