OASIS Data Collection: Time Points, Patient Populations & Regulations

Sponsored by: Wyoming Department of Health Office of Healthcare Licensing & Surveys
Presented by: Linda Krulish, PT MHS COS-C OASIS Answers, Inc.
1:00-2:30 pm Mountain Time
OBJECTIVES:
Provide home health clinicians, managers, and auditors with a CMS-based update on OASIS data collection rules:

- **Data collection regulations** - Who in the agency can collect OASIS data?
- **Patient populations** - Which patients require OASIS data collection?
- **Time points** - What events occur that trigger OASIS data collection?

CRITICAL INSIGHT!

**INITIAL ASSESSMENT VISIT**
**COMPREHENSIVE ASSESSMENT**
**OASIS**
**START OF CARE DATE**

OASIS REGULATIONS

COMPREHENSIVE ASSESSMENT OF PATIENTS STANDARDS (SECTION 484.55)

(a) Initial Assessment Visit
(b) Completion of the Comprehensive Assessment
(c) Drug Regimen Review
(d) Update of the Comprehensive Assessment
(e) Incorporation of the OASIS Data Set

INITIAL ASSESSMENT VISIT – STANDARD (A)

**INITIAL = “FIRST”**

1. DETERMINES IMMEDIATE CARE AND SUPPORT NEEDS
2. DETERMINES ELIGIBILITY & HOMEBOUND STATUS (FOR MEDICARE BENEFICIARIES)

MUST BE CONDUCTED EITHER
- Within 48 hours of referral
- Within 48 hours of return home
- On physician-ordered SOC date
INITIAL ASSESSMENT VISIT – STANDARD (A)

IF ORDERS ARE PRESENT FOR SKILLED NURSING AT SOC, RN MUST CONDUCT THE INITIAL ASSESSMENT VISIT

- (CMS OASIS Q&A Cat 2 Q51)

IF THERAPY ONLY:
- Appropriate therapist may perform initial assessment
- OT may only complete assessment if need for OT establishes program eligibility
  - Not for Medicare
  - Possible for other payers

OASIS Assessment Items (When required)

COMPONENTS OF THE COMPREHENSIVE ASSESSMENT

OASIS DATA MUST BE COLLECTED ON SKILLED MEDICARE AND SKILLED MEDICAID PATIENTS

- Not required to collect on:
  - Maternity patients
  - Patients who are currently or were recently pregnant and are receiving treatment as a direct result of the pregnancy
  - Pediatric patients (< 18 years old)
  - Personal care patients, or
  - Single visit episodes

- (CMS OASIS Q&A Cat 1 Q11)

Components of the Comprehensive Assessment

OASIS Assessment Items

Agency’s Core Comprehensive Assessment Items

Agency’s Discipline Specific Assessment Items

Who requires a comprehensive assessment?

Who requires OASIS?
COMPLETION OF THE COMPREHENSIVE ASSESSMENT – STANDARD (B)

IF ORDERS ARE PRESENT FOR SKILLED NURSING AT SOC, RN MUST CONDUCT THE SOC COMPREHENSIVE ASSESSMENT

- (CMS OASIS Q&As Cat 2 Q51)

MUST BE COMPLETED IN A TIMELY MANNER

- Consistent with patient’s immediate needs
- No later than 5 days after SOC
- SOC = “Day 0”
- May not be started/completed before the SOC date

- (CMS OASIS Q&As Cat 4b Q23.1; CMS OASIS OCCB Q&As 01/08 Q1)

M0030 START OF CARE DATE

THE DATE THAT REIMBURSEABLE CARE BEGINS.

SOC DATE = DATE WHEN THE FIRST REIMBURSEABLE SERVICE IS DELIVERED.

(CMS OCCB Q&As 5/07 Q7)

M0100 – OASIS TIME POINTS

M0100 – REASON FOR ASSESSMENT (RFA)

1 – Start of Care
3 – Resumption of Care
4 – Recertification (Follow-up)
5 – Other Follow-up
6 – Transfer to Inpatient Facility – Not Discharged
7 – Transfer to Inpatient Facility – Discharged
8 – Death at Home
9 – Discharge from Agency
M0090 DATE ASSESSMENT COMPLETED

M0090 = Date last information required to complete the comprehensive assessment is collected.

COMPREHENSIVE ASSESSMENT MAY TAKE MORE THAN ONE DAY TO COMPLETE

USUALLY COMPLETED ON FIRST VISIT

USUALLY COMPLETED ON DATE OF A VISIT

MAY OCCASIONALLY BE A DATE WHICH DOES NOT COINCIDE WITH A VISIT

- Example: Physician or daughter calls back next day
  - (CMS Q&As Cat 4b Q16 & 17)

- If RN admits on Monday and confers with therapist on Tuesday regarding M0825(M0826), then Tuesday = M0090 Date Assessment Completed
  - (CMS OASIS Q&As Cat 4b Q19.1)

MUST BE COMPLETED BY ONE CLINICIAN

- If two clinicians are seeing the patient at the same time:
  - Reasonable to confer about the interpretation of assessment data
  - Reasonable for the clinician performing the assessment to follow-up on any observations of patient status reported by other agency staff
    - (CMS OASIS Q&As Cat 2 Q52)

- Clerical staff may enter demographic and agency ID items – assessing clinician must verify accuracy
  - (CMS Q&A Cat 4b Q3)

- Assessment, however, is the responsibility of one clinician – RN, PT, OT, or SLP.
  - (OASIS User’s Manual, pg. 4.9)

DIFFERENTIATING TERMS:
SOC ORDERS: RN+ ...

SOC ORDERS: THERAPY ONLY

DIFFERENTIATING TERMS:
SOC ORDERS: RN+ …
SOC ORDERS: RN OPENS FOR PT ONLY CASE

<table>
<thead>
<tr>
<th>SUN</th>
<th>MON</th>
<th>TUE</th>
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- Initial Assessment Visit
- Start of Care Visit/Date
- Comprehensive Assessment

COMPLETE WITHIN 5 CALENDAR DAYS FROM SOC

M0100 ~ OASIS TIME POINTS

M0100 – REASON FOR ASSESSMENT (RFA)
- 1 – Start of Care
- 3 – Resumption of Care
- 4 – Recertification (Follow-up)
- 5 – Other Follow-up
- 6 – Transfer to Inpatient Facility – Not Discharged
- 7 – Transfer to Inpatient Facility – Discharged
- 8 – Death at Home
- 9 – Discharge from Agency

UPDATE OF THE COMPREHENSIVE ASSESSMENT – STANDARD (D)

COMPREHENSIVE ASSESSMENT (INCLUDING OASIS) MUST BE UPDATED AND REVISED
- Not less frequently than the last five days of every 60-day episode beginning with the SOC date – that is days 56-60 of each cert period
- Major decline or improvement in patient’s health
- Within 48 hours of patient’s return home from an inpatient facility admission of 24 hours or more for reasons other than diagnostic tests
  - At discharge

DISCIPLINE IS NOT MANDATED AFTER SOC
- (CMS Q&As Cat 2 Q10; Cat 4b Q23.9)

M0100 RFA 3 – RESUMPTION OF CARE (AFTER INPATIENT STAY)

RESUMPTION OF CARE (ROC)
- Following an inpatient stay of 24 hours or longer
- For reasons other than diagnostic tests
- Requires home visit
- Must be completed within 2 calendar days of patient’s return home (or knowledge of the patient’s return home)

- (OASIS Assessment Reference Sheet)
- (CMS Q&As Cat 2 Q2)
M0100 RFA 3 – RESUMPTION OF CARE
(AFTER INPATIENT STAY)

RETURN HOME FROM INPATIENT STAY DURING THE LAST 5 DAYS OF AN EPISODE

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<td>61</td>
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</tbody>
</table>

EFFECTIVE OCTOBER 1, 2004
- If patient returns home during the last 5 days of the current episode, complete the RFA 3, ROC only
- Recertification assessment not required
- ROC determines case mix assignment for subsequent 60-day episode
  - Answer M0110 & M0826 accordingly

- (OASIS Considerations for Medicare PPS Patients)

M0100 RFA 4 – RECERTIFICATION (FOLLOW-UP) REASSESSMENT

COMPREHENSIVE ASSESSMENT (REASSESSMENT) DURING THE LAST FIVE DAYS OF THE 60-DAY CERTIFICATION PERIOD

REQUIRES A HOME VISIT

IF AGENCY MISSES RECERT WINDOW, BUT STILL PROVIDES CARE:
- Do not discharge & readmit
- Make a visit and complete Recertification assessment as soon as oversight identified
- M0090 = the date the assessment completed
- A warning message will result
- Explain circumstances in clinical documentation

- (CMS Q&As Cat 3 Q11)

M0100 RFA 5 – OTHER FOLLOW-UP

COMPREHENSIVE ASSESSMENT (REASSESSMENT) DUE TO MAJOR DECLINE OR IMPROVEMENT IN PATIENT CONDITION
- At time other than during the last 5 days of the episode
- Requires home visit
- May indicate need to update the patient’s plan of care
- Policies regarding criteria for RFA 5 must be determined by individual agencies

- (CMS Q&As Cat 3 Q12)

MUST BE COMPLETED WITHIN 2 CALENDAR DAYS OF IDENTIFYING A MAJOR IMPROVEMENT OR DECLINE IN PATIENT’S HEALTH STATUS

- (OASIS Assessment Reference Sheet)

SCIC PAYMENT ADJUSTMENT REMOVED FROM 2008 PPS MODEL
- Must still complete the Other Follow-Up comprehensive assessment when patient experiences a major in their health status

- (CMS OASIS OCCB Q&As 4/08)

M0100 RFA 6 – TRANSFER TO AN INPATIENT FACILITY PATIENT NOT DISCHARGED FROM AGENCY

TRANSFERRED TO INPATIENT FACILITY
- Transferred and admitted to inpatient bed of inpatient facility
- Stay of 24 hours or longer
- For reasons other than diagnostic tests
- Does not require a home visit
- Must be completed within 2 calendar days of Transfer date (M0906) or knowledge of transfer that meets criteria
- Agency’s choice to place on “hold” (vs. DC)
- If patient does not return to agency after inpatient admission, no further assessment required

- (OASIS Considerations for MC PPS Patients)
- (CMS Q&As Cat 2 Q41)
YOU MAKE A ROUTINE VISIT AND DISCOVER THE PATIENT HAD A QUALIFYING STAY IN AN INPATIENT FACILITY AND YOU HAD NOT BEEN INFORMED

- Within 2 calendar days of knowledge of transfer
  - Complete the RFA 6 – Transfer to Inpatient Facility
  - Then, complete the RFA 3 – Resumption of Care

(M0906) or knowledge of transfer that meets criteria
Agency’s choice to discharge (vs. “hold”)

RFA 8 DEATH AT HOME
DEATH ANYWHERE EXCEPT IN AN INPATIENT FACILITY OR IN THE EMERGENCY DEPARTMENT

- Examples: Patient dies at home, at church, in an ambulance, is pronounced DOA in ER

MUST BE COMPLETED WITHIN 2 CALENDAR DAYS OF DEATH DATE (M0906)
DOES NOT REQUIRE A HOME VISIT

- (CMS Q&As Cat 2 Q22)
- (OASIS Assessment Reference Sheet)
UNPLANNED OR UNEXPECTED DISCHARGES

IF DISCHARGE IS UNPLANNED – THE REQUIREMENTS MUST STILL BE MET

DISCHARGE ASSESSMENT MUST REPORT PATIENT STATUS AT AN ACTUAL VISIT – *Not information gathered on a telephone call*

- (CMS Q&As Cat 2 Q37[3])

ASSESSMENT DATA SHOULD BE BASED ON THE LAST VISIT CONDUCTED BY A QUALIFIED ASSESSING CLINICIAN – RN, PT, OT, OR SLP

- (CMS OASIS Q&As Cat 4b Q37)

- Explain this in the clinical documentation

DON’T INCLUDE ANY EVENTS - GOOD OR BAD - THAT OCCURRED AFTER THE LAST VISIT BY A QUALIFIED CLINICIAN, E.G. ER VISIT, FOLEY DC’D, CHANGE IN MEDICAL TREATMENT

- (CMS OASIS Q&As Cat 4b Q181.3)

UNPLANNED OR UNEXPECTED DISCHARGES

DATES:

M0906 DISCHARGE DATE

- Determined by agency policy
- Can’t be before the last visit

M0090 DATE ASSESSMENT COMPLETED

- Actual date agency completed assessment

M0903 DATE OF THE LAST (MOST RECENT) HOME VISIT

- Date of the last visit by agency staff
- Visit by any agency staff included on the plan of care

OASIS IMPLEMENTATION MANUAL

*Outcome and Assessment Information Set* IMPLEMENTATION MANUAL,

Implementing OASIS at a Home Health Agency to Improve Patient Outcomes

Revised (January 2008)

OASIS REGULATION RESOURCES

OASIS ASSESSMENT REFERENCE SHEET

01 SOC - further visits planned within 5 calendar days after the SOC Date (SOC = Day 1) - Effective 02/21/2008
03 ROC - after payment may have been received

CMS Q&As – BY CATEGORY

Questions and Answers About OASIS

August 2008

CMS OCCB Q&As

OASIS Certificate and Competency Board

OASIS Q&As


http://www.qtso.com/download/hha/OASIS_Ref_Sheet.07.19.06.pdf

http://www.oasiscertificate.org

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**FAQs, SPECIAL ALERTS & GUIDANCE**

**ADVANCED SCENARIOS**

**OASIS GAME**

**OASIS TEST**

**STAFF DEVELOPMENT GUIDE**

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**FIND “IMPORTANT RESOURCES” UNDER REFERENCES**

Enhanced Version 3.0

www.oasistraining.org

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**REFERENCES**

**HOME HEALTH AGENCY CENTER**
www.cms.hhs.gov/center/hha

**CMS OASIS WEBSITE**
www.cms.hhs.gov/oasis

**OASIS-B1 (01/2008) DATA SET**
http://www.cms.hhs.gov/HomeHealthQualityInitis/12_HHQIOASISDataSet.asp#TopOfPage

**CASE MIX PROFILE—OBQM MANUAL**
www.cms.hhs.gov/HomeHealthQualityInitis/downloads/HHQIOASISOBQMCas eMx.pdf

**CMS OCCB Q&As**
www.oasiscertificate.org

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**RESOURCES**

**OASIS Management for Single Visit at Start of Care (SOC) or Resumption of Care (ROC)**

<table>
<thead>
<tr>
<th></th>
<th>Soc Mix Overview</th>
<th>OASIS Overview</th>
<th>Exchange Overview</th>
<th>Agency Overview</th>
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<tbody>
<tr>
<td>SOC</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>OASIS</td>
<td>Yes</td>
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<tr>
<td>Exchange</td>
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<tr>
<td>Agency</td>
<td>No</td>
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</table>
Conditions of Participation: The Comprehensive Assessment of Patients

OASIS Collection Regulation – published January 1999

§484.55 Condition of participation: Comprehensive assessment of patients.

Each patient must receive, and an HHA must provide a patient-specific, comprehensive assessment that accurately reflects the patient’s current health status and includes information that may be used to demonstrate the patient’s progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient’s continuing need for home care and meet the patient’s medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient’s eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient’s return home, or on the physician-ordered start of care date.

(2) When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.

(b) Standard: Completion of the comprehensive assessment.

(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient’s immediate needs, but no later than 5 calendar days after the start of care.

(2) Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status.

(3) When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy established program eligibility.

(c) Standard: Drug regimen review.

The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient’s condition warrants due to a major decline or improvement in the patient’s health status, but not less frequently than—

(1) Every second calendar month beginning with the start of care date;

(2) Within 48 hours of the patient’s return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests;

(3) At discharge.

(e) Standard: Incorporation of OASIS data items. The OASIS data items determined by the Secretary must be incorporated into the HHA’s own assessment and must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.

[64 FR 3784, Jan. 25, 1999]

(Source:www.access.gpo.gov/su_docs/fedreg/a990125c.html)
## COMPREHENSIVE ASSESSMENT REQUIREMENTS FOR MEDICARE-APPROVED HHAS

<table>
<thead>
<tr>
<th>PATIENT CLASSIFICATION/PAYER</th>
<th>Does OASIS Apply?</th>
<th>Comprehensive Assessment Only Excluding OASIS&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Timing of Follow-up Comprehensive Assessment</th>
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<tr>
<td><strong>SKILLED</strong></td>
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<tr>
<td>Medicare (traditional fee-for-service)</td>
<td>Yes</td>
<td>NA</td>
<td>Day 56-60&lt;sup&gt;2&lt;/sup&gt;</td>
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<td>Medicare (HMO/Managed Care)</td>
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<tr>
<td>Medicaid (traditional fee-for-service)</td>
<td>Yes</td>
<td>NA</td>
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<tr>
<td>Medicaid (HMO/Managed Care)</td>
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<tr>
<td><strong>SKILLED</strong></td>
<td>No&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Yes</td>
<td>Anytime after SOC assessment up to day 60; subsequent Follow-up assessment must be within 60 days.&lt;sup&gt;4&lt;/sup&gt;</td>
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<tr>
<td>Non-Medicare/Non-Medicaid:</td>
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<td>Workers’ Compensation</td>
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<td>Title Programs</td>
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<td>Other Government</td>
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<td>Private HMO/Managed Care</td>
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<td>Self-pay; other; unknown</td>
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<td><strong>PERSONAL CARE ONLY</strong></td>
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<tr>
<td>Medicaid (traditional fee-for-service)</td>
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<td>Yes</td>
<td>Anytime after SOC assessment up to day 60; subsequent Follow-up assessment must be within 60 days.</td>
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<tr>
<td>Medicaid (HMO/Managed Care)</td>
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<tr>
<td>Waiver service or home health aide services without skilled services</td>
<td>No</td>
<td>Yes</td>
<td>Anytime after SOC assessment up to day 60; subsequent Follow-up assessment must be within 60 days.</td>
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<td>Non-Medicaid:</td>
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<td>Workers’ Compensation</td>
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<td>Other Government</td>
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<tr>
<td><strong>OASIS EXCLUDED</strong></td>
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<tr>
<td>Patients under age 18; regardless of payer source</td>
<td>No&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Yes</td>
<td>Anytime after SOC assessment up to day 60; subsequent Follow-up assessment must be within 60 days.</td>
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<tr>
<td>Patients receiving pre &amp; post partum maternity services; regardless of payer source</td>
<td>No&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Yes</td>
<td>Anytime after SOC assessment up to day 60; subsequent Follow-up assessment must be within 60 days.</td>
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<tr>
<td><strong>OASIS EXCLUDED</strong></td>
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<tr>
<td>Patients receiving only chore and housekeeping services&lt;sup&gt;6&lt;/sup&gt;</td>
<td>No</td>
<td>No</td>
<td>NA</td>
</tr>
</tbody>
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<sup>1</sup> HHAs may develop own comprehensive assessment for each time point excluding OASIS.

<sup>2</sup> 42 CFR 484.55(d).

<sup>3</sup> HHAs may collect OASIS information for their own use.

<sup>4</sup> S&C Memo 04-45, published 9/9/04.

<sup>5</sup> HHAs expecting payment for a pediatric or maternity Medicare patient must collect payment items to provide a HIPPS code.

<sup>6</sup> S&C Memo 05-06, published 11/12/04

<table>
<thead>
<tr>
<th>RFA Type</th>
<th>RFA Description</th>
<th>Assessment Completed</th>
<th>Locked Date</th>
<th>Submission Timing</th>
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</thead>
<tbody>
<tr>
<td>01</td>
<td>SOC - further visits planned</td>
<td>Within 5 calendar days after the SOC Date (SOC = Day 0)</td>
<td>Effective 6/21/2006 No required lock date</td>
<td>Effective 6/21/2006 Transmission required within 30 calendar days of completing the assessment (M0090)</td>
</tr>
<tr>
<td>03</td>
<td>ROC - after inpatient stay</td>
<td>Within 2 calendar days of the facility discharge date or knowledge of pt’s return home</td>
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<td>04</td>
<td>Recertification - F/U</td>
<td>The last 5 days of every 60 days, i.e., days 56-60 of the current 60-day period.</td>
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<td>05</td>
<td>Other F/U</td>
<td>Complete assessment within 2 calendar days of identification of significant change of patient’s condition</td>
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<tr>
<td>06</td>
<td>Transferred to Inpatient Facility - not discharged from agency</td>
<td>Within 2 calendar days of the disch/trans/death date or knowledge of a qualifying transfer to inpatient facility</td>
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<tr>
<td>07</td>
<td>Transferred to Inpatient Facility - discharged from agency</td>
<td>Within 2 calendar days of the disch/trans/death date or knowledge of a qualifying transfer to inpatient facility</td>
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<tr>
<td>08</td>
<td>Died at home</td>
<td>Within 2 calendar days of the disch/trans/death date</td>
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<td>09</td>
<td>Discharged from agency: Not to Inpatient Facility</td>
<td>Within 2 calendar days of the disch/trans/death date</td>
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* RFA= Reason for Assessment
RFA 02 and RFA 10 are no longer required records and are rejected by the state system

(Source: www.cms.hhs.gov/apps/hha/hharefch.asp Modified 7/19/06 to reflect change posted in Federal Register/Vol. 70, #246/Friday, December 23,2005/Rules and Regulations, pg. 76199)

Revisions for RFA 3, 6, & 7 based on CMS 6/05Q&As Cat 2, Questions 2& 8 and 8/06 OCCB Q&As.
Revisions to RFA 1 based on OASIS-B1 Data Specification Notes July 24, 2003 pg. 6