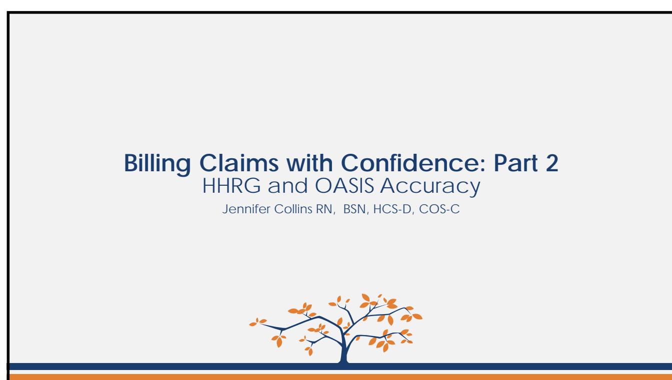

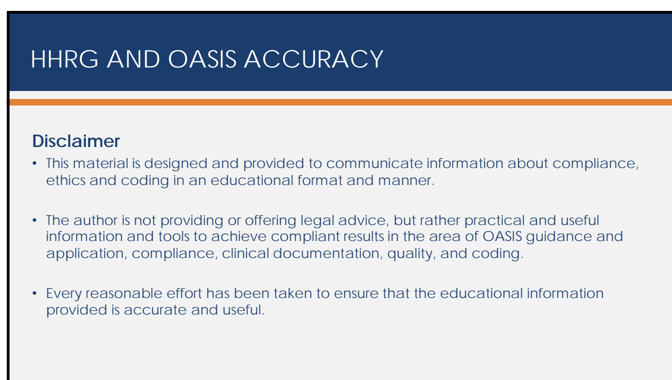

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OASIS-C2: OBJECTIVES

- Understand purpose of OASIS-C2 and importance of Accuracy
- Identify "Conventions for Completing OASIS"
- Review item-specific guidance for accuracy with OASIS items specific to HHRG calculations
- Identify potential logic inconsistencies between OASIS responses & other portions of the assessment
- Describe strategies to adequately support OASIS responses within clinical documentation

OASIS-C2: WHAT AND WHY?

- Quality Measurement:
  - OASIS-C2: Group of standard data elements developed, tested and refined over 2 decades through a research and demonstration program
  - Designed to enable systematic comparative measurement of home health care patient outcomes at two points in time.
- Payment Determination
  - OASIS data are used to adjust per-episode payment rates for patient conditions that affect care needs

OASIS-C2: ACCURACY

"The quality of the output is only as good as the quality of the data input."

CMS recommends that agencies develop internal systems for monitoring data accuracy in addition to data checking features incorporated into CMS-supplied data entry software and other data entry systems. These may include clinical record audits, data entry audits, reports produced from electronic health record systems or other activities."

OASIS-C2 Guidance Manual Chapter 1-5

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OASIS-C2: CASE MIX ADJUSTMENT

- Medicare Benefit Manual: Chapter 7: 10.2 A
- "The 60-day episode rates are adjusted by case mix methodology based on data elements from the Outcome and Assessment Information Set (OASIS)."
- In a prospective payment system, the HHRG/NRS scoring is intended to predict resource utilization.
- Accuracy in OASIS data collection reciprocates accurate reimbursement
  - Under-scoring often results in lower reimbursement
  - It is never appropriate to select an OASIS response based solely on it's effect on payment

OASIS-C2: OUTCOME MEASUREMENT

- Types of Outcome Measures:
  - End result functional and physical health improvement/stabilization
  - Process Measures:
    - indicate how often HHA follows best practices to improve patient outcomes
  - Measures of Potentially Avoidable Events:
    - Negative outcomes that clinical evidence indicates can be influenced by following best practices in providing care
  - Utilization of care measures
    - Hospitalization and Emergency Department use

OASIS-C2: OUTCOME MEASURES

- Agency Efficacy
  - Provide data for the agency to assess and improve quality of patient care
- Home Health Compare
- STAR Ratings
- HHVBP: Pay for Performance – (9 States in the model)
- Accuracy in OASIS Data collection tells the "truth" about your agency's quality of patient care.

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OASIS-C2: AUDIT FINDINGS

Common findings of OASIS' audits:

- Inaccurate responses (inconsistent with conventions and/or item-specific instructions)
  - "Day of assessment" and "usual status"
  - "Actual performance" versus ability to safely complete the activity
- Inconsistent documentation of patient's need for and/or:
  - Use of assistive devices
  - Level of assistance from another person (hands-on, verbal cueing, supervision)
- Clinician's "favorite" or "habitual" responses

OASIS-C2: OASIS ITEM CONVENTIONS

- "General Rules" that should be observed when completing OASIS
  - OASIS-C2 Guidance Manual Chapter 1-4, effective 1/1/2018
- Specific Conventions for ADL/IADL Items
  - OASIS-C2 Guidance Manual Chapter 1-5, effective 1/1/2018

OASIS-C2: GENERAL OASIS ITEM CONVENTIONS

1. Understand the time period under consideration for each item. Report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance. Day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home.
2. For OASIS purposes, a quality episode must have a beginning (that is, an SOC or ROC assessment) and a conclusion (that is, a Transfer or Discharge assessment) to be considered a complete quality episode.
3. If the patient's ability or status varies on the day of the assessment, report the patient's "usual status" or what is true greater than 50% of the assessment time frame, unless the item specifies differently.
4. Minimize the use of NA and Unknown responses.

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OASIS-C2: GENERAL OASIS ITEM CONVENTIONS

5. Some items allow a dash response. A dash (-) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. CMS expects dash use to be a rare occurrence.

6. Responses to items documenting a patient's current status should be based on independent observation of the patient's condition and ability at the time of the assessment without referring back to prior assessments. Several process items require documentation of prior care, at a time of or since the time of the most recent SOC or ROC OASIS assessment. These instructions are included in item guidance for the relevant OASIS questions.

OASIS-C2: GENERAL OASIS ITEM CONVENTIONS

7. Combine observation, interview, and other relevant strategies to complete OASIS data items as needed (for example, it is acceptable to review the hospital discharge summary to identify inpatient procedures and diagnoses at Start of Care, or to examine the care notes to determine if a physician-ordered intervention was implemented at Transfer or Discharge). However, when assessing physiologic or functional health status, direct observation is the preferred strategy.

8. When an OASIS item refers to assistance, this means assistance from another person. Assistance is not limited to physical contact and can include verbal cues and/or supervision.

9. Complete OASIS items accurately and comprehensively, and adhere to skip patterns.

10. Understand the definitions of words as used in the OASIS.

OASIS-C2: GENERAL OASIS ITEM CONVENTIONS

11. Follow rules included in the item Specific Guidance (Chapter 3 of this manual).

12. Stay current with evolving CMS OASIS guidance updates. CMS may post updates to the guidance manual up to twice per year, and releases OASIS Q&As quarterly.

13. Only one clinician may take responsibility for accurately completing a comprehensive assessment. However, for all OASIS data items integrated within the comprehensive assessment, collaboration with the patient, caregivers, and other health care personnel, including the physician, pharmacist, and/or other agency staff is appropriate and would not violate the one clinician convention. When collaboration is utilized, the assessing clinician is responsible for considering available input from these other sources and selecting the appropriate OASIS item response(s) within the appropriate timeframe and consistent with data collection guidance.

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OASIS-C2: GENERAL OASIS ITEM CONVENTIONS

14. The use of the term "specifically," means scoring of the item should be limited to only the circumstances listed. The use of "for example," means the clinician may consider other relevant circumstances or attributes when scoring the item.

OASIS C2: (M0110) EPISODE TIMING

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?

Enter Code		
☐	1	Early
	2	Later
	UK	Unknown
	NA	Not Applicable: No Medicare case mix group to be defined by this assessment.

OASIS C2: (M0110) EPISODE TIMING

A "sequence of adjacent Medicare home health payment episodes" is a continuous series of Medicare payment episodes, regardless of whether the same home health agency provided care for the entire series.

- Low utilization payment adjustment (LUPA) episodes (less than 5 total visits) are counted.
- "Adjacent" means that there was no gap between Medicare-covered episodes of more than 60 days.
- Periods of time when the patient is "outside" a Medicare payment episode but on service with a different payer - such as HMO, Medicaid, or private pay - are counted as gap days when counting the sequence of Medicare payment episodes.
- **"Early"** means the only episode OR the first or second episode in a sequence of adjacent episodes.
- **"Later"** means the third or later episode in a sequence of adjacent episodes.

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OASIS-C2: (M0110) EPISODE TIMING

- Accuracy: Item Specific Guidance and Q&As
  - Consult Medicare systems such as: Health Insurance Query for Home Health (HIQH) / Common Working File (CWF)
  - HMO, Medicaid, or Private Pay do not count as part of a sequence
  - Agency change during 2nd early episode
  - Denied Episodes
  - Use of "Unknown", auto-adjustment at EOE

OASIS-C2: (M1030) THERAPIES

(M1030) Therapies the patient receives <u>at home</u>:
(Mark all that apply.)

- ☐ 1 – Intravenous or infusion therapy (excludes TPN)
- ☐ 2 - Parenteral nutrition (TPN or lipids)
- ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 - None of the above

OASIS-C2: (M1030) THERAPIES

- Accuracy: Item Specific Guidance
  - Intermittent flushes
  - Implanted Insulin and Morphine pumps
  - PRN Use
  - Patient refusal
  - Hydration vs Nutrition
  - Meds
  - Therapy DC'd day of admission
  - Intermittent Flushes

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OASIS-C2: (M1030) THERAPIES

Consistency and Logic:
- M1340: Surgical Wound
  - Venous access devices, implanted pumps, etc
- M1870: Feeding or Eating
  - If a feeding tube is being used to provide all or some nutrition, response 3 or 4
  - Patient is receiving IV fluids or TPN, response 5
- M1880: Plan and Prepare Light Meals
  - If tube feedings, assess the patient's ability to plan and prepare – knowledge of feeding amount and ability to prepare – not ability to manage equipment
- M2102: Types and Sources of Assistance
  - CG available and ability to safely manage equipment as ordered

OASIS-C2: (M1200) VISION

(M1200) Vision (with corrective lenses if the patient usually wears them):	
Enter Code ☐	0 Normal vision: sees adequately in most situations; can see medication labels, newsprint. 1 Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length. 2 Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.

Note: this item is in HHRG, but contributes zero points to case mix

OASIS-C2: (M1200) VISION

- Accuracy: Item Specific Guidance and Q&As
  - Measures patient's ability to see and visually manage (function) in his/her environment
  - Assessed with corrective lenses ONLY if usually worn
  - Corrective lens vs magnifying lens
  - Limited neck ROM / Orbital Swelling
  - Consideration for cognitive impairment
  - Font Size

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OASIS-C2: (M1200) VISION

- Consistency and Logic:
  - M2020 and M2030: medication management
  - M1700: Cognitive Functioning, M1710: When Confused
  - M1800s: ADLs/IADLs
  - M2102: Types and Availability of Assistance

OASIS-C2: (M1242) FREQUENCY OF PAIN INTERFERING WITH ACTIVITY

(M1242) **Frequency of Pain Interfering** with patient's activity or movement:	
Enter Code ☐	0 Patient has no pain 1 Patient has pain that does not interfere with activity or movement 2 Less often than daily 3 Daily, but not constantly 4 All of the time

OASIS-C2: (M1242) FREQUENCY OF PAIN INTERFERING WITH ACTIVITY

- Accuracy: Item Specific Guidance and Q&As
  - Define "interferes with activity"
  - Medications present, explore presence of pain, how often med needed, and why: activity related
  - Assistive Devices help relieve pain: Interference?
  - Pain free with medication, but has side effects: interference with activity?
  - Time period under consideration: "pertinent past"
  - Medical restrictions

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OASIS-C2: (M1242) FREQUENCY OF PAIN INTERFERING WITH ACTIVITY

- Consistency and Logic:
  - M1018: 3-intractable pain
  - M1800s: devices used to ease pain with transferring, ambulating, etc
  - Clinical note and comprehensive assessment:
    - all types & sources of pain such as those described in cardiac, respiratory, neuro/emotional, musculoskeletal (including phantom pain), gastrointestinal, elimination status (including UTI), wounds, other medical history, diagnoses, medication profile, etc.

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. **Stage 2**: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	☐
A2. **Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
B1. **Stage 3**: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	☐
B2. **Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
C1. **Stage 4**: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 at FU/DC Go to M1311D1]	☐
C2. **Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
D1. **Unstageable: Non-removable dressing**: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 at FU/DC Go to M1311E1]	☐
D2. **Number of these unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
E1. **Unstageable: Slough and/or eschar**: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 at FU/DC Go to M1311F1]	☐
E2. **Number of these unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
F1. **Unstageable: Deep tissue injury**: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 – Go to M1322 (at Follow up), Go to M1313 (at Discharge)]	☐
F2. **Number of these unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
[Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC]	

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OASIS-C2: (M1311) CURRENT NUMBER OF UNHEALED PRESSURE ULCERS

- Accuracy: Item Specific Guidance and Q&As
  - Understand pressure ulcer staging, unstageable and DTI
  - Closed / healed reporting – new 1/1/17
  - Muscle flaps, skin grafts, debridement
  - Pressure Injury vs Pressure Ulcer Q89.1.1
  - Scab versus Eschar/Slough and staging Q98.4.4

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OASIS-C2: (M1311) CURRENT NUMBER OF UNHEALED PRESSURE ULCERS

- Consistency and Logic:
  - Stage 2 or higher, and/or unstageable ulcers are potentially reportable in the following items:
    - M1306, M1307 (Stage 2 only), M1313, M1320, M1324
  - Diagnosis codes
  - Braden Scale Assessment
  - M1300,M1302,M2250,M2400 – Process Measures
  - M1242:Pain interfering with Activity (walking / sitting / sleeping / transferring)
  - M2102: Types and Sources of Assistance
  - M1340,M1342 if muscle / skin / rotational flap or skin graft
  - Interventions present / appropriate
  - Clinical documentation with wound location, description, and severity

OASIS-C2: (M1324) STAGE OF MOST PROBLEMATIC PRESSURE ULCER

(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

Enter Code		
☐	1	Stage 1
	2	Stage 2
	3	Stage 3
	4	Stage 4
	NA	Patient has no pressure ulcers or no stageable pressure ulcers

OASIS-C2: (M1324) STAGE OF MOST PROBLEMATIC PRESSURE ULCER

- Accuracy: Item Specific Guidance and Q&As
  - Determine which pressure ulcers are stageable
  - Then determine which one is most problematic using clinical judgment: largest, most difficult to access to treat, most difficult to off-load pressure, etc
  - Stage of ulcer as it heals – Do not reverse stage pressure ulcers

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OASIS-C2: PRESSURE ULCER RISK (BRADEN)

- Sensory Perception: ability to respond meaningfully to pressure-related discomfort
  - M1242 Pain Interfering with Activity or Movement
- Moisture: degree to which skin is exposed to moisture
  - M1610 Urinary Incontinence/Catheter
  - M1620 Bowel Incontinence Frequency
- Activity: degree of physical activity
- Mobility: ability to change and control body position
- Friction & Shear
  - M1850 Transferring
  - M1860 Ambulation/Locomotion
- Nutrition: usual food intake pattern
  - M1030 Therapies the patient receives at home

OASIS-C2: (M1334) STATUS OF MOST PROBLEMATIC STASIS ULCER

(M1334) Status of Most Problematic Stasis Ulcer that is Observable:	
Enter Code ☐	1 Fully granulating 2 Early/partial granulation 3 Not healing

OASIS-C2: (M1334) STATUS OF MOST PROBLEMATIC STASIS ULCER

- Accuracy: Item Specific Guidance and Q&As
  - Observable vs non-observable
  - "Most problematic" may be based on healing status, size, difficulty in accessing for treatment, etc.
  - Arterial vs Venous Stasis Ulcers
  - Contiguous – reporting dependent upon timing and progression

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OASIS-C2: (M1334) STATUS OF MOST PROBLEMATIC STASIS ULCER

- Consistency and Logic:
  - M1330: Stasis Ulcer
  - M1332: Current Number of Stasis Ulcers
  - Diagnosis: I87.31x Chronic Venous Hypertension (idiopathic) with ulcer of… plus L97.x Non-pressure chronic ulcer of…
  - M2102: Types and Sources of Assistance
  - M1242: Pain interfering with Activity
  - Clinical Documentation with description, location, severity of wound
  - Interventions present

OASIS-C2: (M1340) SURGICAL WOUND

(M1340) Does this patient have a **Surgical Wound?**	
Enter Code ☐	0 No ***[At SOC/ROC, go to M1350 ; At FU//DC, go to M1400]*** 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device ***[At SOC/ROC, go to M1350 ; At FU/DC, go to M1400]***

OASIS-C2: (M1340) SURGICAL WOUND

- Accuracy: Item Specific Guidance and Q&As
  - Outcome Measure only, but a "yes" response leads to M1342 which impacts HHRG/NRS
  - For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection
  - After 30 days (of complete epithelialization), it is generally described as a scar and should not be included as a current surgical wound
- Must reference Q&As and stay current with Quarterly Q&As

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OASIS-C2: (M1340) SURGICAL WOUND

INCLUDES:
- Muscle flap, skin advancement flap, rotational flap replacing a pressure ulcer
- Placement of a skin graft
- A "take-down" of a previous bowel ostomy
- Orthopedic pin sites, central line sites, stapled or sutured incisions, wounds with drains, implanted infusion devices, venous access devices

EXCLUDES:
- Scars, keloid formation
- Pressure ulcer that has been surgically debrided
- Simple I&D of Abscess
- All ostomies
- Cataract surgery of the eye, surgery to the mucosal membranes, gynecological surgical procedures via vaginal approach

OASIS-C2: (M1340) SURGICAL WOUND

- Consistency and Logic:
  - M1030: Therapies
  - Dx: End Stage Renal Disease / Dialysis Access site: M1610 (Anuria?)
  - Aftercare diagnosis?
  - Attention to / Encounter for… drain present?
  - M1242: Any pain associated with wound / wound care / etc?
  - M1800s: Does it affect dressing, bathing, transferring, ambulating?

OASIS-C2: (M1342) STATUS OF MOST PROBLEMATIC SURGICAL WOUND

(M1342) Status of Most Problematic Surgical Wound that is Observable	
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

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OASIS-C2: (M1342) STATUS OF MOST PROBLEMATIC SURGICAL WOUND

- Accuracy: Item Specific Guidance and Q&As
  - Determine which surgical wounds are observable
    - Includes all surgical wounds (as defined in M1340 guidance) that are not covered by a non-removable dressing/device or cast
  - Identify the most problematic observable surgical wound
    - "Most problematic" may be the largest, the most resistant to treatment, an infected surgical wound, etc., depending on the specific situation

OASIS-C2: (M1342) STATUS OF MOST PROBLEMATIC SURGICAL WOUND

- Accuracy: Item Specific Guidance and Q&As
  - Primary Intention:
    - Surgical incisions healing by primary intention do not granulate, therefore the only appropriate responses would be 0-Newly epithelialized or 3-Not healing
    - If the wound is healing solely by primary intention, observe if the incision line has re-epithelialized (select "newly epithelialized")
    - If there is not full epithelial resurfacing (such as in the case of a scab adhering to underlying tissue), the correct response would be "not healing" for the wound healing by primary intention

OASIS-C2: (M1342) STATUS OF MOST PROBLEMATIC SURGICAL WOUND

- Accuracy: Item Specific Guidance and Q&As
  - Secondary Intention:
    - If it is determined that there is incisional separation, healing will be by secondary intention
    - Surgical incisions healing by secondary intention do granulate
    - These incisions may be reported with any of the four responses to M1342

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OASIS-C2: (M1342) STATUS OF MOST PROBLEMATIC SURGICAL WOUND

- Accuracy: Item Specific Guidance and Q&As
  - Epithelialization is characterized by "Epidermal resurfacing" and means the opening created during the surgery is covered by epithelial cells
    - If epidermal resurfacing has occurred completely, select "newly epithelialized" until 30 days have passed without complication, at which time it is no longer a reportable surgical wound
  - Q105.3. Implanted infusion devices and venous access devices are considered surgical wounds. Once the associated incision is fully epithelialized, the site will remain a current surgical wound with a status of "Newly epithelialized" for as long as the device or venous access is present in the patient's body *(this is an exception to the "30-days after complete epithelialization" guidance)*

OASIS-C2: (M1400) SHORT OF BREATH

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?		
Enter Code ☐	0	Patient is not short of breath
	1	When walking more than 20 feet, climbing stairs
	2	With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
	3	With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation
	4	At rest (during day or night)

Note: this item is in HHRG, but contributes zero points to case mix

OASIS-C2: (M1400) SHORT OF BREATH

- Accuracy: Item Specific Guidance and Q&As
  - Focus is on identification of the level of exertion that results in dyspnea, not "is the patient short of breath?" or "How often is the patient short of breath?"
  - Assess with oxygen on or off?
    - Patient uses O2 continuously, assess for dyspnea with O2 on
    - Patient uses O2 intermittently, assess for dyspnea without O2
    - Response is based on patient's ACTUAL use of O2 in the home, not on the physician's order

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OASIS-C2: (M1400) SHORT OF BREATH

- Consistency and Logic:
  - M1410: Oxygen therapy
  - M2102: Types and sources of assistance
  - Minimal exertion: M1870 and M1880
  - Chairfast / bedbound patient: M1800s
  - Diagnosis: HTN, COPD, CHF, A-fib, etc

OASIS-C2: (M1610) URINARY INCONTINENCE / CATHETER PRESENCE

(M1610) Urinary Incontinence or Urinary Catheter Presence:	
Enter Code ☐	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) *[Go to M1620]* 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) *[Go to M1620]*

OASIS-C2: (M1610) URINARY INCONTINENCE / CATHETER PRESENCE

- Accuracy: Item Specific Guidance and Q&As
  - Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling
  - Pouched versus tube/catheter:
    - Response 0 if patient has a urinary diversion that is pouched, with or without a stoma
    - Response 2 if a catheter or tube is utilized for drainage (continuous or intermittent)
  - Any incontinence AT ALL is captured in Response 1 (including occasional dribbling, leaking, stress or urge incontinence)
  - Catheter inserted during assessment, select Response 2
  - Catheter discontinued during assessment (or if both inserted & discontinued), select Response 0 or 1 dependent on whether patient is incontinent

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OASIS-C2: (M1610) URINARY INCONTINENCE / CATHETER PRESENCE

- Accuracy: Item Specific Guidance and Q&As
  - Timed Voiding Program
  - Night time diaper use
  - Capped Nephrostomy Tube
  - Straight Cath for lab specimen

OASIS-C2: (M1610) URINARY INCONTINENCE / CATHETER PRESENCE

- Consistency and Logic:
  - M1620: When urinary incontinence occurs
  - Braden Risk Assessment
  - MAHC-10 Fall Risk Assessment
  - M1845: Toileting Hygiene
  - Diagnosis:
    - BPH with / without symptoms
    - End Stage Renal Disease / Dialysis / Anuria?
    - Encounter for fitting/adjusting urinary device
    - Status of nephrostomy, cystostomy, ureterostomy, urethrostomy – Z93.xx

OASIS-C2: (M1620) BOWEL INCONTINENCE FREQUENCY

(M1620) Bowel Incontinence Frequency:		
Enter Code ☐	0	Very rarely or never has bowel incontinence
	1	Less than once weekly
	2	One to three times weekly
	3	Four to six times weekly
	4	On a daily basis
	5	More often than once daily
	NA	Patient has ostomy for bowel elimination
	UK	Unknown ***[Omit "UK" option on FU, DC]***

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OASIS-C2: (M1620) BOWEL INCONTINENCE FREQUENCY

- Accuracy: Item Specific Guidance and Q&As
  - Timeframe under consideration
  - Identifies how often patient experiences bowel incontinence
  - Response 4-On a daily basis indicates the patient experiences bowel incontinence once per day
    - Differs from common vernacular in which "on a daily basis" might mean "everyday"
    - Bowel incontinence occurring more than once daily is described in Response 5
  - Incontinence may result from multiple causes (physiologic reasons, mobility problems, or cognitive impairments)

OASIS-C2: (M1620) BOWEL INCONTINENCE FREQUENCY

- Logic and Consistency:
  - Braden Risk Assessment
  - MAHC-10 Risk Assessment
  - M1840: Toilet Transferring
  - M1845: Toileting Hygiene

OASIS-C2: (M1630) OSTOMY FOR BOWEL ELIMINATION

(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?

Enter Code		
☐	0	Patient does not have an ostomy for bowel elimination.
	1	Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
	2	The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

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OASIS-C2: (M1630) OSTOMY FOR BOWEL ELIMINATION

- Accuracy: Item Specific Guidance and Q&As
  - Identifies whether patient has a bowel ostomy and whether it (within the last 14 days) was related to recent inpatient stay or caused a change in medical treatment plan
  - Applies to any type of ostomy for bowel elimination (for example, colostomy, ileostomy)
    - Excludes all other types of ostomies (for example, urinary, tracheostomies, those for enteral nutrition)
  - If a bowel ostomy has been reversed, the patient does not have an ostomy at the time of assessment

OASIS-C2: CONVENTIONS SPECIFIC TO ADL/IADL ITEMS

1. Report the patient's physical and cognitive ability to perform a task. Do not report on the patient's preference or willingness to perform a specified task.
2. The level of ability refers to the level of assistance (if any) that the patient requires to safely complete a specified task.
3. While the presence or absence of a caregiver may impact the way a patient carries out an activity, it does not impact the assessing clinician's ability to assess the patient in order to determine and report the level of assistance that the patient requires to safely complete a task.

OASIS-C2: CONVENTIONS SPECIFIC TO ADL/IADL ITEMS

4. Understand what tasks are included and excluded in each item and select the OASIS response based only on included tasks.
5. If the patient's ability varies between the different tasks included in a multi-task item, report what is true in a majority of the included tasks, giving more weight to tasks that are more frequently performed.
6. Consider medical restrictions when determining ability. For example, if the physician has ordered activity restrictions, consider this when selecting the best response to functional items related to ambulation, transferring, bathing, etc.

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OASIS-C2: (M1810) ABILITY TO DRESS UPPER BODY & (M1820) ABILITY TO DRESS LOWER BODY

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:		
Enter Code ☐	0	Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
	1	Able to dress upper body without assistance if clothing is laid out or handed to the patient.
	2	Someone must help the patient put on upper body clothing.
	3	Patient depends entirely upon another person to dress the upper body.

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:		
Enter Code ☐	0	Able to obtain, put on, and remove clothing and shoes without assistance.
	1	Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
	2	Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
	3	Patient depends entirely upon another person to dress lower body.

OASIS-C2: (M1810) ABILITY TO DRESS UPPER BODY & (M1820) ABILITY TO DRESS LOWER BODY

- Accuracy: Item Specific Guidance and Q&As
  - Identifies patient's ability to dress upper body (M1810) and lower body (M1820) with or without dressing aids including the ability to **obtain, put on, and remove** whatever clothing is **routinely worn**
    - Upper: including undergarments, pullovers, front-opening shirts/blouses, managing zippers, buttons, and snaps
    - Lower: including undergarments, slacks, socks/nylons, shoes

OASIS-C2: (M1810) ABILITY TO DRESS UPPER BODY & (M1820) ABILITY TO DRESS LOWER BODY

- Accuracy: Item Specific Guidance and Q&As
  - Day of assessment, ability varies
  - Routine Clothing / What pt usually wears
  - Orthotics, splints, TED hose, Ace Wraps, etc.
  - Majority of tasks vs critical items
  - Wound dressings

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OASIS-C2: (M1830) BATHING

(M1830) Bathing: Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**

Enter Code ☐

- 0 Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- 2 Able to bathe in shower or tub with the intermittent assistance of another person:
  - (a) for intermittent supervision or encouragement or reminders, OR
  - (b) to get in and out of the shower or tub, OR
  - (c) for washing difficult to reach areas.
- 3 Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- 4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- 5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
- 6 Unable to participate effectively in bathing and is bathed totally by another person.

OASIS-C2: (M1830) BATHING

- Accuracy: Item Specific Guidance and Q&As
  - Ability vs Actual Performance
  - Response 0 – Bath/Shower and Alone
  - Response 1 - Bath/Shower and Alone with Device
  - Response 2 – Bath/Shower with Intermittent Assistance
    - OR = And/Or
  - Response 3 – Bath/Shower with Continuous Assistance
  - Response 4 – Not safe in Bath/Shower, but safe Alone in alternate location
  - Response 5 – Not safe in Bath/Shower, able to participate with assistance
  - Response 6 – Does not provide meaningful participation in bathing activity

OASIS-C2: (M1830) BATHING

- Accuracy: Item Specific Guidance and Q&As
  - Medical restrictions
  - Fear of falling and ability
  - Usual Status / varying ability on day of assessment
  - Able to bathe in shower/tub but chooses to bathe at sink
  - Assistance with ambulation to get to tub/shower
  - Long-handled sponge – device?

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OASIS-C2: (M1840) TOILET TRANSFERRING

(M1840) Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

Enter Code		
☐	0	Able to get to and from the toilet and transfer independently with or without a device.
	1	When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
	2	Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3	Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4	Is totally dependent in toileting.

OASIS-C2: (M1840) TOILET TRANSFERRING

- Accuracy: Item Specific Guidance and Q&As
  - Identifies patient's ability to get to/from and transfer on/off toilet or bedside commode
  - Response 0 –able to get to and from toilet "and" transfer on/off = must be able to perform both independently to score this response (=and only)
  - Response 1 – When reminded, assisted, or supervised by another person, able to get and from the toilet "and" transfer = may need assistance with one or both to score this response (=and/or)
  - In the absence of a toilet in the home, then assess with BSC, if no BSC, then bedpan/urinal - If equipment is not present in the home for to allow assessment, Response 4 would be appropriate.

OASIS-C2: (M1840) TOILET TRANSFERRING

- Accuracy: Item Specific Guidance and Q&As
  - Urinary catheters
  - Ability vs Actual performance
  - Ability varies on day of assessment
  - Presence or absence of Caregiver
  - Urinal vs Bedpan
  - Hoyer lift
  - Bedside commode over toilet
  - Response 3 on M1860

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OASIS-C2: (M1850) TRANSFERRING

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

Enter Code		
☐	0	Able to independently transfer.
	1	Able to transfer with minimal human assistance or with use of an assistive device.
	2	Able to bear weight and pivot during the transfer process but unable to transfer self.
	3	Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
	4	Bedfast, unable to transfer but is able to turn and position self in bed.
	5	Bedfast, unable to transfer and is unable to turn and position self.

OASIS-C2: (M1850) TRANSFERRING

- Accuracy: Item Specific Guidance and Q&As
  - For most patients, the transfer between bed and chair will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair, and back into bed from the chair or sitting surface
  - If no chair in bedroom or that is not routine – then assess what is applicable to the patient's environment and need
  - Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed

OASIS-C2: (M1850) TRANSFERRING

- Accuracy: Item Specific Guidance and Q&As
  - Define minimal human assistance
  - M1860 and location of sitting surface
  - Assistive devices
  - Bedfast and transferring
  - Safe Ability
  - Sliding board vs Bear weight and pivot
  - Recliner vs Bed
  - And/Or Situations

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OASIS-C2: (M1860) Ambulation/Locomotion

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Enter Code		
☐	0	Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
	1	With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
	2	Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
	3	Able to walk only with the supervision or assistance of another person at all times.
	4	Chairfast, unable to ambulate but is able to wheel self independently.
	5	Chairfast, unable to ambulate and is unable to wheel self.
	6	Bedfast, unable to ambulate or be up in a chair.

OASIS-C2: (M1860) AMBULATION/LOCOMOTION

- Accuracy: Item Specific Guidance and Q&As
  - Physician-ordered activity restriction
  - Uses wheelchair and ambulates, "usual status" convention
  - Walker available / wheelchair unavailable at time of assessment
  - Even and uneven surfaces
  - Patient able to take a few steps
  - Knee Scooter – Response 1, 2, or 3
  - Cognitive impairment vs physician ability

OASIS-C2: ADLS/IADLS (M1800s)

- Consistency and Logic:
  - M1700, M1710, M1740, M1745 – supervision or cuing required
  - M1200: vision impairment
  - Braden Assessment
  - MAHC-10 Fall Risk Assessment
  - Environmental Assessment
  - Locator 14 – Plan of Care
  - Clinical note
  - M2102: Types and Sources of Assistance
  - M2020, M2030 – "Obtain the medication from where it is routinely stored" (See Q&A under M2020, M2030)

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OASIS-C2: ADL/IADLS (M1800s)

- Consistency and Logic:
  - Reasons Homebound: Structural, functional, and acitivity limitations
    - Considerable & taxing effort
    - Requires assistance of another person to leave home
    - Requires assistive devices to leave home
    - Medical restrictions
    - Detailed narrative description of factors that contribute to patient's "confined to home" status should be logical and consistent with OASIS responses

OASIS-C2: ADL/IADLS

- Consistency with Plan of Care:
  - 485 (18A) Functional Limitations
    - Bowel/Bladder Incontinence
    - Amputation, Contracture, Paralysis, Ambulation
    - Endurance, Dyspnea
    - Legally Blind
  - 485 (18B) Activities Permitted
    - Bedrest
    - Transfer Bed/Chair
    - Partial Weight Bearing
    - Crutches, Cane, Walker, Wheelchair

OASIS-C2: ADL/IADLS

- Consistency with clinical note:
  - Musculoskeletal assessment (gait, post-surgical status, spinal and/or joint problems, etc.)
  - Cognitive (safety risks associated with confusion, anxiety, cognitive, impaired decision-making, etc.)
  - Neurological assessment (dizziness, balance, altered LOC or mentation, etc.)
  - Assistive Devices
    - Currently has and/or potentially needs
    - Compliance with safe use of devices
  - Supportive Assistance
    - Availability, ability, and willingness
    - Who, when, and what

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OASIS-C2: (M2020) MANAGEMENT OF ORAL MEDICATIONS & (M2030) INJECTABLE MEDICATIONS

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

Enter Code ☐

- 0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- 1 Able to take medication(s) at the correct times if:
  - (a) individual dosages are prepared in advance by another person; OR
  - (b) another person develops a drug diary or chart.
- 2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
- 3 Unable to take medication unless administered by another person.
- NA No oral medications prescribed.

OASIS-C2: (M2020) MANAGEMENT OF ORAL MEDICATIONS & (M2030) INJECTABLE MEDICATIONS

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

Enter Code ☐

- 0 Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
- 1 Able to take injectable medication(s) at the correct times if:
  - (a) individual syringes are prepared in advance by another person; OR
  - (b) another person develops a drug diary or chart.
- 2 Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
- 3 Unable to take injectable medication unless administered by another person.
- NA No injectable medications prescribed.

OASIS-C2: (M2020) MANAGEMENT OF ORAL MEDICATIONS & (M2030) INJECTABLE MEDICATIONS

- Accuracy: Item Specific Guidance and Q&As
  - M2020: Management of Oral Medications
    - Assessment includes the ability to obtain the medication from where it is routinely stored, the ability to read the label (or otherwise identify the medication correctly), open the container, select the pill / tablet or milliliters of liquid and orally ingest it at the correct times.
  - M2030: Management of Injectable Meds
    - Assessment includes the ability to obtain the medication from where it is routinely stored, draw up the correct dose accurately using aseptic technique, inject it in an appropriate site using correct technique and dispose of the syringe properly.

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OASIS-C2: (M2020) MANAGEMENT OF ORAL MEDICATIONS & (M2030) INJECTABLE MEDICATIONS

- Accuracy: Item Specific Guidance and Q&As
  - M2020 Management of Oral Medications
    - If a medication is ordered PRN, and on the day of assessment the patient needed a reminder for this PRN medication, select Response 2
    - If the patient did not need any PRN medication on the day of assessment, assess the patient's ability on all the medications taken on the day of assessment
  - M2030 Management of Injectable Medications
    - PRN injectables, ordered and included on POC, are to be considered when determining the patient's ability
    - If PRN medication was not needed on the day of assessment, use clinical judgment regarding the patient's ability by asking for description and demonstration of the steps for administration and disposal

OASIS-C2: (M2020) MANAGEMENT OF ORAL MEDICATIONS & (M2030) INJECTABLE MEDICATIONS

- Accuracy: Item Specific Guidance and Q&As
  - Use of a medication list
  - ALF staff administers medications
  - Usual storage place
  - Pharmacy dispensed bubble packs/prefilled syringes
  - Compliance vs Ability
  - Unsteady ambulation / stairs in home and obtaining meds
  - Ability varies on day of assessment
  - G-Tube / unable to swallow
  - Report on medication requiring the most assistance
  - Medication orders vary from SOC/ROC to DC
  - Physician orders RN administration

OASIS-C2: (M2200) THERAPY NEED

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(☐☐☐) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐ NA – Not Applicable: No case mix group defined by this assessment.

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OASIS-C2: (M2200) THERAPY NEED

- Accuracy: Item Specific Guidance and Q&As
  - Identifies the total number of therapy visits (physical, occupational, or speech therapy combined) planned for the episode
  - Therapy visit must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapists, and (b) be reasonable and necessary to the treatment of the patient's illness or injury
  - In the event that a ROC/RC is completed, the total number of therapy visits planned for the upcoming 60-day episode should be reported

OASIS-C2: (M2200) THERAPY NEED

- Consistency and Logic:
  - M1021, M1023 – diagnosis to support
  - M1800s – functional scores support need (balance, safety cues, equipment training)
  - M2020, M2030 – able to obtain and return meds, get water, dispose of sharps, etc
  - M1400 - improvement in dyspnea needed
  - M1700, M1710 – speech therapy
  - M1200 – low vision therapy
  - M2102 – caregiver availability and training needed

(M1021) Primary Diagnosis & (M1023) Other Diagnoses		(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses.	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved.	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code).
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM
(M1021) Primary Diagnosis a. ________	V, W, X, Y codes NOT allowed a. □□□□□□□ □0 □1 □2 □3 □4	V, W, X, Y, Z codes NOT allowed a. ________ (□□□□□□□)	V, W, X, Y, Z codes NOT allowed a. ________ (□□□□□□□)
(M1023) Other Diagnoses b. ________	All ICD-10-C M codes allowed b. □□□□□□□ □0 □1 □2 □3 □4	V, W, X, Y, Z codes NOT allowed b. ________ (□□□□□□□)	V, W, X, Y, Z codes NOT allowed b. ________ (□□□□□□□)
c. ________	c. □□□□□□□ □0 □1 □2 □3 □4	c. ________ (□□□□□□□)	c. ________ (□□□□□□□)
d. ________	d. □□□□□□□ □0 □1 □2 □3 □4	d. ________ (□□□□□□□)	d. ________ (□□□□□□□)
e. ________	e. □□□□□□□ □0 □1 □2 □3 □4	e. ________ (□□□□□□□)	e. ________ (□□□□□□□)
f. ________	f. □□□□□□□ □0 □1 □2 □3 □4	f. ________ (□□□□□□□)	f. ________ (□□□□□□□)

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OASIS-C2: (M1021/M1023/M1025) PRIMARY/SECONDARY DIAGNOSIS

- Accuracy: Item Specific Guidance and Q&As
- The assessing clinician is responsible for determination of the primary diagnosis & secondary diagnoses, and for the assignment of symptom control ratings
- Sequencing of the diagnoses should be consistent with plan of care orders, exacerbation of conditions, new/changed meds, assessment findings, coding guidelines, etc.
- Consistency with all OASIS items that indicate functional deficit (PT/OT/ST and/or Aide) and/or clinical need for SN
  - ADL/IADL items
  - Wounds
  - Diagnoses related to patient's dyspnea, elimination, pain, etc.
  - Diagnoses supporting IV/infusion and/or enteral therapy, injectable medications, etc.

OASIS-C2: (M1021/M1023/M1025) PRIMARY/SECONDARY DIAGNOSIS

- Accuracy: Item Specific Guidance and Q&As
- Diagnosis must comply with the following to be a primary or secondary diagnosis:
  - ICD-10-CM Coding Guidelines
  - Code only diagnoses which are unresolved
  - Code only relevant medical diagnoses
  - Code only diagnoses supported by patient's medical record documentation (Physician confirmed)
    - Clinical comprehensive assessment
    - Medical condition
    - Clinical care notes
    - History and Physical

OASIS-C2: (M1021/M1023/M1025) PRIMARY/SECONDARY DIAGNOSIS

Primary Diagnosis:

- Accuracy: Item Specific Guidance and Q&As
  - Accurately report patient's primary home health diagnosis
  - Document degree of symptom control
  - Should be chief reason for providing homecare, most related to the current plan of care
  - Clinician expected to complete assessment prior to selecting primary diagnosis.
  - May or may not relate to recent hospital stay, but MUST relate to skilled services being provided
  - Exception: when there is a conflict with official guidelines (etiology/manifestation)

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OASIS-C2: (M1021/M1023/M1025) PRIMARY/SECONDARY DIAGNOSIS

Secondary Diagnosis:

- Accuracy: Item Specific Guidance and Q&As
  - Co-existing conditions actively addressed in the patient's plan of care, and any co-morbid conditions having the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis
  - Document the degree of symptom control for each diagnosis
  - The order should be determined by the degree that they impact the patient's health and need for home health care
  - Clinician expected to complete the assessment prior to selecting secondary diagnoses.

OASIS-C2: (M1021/M1023/M1025) PRIMARY/SECONDARY DIAGNOSIS

Symptom Control Rating

- Accuracy: Item Specific Guidance and Q&As
  - Ensure that "symptom" is not interpreted in such a manner that only clinical signs & symptoms of the disease are considered
  - Assessing degree of symptom control includes:
    - Review of presenting signs and symptoms
    - Type and number of medications
    - Frequency of treatment readjustments
    - Frequency of contact with health care provider
    - The degree to which each condition limits daily activities
    - Symptom control by current treatments
    - Diagnosis/symptom control in recent past

OASIS-C2: (M1021/M1023/M1025) PRIMARY/SECONDARY DIAGNOSIS

- Accuracy: Item Specific Guidance and Q&As
  - Q&A 44.1.5. . Coding may be done in accordance with agency policies and procedures, as long as the assessing clinician determines the primary and secondary diagnoses and records the symptom control ratings. The clinician should document the medical diagnoses requested in (M1011) (M1017) Inpatient Diagnoses, (M1021/23/25) Diagnoses Requiring Medical or Treatment Regimen Change, and Primary/Secondary and Other Diagnoses, if applicable. A coding specialist may enter the actual numeric ICD codes once the assessment is completed.

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OASIS-C2: (M1021/M1023/M1025) PRIMARY/SECONDARY DIAGNOSIS

- Accuracy: Item Specific Guidance and Q&As
  - Q&A 44.2.1 When a co-morbid condition is not going to be a focus of home health treatment (for example a "low vision" diagnosis that will not receive clinical interventions during the episode), the clinical documentation should reflect IF/HOW that co-morbidity will affect the patient's responsiveness to treatment, rehab prognosis, etc

OASIS-C2: (M1021/M1023/M1025) PRIMARY/SECONDARY DIAGNOSIS

- Consistency and Logic:
  - MUST be supported in comprehensive assessment
  - Clinician should be asking / documenting:
    - How it affects the patient outcome
    - How condition affects other diagnoses
    - What skilled services are needed for the diagnosis or condition
  - Interventions and focus of plan of care supports top 6 diagnosis

OASIS-C2: (M1021/M1023/M1025) PRIMARY/SECONDARY DIAGNOSIS

Impact on Case Mix:

- Points available if the case mix codes is in the appropriate place in M1021 or M1023.
- Grouper Logic no longer scores diagnoses placed in M1025 (clinical, NRS, or risk adjustment variable)
- Codes recognized by the grouper for scoring are assigned to 1 of 22 Diagnosis Groups (DG).
  - Including three Z codes with case mix value:
    - Colostomy, tracheostomy, urostomy/cystostomy
  - 5 diagnosis groups remain on case mix table but no longer provide case mix value.

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OASIS-C2: (M1021/M1023/M1025) PRIMARY/SECONDARY DIAGNOSIS

- Blindness & low vision*
- Blood disorders
- Cancer & selected benign neoplasms
- Diabetes
- Dysphagia
- Gait abnormality
- Gastrointestinal disorders*
- Heart Disease
- Hypertension
- Neuro 1 (Brain)
- Neuro 2 (Peripheral)
- Neuro 3 (CVA)
- Neuro 4 (MS)
- Ortho 1 (leg/gait)
- Ortho 2 (other ortho)
- Psych 1(affective)*
- Psych 2 (degenerative)*
- Pulmonary disorders
- Skin 1 (trauma)
- Skin 2 (ulcer & other)
- Tracheostomy Care
- Urostomy/Cystostomy care

* = Diagnosis Group with no case mix points allocated

OASIS-C2: (M1021/M1023/M1025) PRIMARY/SECONDARY DIAGNOSIS

- Consistency and Logic:
- M1021 or M1023: GI diagnosis and M1630 ostomy response is 1 or 2 = 7 points (if early episode high therapy).
- M1021 or M1023: Pulmonary and M1860 ambulation response is 1 or more = 1 point (if early episode and high therapy.)
- Many unspecified codes no longer have case mix value (clinical points)
  - Example:
    - C43.9 Malignant melanoma of the skin, unspecified
    - Did not indicate:
      - *Location*
      - *Laterality*
      - *(e.g. nose or right ear)*

OASIS-C2: CRITICAL ACTION STEPS FOR ACCURACY

- Know and apply the "Conventions for Completing OASIS"
- Frequently review OASIS item-specific guidance, Q&As, & apply accordingly
- Identify & resolve potential logic inconsistencies among OASIS responses and assessment
- Adequately support OASIS responses and comprehensive assessment with thorough and descriptive clinical documentation
- Know and apply ICD-10 CM Guidelines for Coding and Reporting

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RESOURCES

- OASIS-C2 Guidance Manual Effective 1/1/2018
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-C2-Guidance-Manual-Effective_1_1_18.pdf
- OASIS Quarterly Q&As
  - https://qtso.cms.gov/hhatrain.html)
- ICD-10-CM Official Guidelines for Coding and Reporting FY 2018
  - https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-CM-Coding-Guidelines.pdf

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