OASIS ITEM

(M0080)	Discipline of Person Completing Assessment
Enter Code ☐	1 RN 2 PT 3 SLP/ST 4 OT

ITEM INTENT

- Specifies the discipline of the clinician completing the comprehensive assessment during an actual visit to the patient's home at the specified OASIS time point or the clinician reporting the transfer to an inpatient facility or death at home.

TIME POINTS ITEM(S) COMPLETED

- All

RESPONSE-SPECIFIC INSTRUCTIONS

- While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, he/she may collaborate to collect data for all OASIS items, if agency policy allows.
- Enter the response associated with the discipline of the individual completing the assessment (referred to as the assessing clinician).
- According to the comprehensive assessment regulation, when both the RN and PT/SLP are ordered on the initial referral, the RN must perform the SOC comprehensive assessment. An RN, PT, SLP, or OT may perform subsequent assessments.
- LPNs, PTAs, COTAs, MSWs, and home health aides do not meet the requirements specified in the comprehensive assessment regulation for disciplines authorized to complete the comprehensive assessment or collect OASIS data.
- When both the RN and qualified therapist are scheduled to conduct discharge visits on the same day, the last qualified clinician to see the patient is responsible for conducting the discharge comprehensive assessment.

DATA SOURCES/RESOURCES

- Agency policy
- Additional information can be found in Chapter 1 of the OASIS Guidance Manual

OASIS ITEM

(M0090) Date Assessment Completed:

		/			/				
month			day			year			

ITEM INTENT

- Specifies the actual date the assessment is completed.

TIME POINTS ITEM(S) COMPLETED

- All

RESPONSE-SPECIFIC INSTRUCTIONS

- If the date or month is only one digit, that digit is preceded by a “0” (for example, May 4, 2019 = 05/04/2019). Enter all four digits of the year.
- Date Assessment Completed cannot be before the SOC date.
- If agency policy allows assessments to be performed over more than one visit date, the last date (when the final assessment data are collected) is the appropriate date to record.
    - The M0090 date assessment completed will indicate the last day the clinician gathered or received any input used to complete the comprehensive assessment document, which includes the OASIS items.
- The comprehensive assessment is a legal document and when signed by the assessing clinician, the signature serves as an attestation that to the best of his/her knowledge, the document, including OASIS responses, reflects the patient status as assessed, documented and/or supported in the patient’s clinical record.
- Some OASIS elements, for instance the Clinical Records Items (Patient Name, Birth Date, Medicare Number, etc.), may be completed initially by clerical staff as part of the intake/referral process; but should be verified by the assessing clinician when completing the assessment. For OASIS items requiring a patient assessment, the collaborating healthcare providers (e.g., other agency clinical staff: LPN/LVN, PTA, COTA, MSW, HHA) should have had direct in-person contact with the patient, or have had some other means of gathering information to contribute to the OASIS data collection (health care monitoring devices, video streaming, review of photograph, phone call, etc.).
- 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. M0090 (Date Assessment Completed) will indicate the last day the assessing clinician gathered or receive an input used to complete the comprehensive assessment document, which includes the OASIS items. Any exception to this general convention concerning collaboration is identified in item-specific guidance.
- If the assessing clinician gathers additional information during the assessment time frame that would result in changing the coding of one or more OASIS items (for instance, identifies functional or cognitive information that he/she believes is more representative of the patient’s usual status than the code originally selected), the M0090 date would be changed to reflect the date the latest information was gathered and the response change was made.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M0090)

- If an error is identified at any time, it should be corrected following the agency's correction policy and M0090 would not necessarily be changed.
- For the following OASIS time points, Transfer to Inpatient Facility – patient not discharged from agency; Transfer to Inpatient Facility – patient discharged from agency or Death at Home, record the date the agency completes the data collection after learning of the event, as a visit is not necessarily associated with these events.
- See information on M0100 Reason for Assessment for additional clarification.

DATA SOURCES/RESOURCES

- Calendar

OASIS ITEM

(M0100)	This Assessment is Currently Being Completed for the Following Reason:
Enter Code ☐	**Start/Resumption of Care** 1 Start of care – further visits planned 3 Resumption of care (after inpatient stay) **Follow-Up** 4 Recertification (follow-up) reassessment ***[Go to M0110]*** 5 Other follow-up ***[Go to M0110]*** **Transfer to an Inpatient Facility** 6 Transferred to an inpatient facility – patient not discharged from agency ***[Go to M1041]*** 7 Transferred to an inpatient facility – patient discharged from agency ***[Go to M1041]*** **Discharge from Agency – Not to an Inpatient Facility** 8 Death at home ***[Go to M2005]*** 9 Discharge from agency ***[Go to M1041]***

ITEM INTENT

- Identifies the "time point" – reason why the assessment data are being collected and reported. Accurate recording of this response is important as the logic in the data reporting software will accept or reject certain data according to the specific response that has been entered for this item.

TIME POINTS ITEM(S) COMPLETED

- All

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter only one response.
  - Response 1: This is the start of care comprehensive assessment. A Plan of Care is being established, whether or not further visits will be provided after the start of care visit. This is the appropriate response anytime an initial HIPPS code (for a Home Health Resource Group) is required.
  - Response 3: This comprehensive assessment is conducted when the patient resumes care following an inpatient stay of 24 hours or longer for reasons other than diagnostic tests. Remember to update the Patient Tracking Sheet ROC date (M0032) when this response is entered. When a patient is discharged from an inpatient facility and care is resumed within the last 5 days of the episode (that is, a recertification assessment is due), a ROC assessment, rather than a recertification assessment, is completed.
  - Response 4: This comprehensive follow-up assessment is conducted during the last five days of the 60-day certification period and is completed to continue the patient's services for an additional 60 day episode of care.
  - Response 5: This comprehensive assessment is conducted due to a major decline or improvement in patient's health status occurring at a time other than during the last five days of the episode. This assessment is done to re-evaluate the patient's condition, allowing revision to the patient's care plan as appropriate.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M0100)

- Response 6: This "Transfer to an Inpatient Facility" OASIS is completed when the home care patient is admitted to an inpatient facility for 24 hours or longer for reasons other than diagnostic tests with the expectation that home health care will be resumed following inpatient discharge; thus the patient is not discharged from the agency. (When the patient resumes care, a Resumption of Care comprehensive assessment is conducted.) This response does not require a home visit; a telephone call may provide the information necessary to complete the required data items. Short stay observation periods in a hospital, regardless of duration, do not meet the definition for transfer to an inpatient facility.
- Response 7: This "Transfer to an Inpatient Facility" OASIS is only completed when the home care patient is admitted to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests) and the agency does NOT anticipate the patient will be returning to care. The patient is discharged from the agency. This response does NOT require a home visit; a telephone call may provide the information necessary to complete the required data items. No additional OASIS discharge data are required. Short stay observation periods in a hospital, regardless of duration, do not meet the definition for transfer to an inpatient facility.
- Response 8: Data regarding patient death anywhere other than death in an emergency department or inpatient facility. A patient who dies **before** being treated in an emergency department or before being admitted to an inpatient facility would have this response entered. Note the "skip pattern" included in the response. A home visit is not required to enter this response; the information necessary to complete the data items may be obtained by telephone.
- Response 9: This comprehensive assessment is conducted when a patient is discharged from the agency for any reason other than transfer to an inpatient facility or death at home. This response includes transfer and **discharge** to another home health agency or an in-home hospice. A patient visit is required to complete this assessment. Note the "skip pattern" present in the response. The Discharge OASIS is not required when only a single visit is made in a care episode (SOC/ROC to TRF/DC).

- Assessment strategies: Why is the assessment being conducted (or the information being recorded)? What has happened to the patient? Accuracy of this response is critical.

DATA SOURCES/RESOURCES

- Agency case manager or other care team provider
- Clinical record
- Hospital or other health care provider information regarding transfer to inpatient facility or death at home

OASIS ITEM

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

☐☐ / ☐☐ / ☐☐☐☐ [*Go to M0110, if date entered*]
month day year

☐ NA - No specific SOC date ordered by physician

ITEM INTENT

- Specifies the date that home care services are ordered to begin or to resume following an inpatient stay of 24 hours or longer and for reasons other than diagnostic tests, if a SOC/ROC date was specified by the physician. The item refers to the order to start home care services (that is, provide the first covered service), or resume home care services (that is provide the first visit following a qualifying inpatient stay) regardless of the type of services ordered (for example, therapy only).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- If the originally ordered Start of Care (SOC)/Resumption of Care (ROC) is delayed due to the patient's condition or physician request (for example, extended hospitalization), then the date specified on the updated/revised order to start/resume home care services would be considered the date of physician-ordered SOC/Resumption of Care (ROC). For example, a patient discharged home on May 15 but for whom the physician orders home care to begin May 20 for a specified order (for example, PT or administration of a subcutaneous drug), would have a physician-ordered SOC date of May 20.
- If the date or month is only one digit, that digit is preceded by a "0" (for example, May 4, 2019 = 05/04/2019). Enter all four digits of the year.
- Mark "N/A" if the initial orders did not specify a SOC or ROC date.
- In order to be considered a physician-ordered SOC/ROC date, the physician must give a specific date to initiate or resume care, not a range of dates. If a single date to initiate or resume services is not provided, the initial contact (via the initial assessment visit or resumption of care visit) must be conducted within 48 hours of the referral or within 48 hours of the patient's return home from the inpatient facility.

DATA SOURCES/RESOURCES

- Physician orders to initiate home care or resume home care following inpatient facility stay

OASIS ITEM

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

		/			/				
month			day			year			

ITEM INTENT

- Specifies the referral date, which is the most recent date that verbal, written, or electronic authorization to begin or resume home care was received by the home health agency.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- A valid referral is considered to have been received when the agency has received adequate information about a patient (name, address/contact info, and diagnosis and/or general home care needs) and the agency has ensured that the referring physician, or another physician, will provide the plan of care and ongoing orders. In cases where home care is requested by a hospitalist who will not be providing an ongoing plan of care for the patient, the agency must contact an alternate, or attending physician, and upon agreement from this following physician for referral and/or further orders, the agency will note this as the referral date in M0104 (unless referral details are later updated or revised).
- If Start of Care or Resumption of Care is delayed due to the patient's condition or physician request (for example, extended hospitalization), then the date the agency received **updated/revised** referral information for home care services to begin would be considered the date of referral. This does not refer to calls or documentation from others such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission.
- The date authorization was received from the patient's payer is NOT the date of the referral (for example, the date the Medicare Advantage case manager authorized service is not considered a referral date).
- If the date or month is only one digit, that digit is preceded by a "0" (for example, May 4, 2019 = 05/04/2019). Enter all four digits of the year.

DATA SOURCES/RESOURCES

- Agency referral form
- Agency records specifying the date the referral was received by the agency
- Hospital or nursing home discharge information

OASIS ITEM

(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.

ITEM INTENT

- Identifies the placement of the current Medicare PPS payment episode in the patient's current sequence of adjacent Medicare PPS payment episodes.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up

RESPONSE-SPECIFIC INSTRUCTIONS

- A "sequence of adjacent Medicare home health payment episodes" is a continuous series of Medicare PPS 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" includes the only PPS episode in a single episode case OR the first or second PPS episode in a sequence of adjacent PPS episodes. **Enter Response 1 – Early – if the episode of care you are assessing the patient for is the patient's first or second episode of care** in a current sequence of adjacent Medicare home health PPS payment episodes.
- "Later" means the third or later PPS episode in a sequence of adjacent episodes. **Enter Response 2 – Later – if this episode is the third or later episode of care** in a current sequence of adjacent Medicare home health PPS payment episodes.
- Enter "UK – Unknown" if the placement of this PPS payment episode in the sequence of adjacent episodes is unknown. For the purposes of assigning a case mix code to the episode, this will have the same effect as entering the "Early" response.
- Enter "NA" if no Medicare case mix group is to be defined for this episode.
- If the patient needs a case mix code for billing purposes (a HIPPS code), a response other than "NA" is required to generate the code. Some payment sources that are not Medicare-fee-for-service payers will use this information in setting an episode payment rate.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M0110)

- Assessment strategies: Consult all available sources of information to answer this item. Medicare systems, such as Health Insurance Query for Home Health (HIQH), can provide this information. If calculating manually, note that the Medicare home health payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date, and that there can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next. Remember that a sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies. Episodes where Medicare fee-for-service is not the payer (such as HMO, Medicaid, or private pay) do NOT count as part of a sequence. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence. Remember that the 60-day gap is counted from the end of the Medicare payment episode, not from the date of the last visit or discharge, which can occur earlier. (If the episode is ended by an intervening event that causes it to be paid as a partial episode payment [PEP] adjustment, then the last visit date is the end of the episode).

DATA SOURCES/RESOURCES

- Medicare systems, such as Health Insurance Query for Home Health (HIQH)