Specifications for OASIS-C (July, 2009 Version) Files Submitted from Home Health Agencies

Data Specification Notes: Version 2.00 Revision 3

Files Included in the Data Specifications

This document and several accompanying documents describe CMS's data specifications for submitting OASIS-C data from a home health agency to CMS.

Below is a list of the documents included with these specifications:

- DS200R3.PDF This document
- HD200R3.PDF Detailed specifications for the header record
- HS200R3.PDF Summary specifications for the header record
- BD200R3.PDF Detailed specifications for the body record
- BS200R3.PDF Summary specifications for the body record
- ID200R3.PDF Detailed specifications for the inactivation record.
- IS200R3.PDF Summary specifications for the inactivation record
- TD200R3.PDF Detailed specifications for the trailer record
- TS200R3.PDF Summary specifications for the trailer record
- BC200R3.PDF Lists changes to the specifications for the body record
- OASIS200R3.MDB Access database containing the data specifications

Most of these documents are Adobe Acrobat® files. You must have the Adobe Acrobat® reader to view and print these files. The Adobe Acrobat® reader can be downloaded from Adobe's web site:

http://www.adobe.com

Excel Data Specification Files

In addition to the documents listed above, four Excel (XLS) files are included which may be helpful to programmers who need to implement the data submission specifications. All four of these files contain one record for every field in the header, body, inactivation, or trailer record.

The files included are:

- HS200R3.XLS Lists every field in the header record.
- BS200R3.XLS Lists every field in the body record.
- IS200R3.XLS Lists every field in the inactivation record.
- TS200R3.XLS Lists every field in the trailer record.

The table below describes the columns in these files. Note that only the first 4 fields listed are included in all four files. The remaining fields describe the reasons for assessment (RFAs) for which each field is required or active. This information pertains only to fields in the body record.

Field Name	Files Included	Description

Field Name	Files Included	Description
ITEM	All	Field name.
LENGTH	All	Field length.
START	All	Field start byte in body record.
END	All	Field end byte in body record.
RFA01	BS200R3.XLS	Required on RFA01: 0=no, 1=yes.
RFA02	BS200R3.XLS	Always blank*
RFA03	BS200R3.XLS	Required on RFA03: 0=no, 1=yes.
RFA04	BS200R3.XLS	Required on RFA04: 0=no, 1=yes.
RFA05	BS200R3.XLS	Required on RFA05: 0=no, 1=yes.
RFA06	BS200R3.XLS	Required on RFA06: 0=no, 1=yes.
RFA07	BS200R3.XLS	Required on RFA07: 0=no, 1=yes.
RFA08	BS200R3.XLS	Required on RFA08: 0=no, 1=yes.
RFA09	BS200R3.XLS	Required on RFA09: 0=no, 1=yes.
RFA10	BS200R3.XLS	Always blank*
RFA_REQ	BS200R3.XLS	List of RFAs for which the field is required (same as "active on RFA" in printed data specs).
RFA_BLANK	BS200R3.XLS	List of RFAs for which the field must be blank (same as "blank on RFA" in printed data specs).

** Note that all records in* BS200R3.XLS *will have RFA02 and RFA10 equal to blank. Starting with Version 1.30 of the data specs, RFA 02 and 10 are no longer active.*

Submission File Structure

A valid submission file consists of fixed length ASCII records. All records in the file must consist of 1446 data bytes followed by a carriage return (ASCII 013) and then a line feed (ASCII 010) for a total of 1448 bytes. Byte 1446 of each record must contain a % (percent sign) to indicate end of data.

Each submission file consists of a **Header Record** as the first record, one or more **Body Records** and/or **Inactivation Records**, and a **Trailer Record** as the last record. The records between the header and trailer records may consist entirely of body records, entirely of inactivation records, or any mixture of the two types of records. Body and/or inactivation records may be in any order within a submission file and the two types of records may be kept separate or may be intermingled. However, each submission file must contain at least one record which is either a body or inactivation record.

Header Record

The header record has *A1* (capital A followed by one) in the first two bytes. The document **HD200R3.PDF** presents a detailed layout for the header record. The header record contains basic identifying information for the agency submitting the OASIS data and for contact persons and phone numbers to use in the event that the file is in error. An abbreviated version of the header record layout is presented in the document **HS200R3.PDF**.

Body Record

The body record has *B1* (capital B followed by one) in the first two bytes. The document **BD200R3.PDF** presents a detailed layout for the body record. The body record contains information for a single OASIS patient assessment. Note that the body record consists of two sections: a record control section followed by a data item section. The record control section contains items which are not on the OASIS assessment, while the data item section contains the OASIS data items (i.e., the M0 items).

All body records consist of exactly the same fields in the exactly the same order. The list of fields which must be completed for an assessment is controlled by the reason for assessment (M0100_ASSMT_REASON) since different reasons for assessment (RFAs) have different skip patterns on the OASIS. A given field may be required on some RFAs, optional on other RFAs, and blank filled on still other RFAs. An abbreviated version of the body record layout is presented in the document **BS200R3.PDF**.

Inactivation Record

The inactivation record has *X1* (capital X followed by one) in the first two bytes. The document **ID200R3.PDF** presents a detailed layout for the inactivation record. An abbreviated version of the inactivation record layout is presented in the document **IS200R3.PDF**. The inactivation record contains information which identifies a previously-submitted data record which the HHA wishes to inactivate. See *"Correction Procedures"* later in this document for a description of the use of inactivation records.

Trailer Record

The trailer record has *Z1* (capital Z followed by one) in the first two bytes. The document **TD200R3.PDF** presents a detailed layout for the trailer record. The trailer record indicates the end of the submission file, and this record includes a count of the total records in the file including the header and trailer records. An abbreviated version of the data record layout is presented in the document **TS200R3.PDF**.

Field by Field Specifications

The detailed record layout and data specifications for each type of record (header, body, inactivation, and trailer) provide the information necessary to construct an acceptable submission file. Each record layout specification report contains the following report elements for each data item:

- **Item Identifier.** This report element provides a unique name for each field in the record layout. Where a field corresponds to an OASIS data item, the item identifier includes the appropriate M0 item designation. For example, item M0100 is referred to in the body record specifications as M0100_ASSMT_REASON. Some OASIS data items (such as checklists) are represented by more than one field on the record layout. For example, M0150 (current payment sources) is represented by M0150_CPAY_NONE, M0150_CPAY_MCARE_FFS, etc., where each field corresponds to the various response options.
- **Item Description.** This element provides a verbal description of the data field.
- **Len.** The length of the data item in the record layout.
- **Start.** The starting byte of the data item in the record layout.
- **End.** The ending byte of the data item in the record layout.
- **OASIS B Identifier.** The transition from OASIS-B to OASIS-C produced three groups of data items: (1) items that were unchanged, (2) items that changed item number only (i.e., the content of the item stayed the same), and (3) entirely new items. The "OASIS-B Identifier" report element indicates which group each item fell into. OASIS-B1 items that were unchanged in OASIS-C are identified with the notation "*** No Change ***". New items are indicated by "*** New Item ***". For items that underwent a numbering change, the name of the corresponding OASIS-B1 item is listed.
- **Active on RFA.** This report element lists the reasons for assessment (RFAs) for which the item is active. For example, for M1036_RSK_OBESITY, the following RFAs are listed: 01and 03. This means that when M0100_ASSMT_REASON (reason for assessment) matches any of these values, this data item is active.

Note that certain required data items may be skipped if additional conditions apply (see "consistency required", below). The "active on RFA" report element is included only on the body record specifications since it is irrelevant for the header, inactivation, and trailer records.

- **Blank on RFA.** This report element lists the reasons for assessment (RFAs) for which the item is inactive and must be blank. For example, for M1036_RSK_OBESITY, the following RFAs are listed: 04, 05, 06, 07, 08, and 09. This means that when M0100_ASSMT_REASON (reason for assessment) matches any of these values, this data item must be blank (i.e., it is skipped when the assessment is administered). The "blank on RFA" report element is included only on the body record specifications since it is irrelevant for the header, inactivation, and trailer records.
- **Picture.** A COBOL-style picture specification for the data field.
- **Type.** Indicates the type of field:
  - **Text.** Indicates a variable length text field (e.g., a city name).
  - **Date.** Indicates a date field (all date fields must be formatted YYYYMMDD).
  - **Code.** Indicates that the field can possess any one of a limited set of coded values.
  - **Count.** Indicates an integer count field.
  - **Filler.** Indicates a field which must be blank filled.
- **Range if Active.** Indicates the range of valid values which a field can assume when the field is active (i.e., when the appropriate RFA is included in the "required on RFA" list). Note that the convention *sp(x)* is used to indicate spaces (e.g., *sp(1)* indicates a single space, *sp(5)* indicates 5 spaces). Note that violations of range rules are always fatal and will result in rejection of the record.
- **Format info.** Provides information about how data must be formatted (e.g., right justified, zero filled, etc.).
- **Consistency if Active.** Provides information about the logical relationships between the current field and other fields in the layout. Note that the rules listed apply only if the item is active for a particular type of assessment. If the item is not active, it must always be blank-filled. Note also that consistency notes that have an asterisk before the note number are fatal errors; violation of such rules will cause the record to be rejected. Rules that are not preceded by an asterisk are non-fatal; violation of these rules will result in warnings but will not cause the record to be rejected. The following are some examples of how this report element is used:
  - **Skip patterns.** The responses to some OASIS items are contingent upon the response to other items.
  - **Checklist patterns.** Some checklists allow only one item in the list to be checked. Other checklists allow multiple responses (i.e., "check all that apply"). Some responses (e.g., "none of the above") preclude responses to the other items in the list.
  - **Date relationships.** Certain dates on OASIS have logical relationships with other dates on the assessment.
- **Version notes.** Information about changes made to the field since the publication of the prior version of the data specifications. Where appropriate, these notes may have version history information in brackets. For example, the designation *[R3]* may be used to refer to "Revision 3" of the specifications.

Body Record Date Consistency

The body record contains the following critical date fields[1]:

M0030_START_CARE_DT	Start of care date
M0032_ROC-DT	Resumption of care date

[1] Prior to Version 1.50, LOCK_DATE was included in this list. Beginning with Version 1.50, LOCK_DATE was made an inactive field. It has therefore been removed from the list of fields that are involved in date checking.

M0066_PAT_BIRTH_DT	Patient date of birth
M0090_INFO_COMPLETED_DT	Date assessment information completed
M1005_INP_DISCHARGE_DT	Most recent inpatient discharge date
M0903_LAST_HOME_VISIT	Date of last home visit
M0906_DC_TRAN_DTH_DT	Discharge, transfer, or death date

The purpose of this section is to describe the rules which govern the relationships among these dates. Some of these rules differ somewhat depending upon the reason for assessment (RFA) contained in M0100_ASSMT_REASON. These rules are described below for each type of assessment. Other rules apply to all types of assessments and are described in a separate section. Many of the rules involve the number of days between certain dates. Please note that these calculations are based upon **calendar** days, not work days.

These consistency rules are of two types. The first type involves date sequencing: insuring that the chronological order of dates is logical (e.g., it is illogical for a patient's date of birth to occur later than the start of care date). Violations of these rules are fatal errors which will lead to record rejection by the state system.

The second type of rule involves timing. The OASIS regulations describe the timing of events (e.g., when an assessment must be completed and submitted). Dates on the OASIS record are used to check the timing of these events (i.e., that the number of days between various events doesn't exceed the regulatory thresholds). Because HHA's are required to always submit data even if these timing rules are not followed, these consistency checks are not fatal; they will result only in warnings and the records with timing rule violations will <u>not</u> be rejected when submitted to the state system.

The first section below describes the fatal errors associated with the date sequencing rules. The remainder of this section describes the timing rules.

Date Sequencing Rules

Date sequencing rules refer to the chronological order of the events described by the dates listed below. There is a logical sequence implied by these dates which must be followed. For example, it is illogical for the patient birth date to be later than the start of care date. Each data record must follow these date sequencing rules or fatal errors will occur leading to rejection of the record when it is submitted to the state system.

The chronological sequence of OASIS dates is as follows:

1. M0066_PAT_BIRTH_DT
2. M1005_INP_DISCHARGE_DT
3. M0030_START_CARE_DT
4. M0032_ROC_DT
5. M0903_LAST_HOME_VISIT
6. M0906_DC_TRAN_DTH_DT
7. M0090_INFO_COMPLETED_DT

Do the following to determine whether dates are in the proper chronological sequence in an assessment:

1. Exclude any dates from this list which do not occur (are blank) in the record (some dates are not completed on certain RFAs).
2. Each remaining date must be less than or equal to every date which follows in the list.
3. A fatal error will occur if any date in the list is later than any other date which follows on the list.

4. If M0032_ROC_DT is not blank, then the following exception applies to M1005_INP_DISCHARGE_DT: M1005_INP_DISCHARGE_DT can be later than M0030_START_CARE_DT, but must be less than or equal to all subsequent dates on the list.

There are several additional fatal date edits:

1. No date can be later than the current date.
2. M0066_PAT_BIRTH_DT can be no more than 140 years prior to the current date and no less than 18 years prior to M0090_INFO_COMPLETED_DT.
3. The effective date (defined later in this document) can be no earlier than 07/19/1999 (the date the OASIS data submission requirement went into effect).

The consistency checks described in the detailed body specifications incorporate these sequencing rules and list violations as fatal errors.

Timing Rules for Start of Care Assessments

1. Start of care assessments (where M0100_ASSMT_REASON is equal to 01) must be completed within 5 days of the start of care. This rule implies the following date consistency rule for start of care assessments:

   0 <= M0090_INFO_COMPLETED_DT - M0030_START_CARE_DT <= 5

   This means that M0090_INFO_COMPLETED_DT minus M0030_START_CARE_DT must be greater than or equal to zero and less than or equal to 5.

2. If M1005_INP_DISCHARGE_DT is not blank and if M0100_ASSMT_REASON=01, then the following rule applies:

   0 >= M0030_START_CARE_DT - M1005_INP_DISCHARGE_DT <=14

   This means that M0030_START_CARE_DT minus M1005_INP_DISCHARGE_DT must be greater than or equal to zero and less than or equal to 14.

Timing Rules for Resumption of Care Assessments

1. Resumption of care assessments (where M0100_ASSMT_REASON is equal to 03) must be completed within 2 days of the resumption of care. This rule implies the following date consistency rule for resumption of care assessments:

   0 <= M0090_INFO_COMPLETED_DT - M0032_ROC_DATE <= 2

   This means that M0090_INFO_COMPLETED_DT minus M0032_ROC_DATE must be greater than or equal to zero and less than or equal to 2.

2. If M1005_INP_DISCHARGE_DT is not blank and if M0100_ASSMT_REASON=03, then the following rule applies:

   0 <= M0032_ROC_DT - M1005_INP_DISCHARGE_DT <= 14

   This means that M0032_ROC_DT minus M00180_INP_DISCHARGE_DT must be greater than or equal to zero and less than or equal to 14.

Timing Rules for Recertification (Follow-up) Assessments

Recertification follow-up assessments (where M0100_ASSMT_REASON is equal to 04) must be completed every 60 days following the start of care if the patient is still in care. For each follow-up, the assessment must be completed on or after the 56th day and on or before the 60th day of the period. This rule is discussed in more detail in a later section (see *Record Timing* below).

Timing Rules for Other Follow-Up Assessments

Other follow-up assessments (where M0100_ASSMT_REASON is equal to 05) can occur at any time after start of care or resumption of care. However, if a recertification (follow-up) assessment (where M0100_ASSMT_REASON is equal to 04) is due, an Other Follow-up Assessment cannot be substituted for it.

Timing Rules for Discharge/Transfer/Death Assessments

Discharge/transfer/death assessments (where M0100_ASSMT_REASON is equal to 06, 07, 08, or 09) must be completed within 2 days of the discharge/transfer/death date. This rule implies the following date consistency rule for discharge/transfer/death assessments:

0 <= M0090_INFO_COMPLETED_DT - M0906_DC_TRAN_DTH_DT <= 2

This means that M0090_INFO_COMPLETED_DT minus M0906_DC_TRAN_DTH_DT must be greater than or equal to zero and less than or equal to 2.

Submission Timing Rules

Agencies are required to submit assessments within 30 days of the completion date. More specifically, the rule is as follows:

[submission date] – M0090_INFO_COMPLETED_DT <= 30

A warning will be issued by the Submission System for any records that do not pass this edit (note that the record will be accepted even if it is late).

Note that this submission timing rule applies only to original assessment records. Correction records (with CORRECTION_NUM greater than zero) may be submitted at any time and no warning is issued if they are submitted more than 30 days after the completion date. See *Submission of Correction Records* below for details.

Body Record Sequencing and Timing Rules

There are various requirements concerning the sequencing and timing of records for a patient within a given home health agency. This section presents those requirements. The requirements for record sequencing and timing are based upon the reason for assessment (RFA) contained in item M0100_ASSMT_REASON and the effective date, which is described in the following section.

Effective Date

The sequence rules are based upon the ordering of records submitted for a particular patient served by a particular home health agency. The sequence of records is determined by ordering the set of records by effective date which is defined as follows:

Reason for Assessment*	**Effective Date**
01 start of care – further visits planned	M0030_START_CARE_DT (start of care date)
02 start of care – no further visits planned	This RFA is no longer in use*.
03 resumption of care – after inpatient stay	M0032_ROC_DATE (resumption of care date)
04 recertification reassessment (follow-up)	M0090_INFO_COMPLETED_DT (date assessment completed)
05 other follow-up	M0090_INFO_COMPLETED_DT (date assessment completed)
06 transferred to an inpatient facility – not discharged from agency	M0906_DC_TRAN_DTH_DT (discharge/transfer/death date)

Reason for Assessment*	**Effective Date**
07 transferred to an inpatient facility – discharged from agency	M0906_DC_TRAN_DTH_DT (discharge/transfer/death date)
08 died at home	M0906_DC_TRAN_DTH_DT (discharge/transfer/death date)
09 discharge from agency – not to an inpatient facility	M0906_DC_TRAN_DTH_DT (discharge/transfer/death date)
10 discharge from agency – not to an inpatient facility: no visits since last SOC assessment	This RFA is no longer in use*.

**Note that beginning with Version 1.30 of the data specs, RFA 02 and 10 are no longer active.*

Record Sequencing

The sequence of records for a patient must conform to certain requirements. For example, a resumption of care record cannot directly follow a start of care assessment record. The following table indicates allowable sequences of records. In this table, the abbreviation *RFA* is used to represent the "reason for assessment" contained in item M0100_ASSMT_REASON. X's in the table are used to indicate allowable record sequences.

To understand this table, consider a sequence of records for a particular patient served by a particular home health agency and assume that the records are ordered by effective date as defined above. Let's suppose a particular record in the sequence is designated *Record A*. If Record A is immediately followed by a second record in the sequence (called *Record B*), the table below can be used to determine what RFAs are allowed for Record B.

For example, suppose Record A has an RFA of 03 (resumption of care after inpatient stay). We can see from the row labeled "03" that there are check marks under RFAs 04 through 10. This means that if a record with an RFA equal to 03 occurs in the record sequence and if it is immediately followed by another record, that record must have an RFA equal to 04, 05, 06, 07, 08, 09, or 10.

RFA on Record A	**RFA on Record B**									
	01	**02***	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10***
01				X	X	X	X	X	X	X
02*	X	X								
03				X	X	X	X	X	X	X
04				X	X	X	X	X	X	
05				X	X	X	X	X	X	
06	X	X	X							
07	X	X								
08										
09	X	X								
10*	X	X								

**Note that beginning with Version 1.30 of the data specs, RFA 02 and 10 are no longer active.*

In general, the initial record in a sequence of records will have an RFA of 01 (start of care – further visits planned) or 02 (start of care – no further visits planned). However, there can be exceptions to this general rule. One example involves patients who turn 18 while under care. For these patients, the HHA is not required to do a start of care assessment, but must instead submit data for the next required comprehensive assessment. Another example occurred when the OASIS electronic submission system was first put in place. Home health agencies were required to submit assessment data for all patients who were currently under care, but the rule requiring an RFA 01 or 02 for an initial record was waived for patients who were currently under care on the startup date.

Record Timing

The allowable completion dates for the first and any subsequent follow-up assessments will be calculated relative to the start of care date. Follow-up assessments must be completed every 60 days that a patient is under care. Each time a follow-up assessment is due, it must be completed on or after the 56th day and on or before the 60th day of the period.

More formally, the rules can be stated as follows:

Let j be the follow-up period number (i.e., 1=first follow-up period, 2=second follow-up period, etc.).

Let SOC be the start of care date.

Let FCD be the completion date of a follow-up assessment.

Given these symbols, the rule for completion of follow-up assessments is as follows:

SOC + (60*j) - 5 <= FCD <= SOC + (60*j) - 1

Where j=1, 2, 3, etc.

If a patient is under care by a home health agency during one of the follow-up windows defined above, a follow-up assessment must be submitted. An exception to this rule can occur if a patient resumes care following an inpatient stay and if the resumption of care date falls within one of the follow-up windows. In this situation, the home health agency has the following options, depending upon whether the patient is a Medicare PPS patient:

- For a non-PPS patient, the home health agency should submit an RFA 03 (resumption of care after inpatient stay) instead of the normal follow-up assessment. Submission of such a resumption of care assessment fulfills the requirement for the follow-up assessment because it includes all of the data items contained in the normal follow-up assessment.
- For a PPS patient, the home health agency must submit an RFA 03 (resumption of care after inpatient stay). In addition, the HHA must also submit a follow-up assessment if it wishes to bill for a SCIC (significant change in condition) adjustment (one visit would cover completion of both assessments).

Fatal vs. Warning Errors

The rules in the data specifications fall into two categories: fatal and warning errors. A record that has one or more fatal errors will be rejected by the Submission System. If a record contains no fatal errors but has warning errors, it will be accepted by the Submission System but the system will produce warning messages on the provider feedback report.

The data specifications rules which are related to fatal errors are marked with asterisks. Some specifications (those not marked with an asterisk) will generate warnings but will not lead to record rejection. In general, the following rules describe how the specifications were selected for movement from warning errors to fatal errors:

- All ranges are mandatory. Records with out of range values will be rejected.
- Consistency checks which describe skip patterns, inter-item logical consistencies, or intra-item consistencies (e.g., "none of the above" patterns) are generally mandatory.

- Date patterns which are logically impossible are generally fatal errors. For example, if the start-of-care date is later than the current date or if it precedes the date of birth, the record will be rejected. These mandatory rules generally specify that certain dates must be less than or greater than other dates.
- Date patterns which are based upon submission rules have generally remained warnings. This has been done so that a record can be submitted even if it is late or does not adhere in some way with timing requirements.

It should be noted that the "blank on RFA" section of the body record specifications is not mandatory. If a record contains non-blank data in a field when the record's RFA is contained in the "blank on RFA" list, the record will be accepted. However, the data in that field will be ignored and will not be stored in the state system's database. For example, M1036_RSK_OBESITY has RFAs 04, 05, 06, 07, and 08 in the "blank on RFA" list. Therefore, if non-blank data is submitted in this field when the RFA is 04, 05, 06, 07, or 08, the record will be accepted but the data in that field will be ignored.

Do not confuse this situation with the requirement that certain fields must be skipped when certain conditions apply. If non-blank data is submitted under these conditions, a fatal error will occur and the record will be rejected.

To avoid confusion, HHA's and their software vendors are urged to avoid submitting non-blank data in fields when the record's RFA is contained in the "blank on RFA" list.

Masking of Identifiers for Non-Medicare/Non-Medicaid Patients

Prior to the implementation of OASIS-C, assessments that did not list Medicare or Medicaid as a payment source had all patient identifiers masked. Beginning on January 1, 2010, this requirement has been changed. ***All records submitted on or after January 1, 2010 will be accepted only if Medicare of Medicaid is listed as a payment source. Records that do not list Medicare or Medicaid as a payment source will be rejected by the Submission System. This new rule applies to both OASIS-B1 and OASIS-C records.***

More specifically, the following rules apply to all records submitted on or after January 1, 2010:

> If M0150_CPAY_MCARE_FFS=1 **or**
> M0150_MCARE_HMO=1 **or**
> M0150_CPAY_MCAID_FFS=1 **or**
> M0150_MCAID_HMO=1,
> then the assessment is considered a Medicare or Medicaid assessment and the record will be accepted by the submission system (if it has no errors).
>
> If M0150_CPAY_MCARE_FFS=0 **and**
> M0150_MCARE_HMO=0 **and**
> M0150_CPAY_MCAID_FFS=0 **and**
> M0150_MCAID_HMO=0,
> then the assessment is considered a non-Medicare/non-Medicaid assessment will be ***rejected*** by the submission system (regardless of whether or not it has any errors).

Note also that the control field MASK_VERSION_CD, which was used to indicate when masking was applied, is no longer used and should be blank-filled. Any data submitted in this field will be ignored by the Submission System. All rules in prior versions of the data specifications that involved MASK_VERSION_CD will be ignored beginning on January 1, 2010.

Prospective Payment System

Grouper software for the home health prospective payment system is available on CMS's web site. The grouper software accepts OASIS assessment data as input and outputs two data elements needed on certain OASIS records: the PPS HIPPS code (SUBM_HIPPS_CODE) and the PPS grouper version code (SUBM_HIPPS_VERSION). In general, these two data elements are required on the OASIS record any time an assessment is used to determine the patient's case mix group for Medicare payment purposes. For example, the two data elements are required on assessments at the start of care and, for patients continuing into an additional 60-day episode, on follow-up assessments. Please refer to the grouper documentation for further information.

Use of VERSION_CD2 and M0090 (Completion Date)

VERSION_CD2 is a control field in bytes 35-39 of the body record which is used to indicate the version of the data specifications under which data are being submitted. M0090_INFO_COMPLETED_DT (bytes 302-309) is the date the assessment was completed. In prior versions of the data specifications (those that applied to the OASIS-B1), these two fields were used for version control. That is, these two fields have been used to determine which version of the data specifications applied to a particular assessment record.

The current version of the data specifications apply only to OASIS-C records. If information is needed related to requirements for OASIS-B1 records, prior versions of the data specifications should be consulted.

Because the current version of the data specifications is the first version that applies to OASIS-C, there is no need for version control at this time. However, we anticipate that as future versions of the data specifications are released the same system of version control will be implemented (i.e., the combination of VERSION_CD2 and M0090 will be used to identify the data specifications that apply).

For now, only a single value ("02.00") will be allowed in VERSION_CD2 for OASIS-C records. ***All records with a completion date (M0090) on or after January 1, 2010 must conform to the current version of the data specifications and must have a value of "02.00" in VERSION_CD2.***

The following table summarizes the formatting and usage of VERSION_CD2 for OASIS-C.

Value of M0090	Value of VERSION_CD2	State System Results
On or after 1/1/2010	"02.00"	Any other value will result in record rejection.

Correction Procedures

After an assessment has been submitted to and accepted by the State System, the original record should not be changed. However, corrections are allowed if a data entry error has been made. The purpose of this section is to describe the proper procedures for making corrections. The discussion of correction procedures below uses two terms which need to be defined.

- ***CORRECTION_NUM*** is a counter field in the body record (bytes 13-14) which is used to track corrections made to an assessment record. This counter field must always be set to *00* when a record is initially locked and submitted. Under certain circumstances (described below) it must be incremented to indicate that a correction record is being submitted (i.e., *01* would be used for the first correction to the assessment record, *02* for the second correction, and so on).
- ***Key fields*** are fields used by the state system to uniquely identify an assessment. The table below lists the key fields contained on an assessment record. Note that several fields are considered key fields only on certain types of assessment.

Key Field Name	Description
HHA_AGENCY_ID	Unique agency ID code
M0030_START_CARE_DT (this is a key field only on start of care assessments where RFA=01 or 02*)	Start of care date
M0032_ROC_DT (this is a key field only on resumption of care assessments where RFA=03)	Resumption of care date
M0040_PAT_LNAME	Patient's last name

Key Field Name	Description
M0040_PAT_FNAME	Patient's first name
M0064_SSN	Patient's social security number
M0066_PAT_BIRTH_DT	Patient date of birth
M0069_PAT_GENDER	Patient's gender
M0090_INFO_COMPLETED_DT (this is a key field only on recertification or follow-up assessments where RFA=04 or 05)	Date assessment information completed
M0100_ASSMT_REASON	Reason for completing assessment
M0906_DC_TRAN_DTH_DT (this is a key field only on transfer to inpatient facility assessments where RFA=06 or 07, death at home assessments where RFA=08, and discharge assessments where RFA=09 or 10*.	Discharge, transfer, death date

**Note that beginning with Version 1.30 of the data specs, RFA 02 and 10 are no longer active.*

The following scenarios explain how corrections should be made:

1. If an assessment has been submitted to the state and is *rejected*, the agency staff can make necessary changes and resubmit it. CORRECTION_NUM should not be incremented in this situation.
2. If an assessment has been submitted and *accepted* by the state, and the home health agency staff determine that corrections must be made to a *non-key fields only* (i.e., fields not contained in the list above), the home health agency should do the following:
   - Make a new copy of the record.
   - Revise any non-key fields necessary in the new assessment record.
   - Increment CORRECTION_NUM by one digit in the new assessment record.
   - Submit the corrected assessment.

   Note that when this type of correction occurs, the submission timing rule that is based on M0090_INFO_COMPLETED_DT will be waived for the correction record(s) (i.e., for any record with a CORRECTION_NUM greater than *00*). Both the original assessment and any subsequent correction assessments are stored in the state database. The state database keeps only the most recent version of the record (i.e., the version with the greatest CORRECTION_NUM) on its current assessment table; all other, corrected versions are retained in a history table. Most OASIS reports use only the active records.
3. If an assessment has been submitted and *accepted* by the state and the agency staff determine that a correction must be made to a *key field* (listed above), then a key field correction must be completed. A key field correction involves submitting an inactivation record, described below, which removes the erroneous assessment from the state system's database of active records. If appropriate, a new, replacement assessment can then be submitted with CORRECTION_NUM set to *00*. Note: this new, replacement assessment is subject to the submission timing rule.
4. It is possible for an assessment to be submitted and accepted for a resident whose episode is not paid for by Medicare or Medicaid. This could occur if the M0150 fields indicated that the resident's episode was paid for by Medicare or Medicaid when, in fact, it was not. If this occurs ***inactivation is not sufficient*** to remove the assessment from CMS's database. The reason for this is that inactivation does not delete a record, it simply moves it from the table of active records to the history table. It is CMS's policy that assessments for non-Medicare/non-Medicaid patients may not be stored in its database. Therefore, a non-Medicare/non-Medicaid assessment that has been inadvertently submitted and accepted must be manually deleted from

the database. When such a deletion is necessary, the HHA can submit a deletion request to their state who will forward the request to the QIES contractor to perform the deletion.

5. If a test batch of assessments is inadvertently submitted as a production batch, ***inactivation is not sufficient*** to remove the assessments from the state's database. The reason for this is the same as described in item #4 above. The same procedure should be followed to request that the assessments be deleted.

The flow chart on the following page summarizes the OASIS correction procedures. Where appropriate, this chart lists the option number in HAVEN which corresponds to each of the correction procedures.

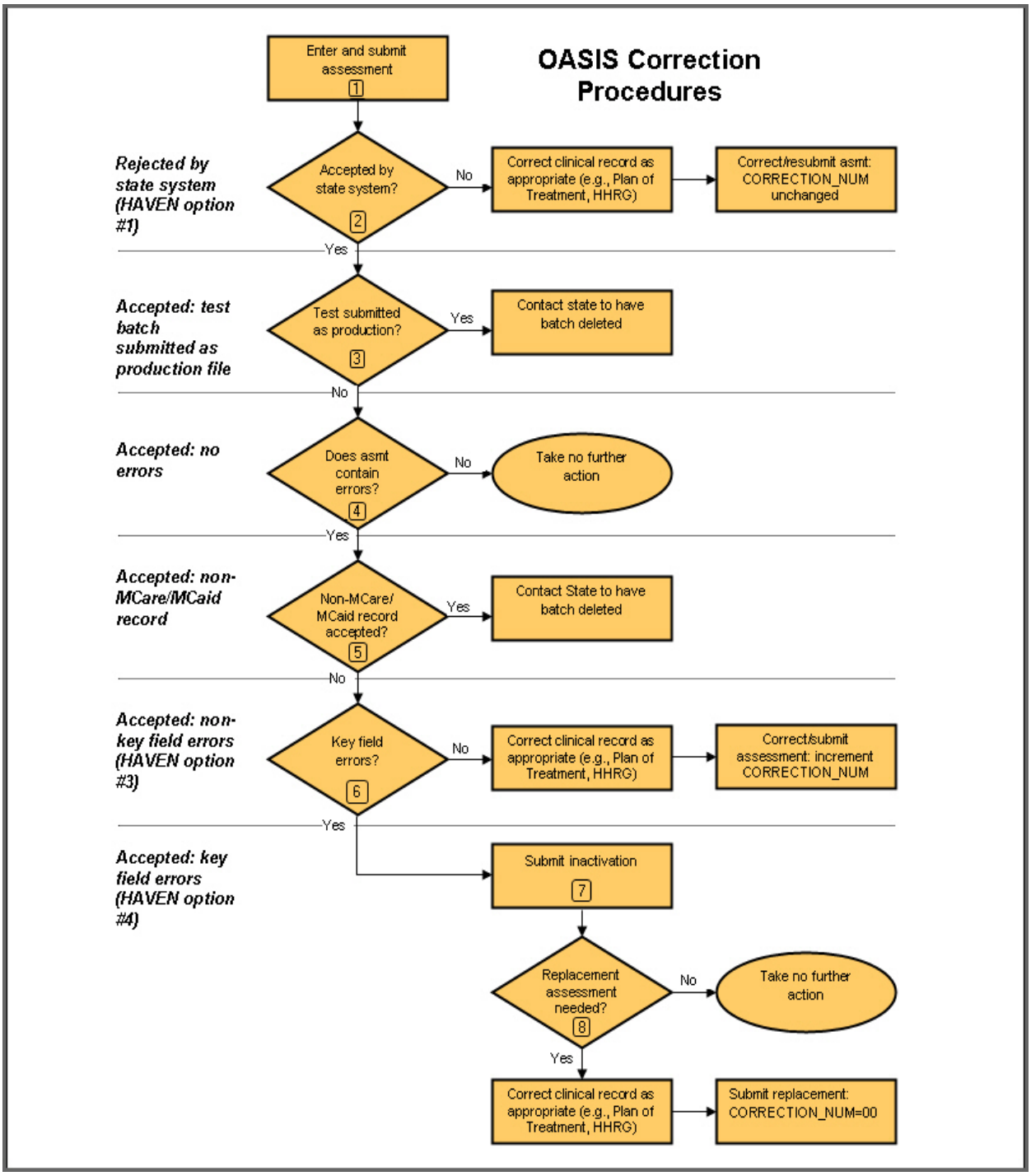
Please note that according to CMS's policy, when a comprehensive assessment is corrected, the HHA must maintain the original assessment record as well as all subsequent corrected assessments in the patient's clinical record for five years. If maintained electronically, the HHA must be capable of retrieving and reproducing a hard copy of these assessments upon request. It is acceptable to have multiple corrected assessments for an OASIS assessment, as long as the OASIS and the clinical record document the changes made.

Inactivations

Inactivations are an automated way to correct an assessment with erroneous information in key fields (such as M0100_ASSMT_REASON) or to remove an assessment which was submitted in error and which is not covered by rule #4 or #5 above (i.e., it should never have been submitted).

By including inactivation request records in their submission files, as described below, users can remove assessments from the state system's active database. Inactivated records are not actually deleted. Instead, they are moved from the active database to a history database which contains records which have been modified or inactivated. This approach keeps an audit trail of modified and inactivated records, but "hides" them from the normal state system reporting procedures.

Please note that the inactivation procedure should be used only if the non-key field record modification procedure does not apply. In other words, if an assessment contains errors only in non-key fields, then the CORRECTION_NUM method described above should be used. However, if an error has been made in one or more key fields or if an assessment was submitted in error, then the erroneous assessment should be inactivated.



STEP	ACTION
1	To begin the process, enter and submit the assessment.
2	Did the state system accept the assessment? • If the state system did not accept the assessment: — Make the appropriate corrections (e.g., Plan of Treatment, HHRG). — Correct and resubmit the assessment. Correction_Num unchanged.
3	If the state system accepted the assessment, was a test batch submitted as a production file? If the test batch was submitted as production, contact the state to have the batch deleted.
4	If the test batch was not submitted as production, does the assessment contain errors? If the assessment contains no errors, no further action is needed.
5	If the assessment contained errors, was the Non-Medicare/Medicaid record accepted? If the Non-Medicare/Medicaid record was accepted, contact the state to have the batch deleted.
6	If the Non-Medicare/Medicaid record was not accepted, did it contain key field errors? • If there were no key field errors: — Make the appropriate corrections (e.g., Plan of Treatment, HHRG). — Correct and resubmit the assessment, increment Correction_Num.
7	If the assessment contained key field errors, submit an inactivation.
8	If an inactivation is submitted, is a replacement assessment needed? • If a replacement assessment is needed: — Correct the clinical record as appropriate (e.g., Plan of Treatment, HHRG). — Submit the replacement assessment. Correction_Num=00. • If a replacement assessment is not needed, no further action is necessary.

Inactivation records are identified by "X1" in the REC_ID field. A submission file is not required to have any inactivation records, but if they occur they must occur between the header and trailer record. Every submission file must begin with one header record, end with one trailer record, and must have one or more body or inactivation records between the header and trailer. The user may submit as many body and/or inactivation records as desired. The record count in the trailer record must include the count of all records in the submission file including the header, the trailer, and any body or inactivation records which are present.

The inactivation record contains a limited number of fields which, for the most part, consist of the key fields listed in the table above. Each of the fields in the inactivation record parallels a field contained in the body record. To assist programmers in upgrading existing data entry and submission software, each of the inactivation fields is in the same record position (i.e., has the same starting and ending bytes) as the corresponding body record field. Intervening segments of the inactivation record contain filler. Any data contained in these filler fields will be ignored by the state system.

To insure that the proper record is inactivated, the data submission software should fill each of the fields in the inactivation record with *exactly* the same information as was contained in the assessment which is to be inactivated.

Note that the CORRECTION_NUM field is not included on the inactivation record. The reason for this is that once an inactivation is successfully processed, all copies of an assessment will have been inactivated (this includes the original assessment, with CORRECTION_NUM = *00*, as well as any subsequent corrections with CORRECTION_NUM = *01, 02*, etc.). Since it is not possible to inactivate a particular correction of a record, there is no reason to include CORRECTION_NUM on the inactivation record.

Once an erroneous assessment has been inactivated, a replacement assessment may be submitted, if appropriate. For example, if an assessment was submitted with an incorrect reason for assessment (M0100_ASSMT_REASON), an inactivation record would be submitted and a replacement assessment with the correct RFA would be submitted. The replacement assessment would have a CORRECTION_NUM equal to *00*. Note that both the inactivation and the replacement assessment may be included in the same submission batch, if desired.

There currently are no requirements regarding the timeliness of inactivation records, either in terms of when they must be completed or submitted. However, we urge users to complete and submit inactivations as quickly as possible after errors are identified so that the state system will be as current and accurate as possible.

Note that two new reports are included with the data specifications. The first report contains detailed data specifications for inactivation records. The second report contains a summary of the specifications for inactivation records.

Use of M0014 (Branch State) and M0016 (Branch ID)

An agency's branch state is reported in OASIS item M0014 and the branch ID is reported in M0016.

CMS assigns identification numbers to every existing branch belonging to a home health agency (HHA) or subunit. The identification system uniquely identifies every branch of every HHA and subunit certified to participate in the Medicare home health program. It also links the HHA or subunit to the branch. The 10-character ID field has the following structure:

AAQBBBBCCC

where

AA = the first two characters of the HHA's or subunit's Medicare provider number (the state code section)

Q = the letter ***Q*** which will always be in the third character of the branch ID

BBBB = the third through sixth characters of the HHA's or subunit's Medicare provider number

CCC = a sequential number (between 001 and 999) identifying the branch.

For example, if an HHA's or subunit's Medicare provider number was 017001, then its branches would be identified as 01Q7001001, 01Q7001002, 01Q7001003, etc.

HHAs and subunits are assigned a Medicare provider number when they are Medicare approved. Branches of HHAs and subunits will be assigned branch IDs as described above. The following edits apply to the reporting of branch IDs:

1. If the assessment was performed by an HHA which has no branches or by a subunit which has no branches, then M0016 must contain the following: "N " (***N*** followed by 9 spaces). This indicates that the assessment was completed by an HHA or subunit which has no branches.
2. If the assessment was performed by the home office of an HHA which has branches or by the home office of a subunit which has branches, then M0016 must contain the following: "P " (***P*** followed by 9 spaces). This indicates that the assessment was completed by the home office (an HHA parent or subunit – not a branch).
3. If the assessment was performed by a branch, then M0016 must contain a standard branch ID. It must contain numbers or uppercase letters in characters 1 and 2, a ***Q*** in character 3, numbers or uppercase letters in characters 4 through 7, and numbers in characters 8 through 10.
4. If M0016 does not contain a standard branch ID, "N ", or "P ", a fatal error will result and the record will be rejected.
5. If a standard branch ID (i.e., not ***N*** or ***P***) is submitted in M0016, then M0014 must contain a valid 2 character postal service state code that indicates the state in which the branch is located.
6. If a standard branch ID (i.e., not ***N*** or ***P***) is submitted, then it will be checked against a state system table of the HHA's or subunit's current and past branch IDs. If the submitted branch ID does not match the list of current IDs but does match a past branch ID, then a warning will be issued and the assessment record will be accepted. If the submitted branch ID does not match a current or past branch ID, then the assessment record will be rejected (i.e., it will result in a fatal error).

What's New: Version 2.00

Version 2.00 of the data specifications coincides with the implementation of OASIS-C. The following changes to the data specifications have been made to accommodate the new version of OASIS:

- Most importantly, many OASIS items have changed in the transition from B1 to C. Many new items have been added and some old items have been deleted. In addition, some items have retained their content but have been assigned new item numbers to put them in the correct order on the data set. Items that have stayed exactly the same (i.e., have retained their item ID and content) have retained their position in the submission body record. Items that have retained their content but changed item IDs have also retained their position in the submission record. Items that were deleted have been replaced by filler. Finally, new items have been assigned positions in the area of the submission record that was formerly occupied by the STATE_DATA field which was never previously used (STATE_DATA occupied 300 characters from bytes 1096 through 1395).
- As a result of all of these item changes, the order of the items in the submission record no longer corresponds well with the order of the items in the data set. Previously, with a few exceptions (items added since the original data specifications release) this correspondence was good. To accommodate these changes, we have added a new field (sort_id) to the table that describes the body record (Body_Record_Definition). Sorting this table on the sort_id field will put the fields in the following "logical order":
  - All items that are part of the OASIS-C data set will appear in the order they appear in published documents.
  - All control fields (except for filler fields) will follow the data set items.
  - All filler fields will follow the control fields.
  - CRG_RTN (carriage return) and LN_FD (line feed) follow the filler fields.
- The report that lists the detailed body record specifications presents OASIS items in submission order. Some users may wish to have a copy of this report that lists items in logical order. Users may produce such

a report by opening the Access database that contains the data specifications and selecting the report that is labeled "Body Record Layout - Detail - Logical Order".

- The current version of the data specifications describes only those rules that apply to OASIS-C records. Records with a completion date (M0090) on or after January 1, 2010 must conform to the new data specifications. Records with older completion dates (including corrections or inactivations of those earlier records) must be OASIS-B1 records and conform to older versions of the data specifications. Please refer to the appropriate earlier versions of the data specifications for rules applying to such records.

- The exception to the implementation rule described above concerns submission of non-Medicare/non-Medicaid records. Prior to the implementation of OASIS-C, assessments that did not list Medicare or Medicaid as a payment source had all patient identifiers masked. Beginning on January 1, 2010, this requirement has been changed. ***All records submitted on or after January 1, 2010 will be accepted only if Medicare or Medicaid is listed as a payment source. Records that do not list Medicare or Medicaid as a payment source will be rejected by the Submission System.*** This new rule applies to both OASIS-B1 and OASIS-C records.

  More specifically, the following rules apply to all records submitted on or after January 1, 2010:

  > If M0150_CPAY_MCARE_FFS=1 **or**
  > M0150_MCARE_HMO=1 **or**
  > M0150_CPAY_MCAID_FFS=1 **or**
  > M0150_MCAID_HMO=1,
  > then the assessment is considered a Medicare or Medicaid assessment and the record will be accepted by the Submission System (if it has no errors).
  >
  > If M0150_CPAY_MCARE_FFS=0 **and**
  > M0150_MCARE_HMO=0 **and**
  > M0150_CPAY_MCAID_FFS=0 **and**
  > M0150_MCAID_HMO=0,
  > then the assessment is considered a non-Medicare/non-Medicaid assessment and the record will be ***rejected*** by the Submission System (regardless of whether or not it has any errors).

  Note also that the control field MASK_VERSION_CD, which was used to indicate when masking was applied, is no longer used and should be blank-filled. Any data submitted in this field will be ignored by the Submission System. All rules in prior versions of the data specifications that involved MASK_VERSION_CD will be ignored beginning on January 1, 2010.

- Several changes have been made to the field-by-field data specifications report:

  — The transition from OASIS-B to OASIS-C produced three groups of data items: (1) items that were unchanged, (2) items that changed item number only (i.e., the content of the item stayed the same), and (3) entirely new items. A new report element ("OASIS B Identifier") indicates which group each item fell into. OASIS-B1 items that were unchanged in OASIS-C are identified with the notation "*** No Change ***". New items are indicated by "*** New Item ***". For items that underwent a numbering change, the name of the corresponding OASIS-B1 item is listed.

  — The label for the section of the report that showed consistency rules was previously named "Consistency Required". In previous versions of the data specs, many rules contained language such as "if M0100_ASSMT_REASON matches one of the active RFA's then…". To avoid unnecessary verbiage, we have removed such phrases because the consistency rules implicitly apply to a field only if it is active. We have therefore renamed this report element "Consistency if Active" to make this change explicit. As these rules are read and implemented, the developer should keep in mind that they apply only if the field is active. If the field is not active, it should contain blanks.

  — In previous updates to the data specifications, the "version notes" report element has been used to identify changes that were made to individual OASIS fields. Because implementation of OASIS-C and Version 2.00 of the data specifications resulted in a large number of changes, it proved unwieldy to track these changes in this report element. This report element will therefore be blank in the initial release of the Version 2.00 data specs. We will resume using this field if subsequent releases are made

of Version 2.00 as well as later releases. A track-changes version of the current document is being made available to help users identify changes that have been made.

- For several years now, we have released the data specifications in both PDF and HTML format. For Version 2.00, we will continue to release both formats. However, the initial release of the HTML format will not be populated with item and response text (all other report elements will be populated, as before). The item and response text was not available at the time Version 2.00 had to be released. We will attempt to populate these report elements in future releases. In addition, we are releasing two versions of the HTML formatted specifications. The first version lists all fields in submission order (in the order that they appear on the submission record). This is the order that they have been listed in previous versions. In addition, we are providing a second version in which the fields in the body record are listed in "logical order" (as described above).