

APPENDIX C – OASIS-C Item Uses

The following key can be used in reading/determining the timepoints and potential uses of OASIS-C data items.

KEY:

- S = Item collected on Start of Care (SOC) Assessment
- R = Item collected on Resumption of Care (ROC) Assessment
- F = Item collected on Follow-up/Recertification (FU) Assessment
- T = Item collected on Inpatient Transfer (TRN) Assessment
- D = Item collected on Discharge (DC) Assessment
- H = Item collected on Death at Home (DAH) Assessment
- \$ = Item potentially scores points used in assigning case to an HHRG for Medicare payment
- C = Consistency - Item is used by Medicare payment grouper software to enforce OASIS-C data consistency specifications
- Q = Item used to calculate quality measures
- RA = Item under consideration for use in risk adjusting quality measures

OASIS-C (August 2009)		Timepoints						Item Uses		
Item #	Item Description	S O C	R O C	F U	T R N	D C	D A H	Medicare Payment	Quality Measures	Risk Adjustment
M0010	CMS Certification Number	S								
M0014	Branch State	S								
M0016	Branch ID Number	S								
M0020	Patient ID Number	S								
M0030	Start of Care Date	S						C	Q	
M0032	Resumption of Care Date		R						Q	RA
M0040	Patient Name	S								
M0050	Patient State of Residence	S								
M0060	Patient Zip Code	S								
M0063	Medicare Number	S								
M0064	Social Security Number	S								
M0065	Medicaid Number	S								
M0066	Birth Date	S							Q	RA
M0069	Gender	S								RA
M0018	National Provider Identifier (NPI) physician who signed plan of care	S								

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Item #	Item Description	S O C	R O C	F U	T R N	D C	D A H	Medicare Payment	Quality Measures	Risk Adjustment
M0140	Race/Ethnicity	S								
M0150	Current Payment Sources	S								RA
M0080	Discipline of Person Completing Assessment	S	R	F	T	D	H			
M0090	Date Assessment Completed	S	R	F	T	D	H	C	Q	
M0100	Reason for Assessment	S	R	F	T	D	H	C	Q	
M0102	Date of Physician-ordered Start of Care (Resumption of Care)	S	R						Q	
M0104	Date Written or Verbal Referral	S	R						Q	
M0110	Episode Timing (Early/Later)	S	R	F				C		RA
M1000	Inpatient Facility Discharges, past 14 days	S	R							RA
M1005	Inpatient Discharge Date (most recent)	S	R							RA
M1010	Inpatient Diagnosis, stay within past 14 days	S	R							RA
M1012	Inpatient Procedure(s) relevant to the plan of care	S	R							
M1016	Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days	S	R							RA
M1018	Conditions Prior to Regimen Change or Inpatient Stay Within Past 14 Days	S	R							RA
M1020	Primary Diagnosis & Degree of Symptom Control	S	R	F				\$		RA
M1022	Other Diagnoses & Degree of Symptom Control	S	R	F				\$		RA
M1024	Payment Diagnoses	S	R	F				\$		RA
M1030	Therapies patient receives at home	S	R	F				\$		RA
M1032	Risk for Hospitalization	S	R							RA

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Item #	Item Description	S O C	R O C	F U	T R N	D C	D A H	Medicare Payment	Quality Measures	Risk Adjustment
M1034	Patient's Overall Status	S	R							RA
M1036	Risk Factors	S	R							RA
M1040	Received Influenza Vaccine from agency during episode				T	D			Q	
M1045	Reason Influenza Vaccine not received				T	D			Q	
M1050	Received Pneumococcal Vaccine from agency during episode				T	D			Q	
M1055	Reason PPV not received				T	D			Q	
M1100	Patient Living Situation/Availability of Assistance	S	R						Q	RA
M1200	Vision	S	R	F				\$		RA
M1210	Ability to hear	S	R							RA
M1220	Understanding of Verbal Content	S	R							RA
M1230	Speech and Oral (Verbal) Expression of Language	S	R			D			Q	RA
M1240	Formal Pain Assessment	S	R						Q	RA
M1242	Frequency of Pain	S	R	F		D		\$	Q	RA
M1300	Pressure Ulcer Assessment	S	R						Q	RA
M1302	Risk of Developing Pressure Ulcers	S	R						Q	RA
M1306	Any unhealed Pressure Ulcer at Stage II+ or "unstageable"	S	R	F		D		C	Q	RA
M1307	Oldest Non-epithelialized Stage II Pressure Ulcer					D			Q	
M1308	Current Number Unhealed (non-epithelialized) Pressure Ulcers at Stages II-IV (or unstageable)	S	R	F		D		\$	Q	RA
M1308	Current Number Unhealed (non-epithelialized) Pressure Ulcers at Stages II-IV (or unstageable) that were present at SOC-ROC			F		D		C		

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Item #	Item Description	S O C	R O C	F U	T R N	D C	D A H	Medicare Payment	Quality Measures	Risk Adjustment
M1310	Length of largest unhealed Stage III or IV pressure ulcer	S	R			D		C		RA
M1312	Width of largest unhealed Stage III or IV pressure ulcer	S	R			D		C		RA
M1314	Depth of largest unhealed Stage III or IV pressure ulcer	S	R			D		C		RA
M1320	Status Most Problematic (Observable) Pressure Ulcer	S	R			D		C		RA
M1322	Current Number Stage I Pressure Ulcers	S	R	F		D		\$		RA
M1324	Stage Most Problematic (Observable) Pressure Ulcer	S	R	F		D		\$	Q	RA
M1330	Any Stasis Ulcer?	S	R	F		D		\$		RA
M1332	Current Number (Observable) Stasis Ulcer(s)	S	R	F		D		\$		RA
M1334	Status Most Problematic (Observable) Stasis Ulcer	S	R	F		D		\$		RA
M1340	Any Surgical Wound?	S	R	F		D		C	Q	RA
M1342	Status Most Problematic (Observable) Surgical Wound	S	R	F		D		\$	Q	RA
M1350	Other Skin Lesion or Open Wound <u>receiving intervention</u> by agency	S	R	F		D		C		RA
M1400	When dyspneic	S	R	F		D		\$	Q	RA
M1410	Respiratory Treatments Received	S	R			D				RA
M1500	Symptoms in Heart Failure Patients				T	D			Q	
M1510	Heart Failure Symptom Follow-up				T	D			Q	
M1600	Urinary Tract Infection treatment in past 14 days	S	R			D			Q	RA
M1610	Urinary Incontinence or Urinary Catheter Presence	S	R	F		D		\$	Q	RA
M1615	When Urinary Incontinence occurs	S	R			D			Q	RA

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Item #	Item Description	S O C	R O C	F U	T R N	D C	D A H	Medicare Payment	Quality Measures	Risk Adjustment
M1620	Bowel Incontinence Frequency	S	R	F		D		\$	Q	RA
M1630	Ostomy for Bowel Elimination	S	R	F				\$		RA
M1700	Cognitive Functioning	S	R			D			Q	RA
M1710	When Confused (Reported or Observed Within the Last 14 Days)	S	R			D			Q	RA
M1720	When Anxious (Reported or Observed Within the Last 14 Days)	S	R			D			Q	RA
M1730	Depression Screening	S	R						Q	RA
M1740	Cognitive, behavioral, and psychiatric symptoms	S	R			D			Q	RA
M1745	Frequency of Disruptive Behavior Symptoms (Reported or Observed)	S	R			D			Q	RA
M1750	Receipt of Psychiatric Nursing Services	S	R							RA
M1800	Grooming	S	R			D			Q	RA
M1810	Ability to Dress Upper Body	S	R	F		D		\$	Q	RA
M1820	Ability to Dress Lower Body	S	R	F		D		\$	Q	RA
M1830	Bathing	S	R	F		D		\$	Q	RA
M1840	Toilet Transferring	S	R	F		D		\$	Q	RA
M1845	Toileting Hygiene	S	R			D			Q	RA
M1850	Bed Transferring	S	R	F		D		\$	Q	RA
M1860	Ambulation/Locomotion	S	R	F		D		\$	Q	RA
M1870	Feeding or Eating	S	R			D			Q	RA
M1880	Plan and Prepare Light Meals	S	R			D			Q	RA
M1900	Prior Functioning ADL/IADL	S	R							RA
M1890	Ability to Use Telephone	S	R			D			Q	RA
M1910	Multi-factor Fall Risk Assessment	S	R						Q	RA

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Item #	Item Description	S O C	R O C	F U	T R N	D C	D A H	Medicare Payment	Quality Measures	Risk Adjustment
M2000	Drug Regimen Review	S	R					C		RA
M2002	Medication Follow-up	S	R						Q	RA
M2004	Medication Intervention				T	D			Q	
M2010	Patient/Caregiver High Risk Drug Education	S	R						Q	RA
M2015	Patient/Caregiver Drug Education Intervention				T	D			Q	RA
M2020	Management of Oral Medications – Current Ability	S	R			D			Q	RA
M2030	Management of Injectable Medications – Current Ability	S	R	F		D		\$		RA
M2040	Prior Medication Management Ability	S	R							RA
M2100	Types of Assistance Needed and Sources/Availability	S	R			D				RA
M2110	Frequency receipt of ADL or IADL assistance (other than agency staff)	S	R			D				RA
M2200	Therapy Need	S	R	F				\$		RA
M2250	Plan of Care Synopsis (Patient-specific parameters for notifying physician, Diabetic foot care, Falls prevention, Depression intervention(s), Intervention(s) to monitor and mitigate pain, Intervention(s) to prevent pressure ulcers, Pressure ulcer treatment)	S	R						Q	RA
M2300	Used Emergent Care				T	D			Q	
M2310	Reason for Emergent Care				T	D			Q	

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Item #	Item Description	S O C	R O C	F U	T R N	D C	D A H	Medicare Payment	Quality Measures	Risk Adjustment
M2400	Intervention Synopsis (Diabetic foot care, Falls prevention interventions, Depression intervention(s), Intervention(s) to monitor and mitigate pain, Intervention(s) to prevent pressure -ulcers, Pressure ulcer treatment)				T	D			Q	
M2410	Type Inpatient Facility to which patient admitted				T	D			Q	
M2420	Discharge Disposition					D			Q	
M2430	Reason for Hospitalization				T				Q	
M2440	Reason(s) Admitted to a Nursing Home				T					
M0903	Date of Last (Most Recent) Home Visit				T	D	H			
M0906	Discharge/Transfer/Death Date				T	D	H		Q	

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