

Specifications for OASIS-B1 (01/2008 Update) Submission Files For Submission from the Home Health Agency to the State

Data Specification Notes: Version 1.60 Correction 1

Files Included in the Data Specifications

This document and several accompanying documents describe CMS's data specifications for submitting OASIS-B1 data from a home health agency to its state agency.

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

- DS160C1.pdf This document.
- DS160C1MU.pdf Markup version of this document
- CH160C1.pdf Describes changes for Version 1.60 of the data specifications.
- HD160C1.pdf Detailed specifications for the header record
- HS160C1.pdf Summary specifications for the header record
- BC160C1.pdf Lists changes to the specifications for the body record
- BD160C1.pdf Detailed specifications for the body record
- BS160C1.pdf Summary specifications for the body record
- ID160C1.pdf Detailed specifications for the inactivation record.
- IS160C1.pdf Summary specifications for the inactivation record
- TD160C1.pdf Detailed specifications for the trailer record
- TS160C1.pdf Summary specifications for the trailer record

Note that the current document is distributed in two different formats: a markup version showing all changes from the previous version and a second version which is finalized (with changes not marked).

All 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:

- HS160C1.XLS Lists every field in header record.
- BS160C1.XLS Lists every field in the body record.
- IS160C1.XLS Lists every field in the inactivation record.

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- TS160C1.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
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	BS160C1.XLS	Required on RFA01: 0=no, 1=yes.
RFA02	BS160C1.XLS	Always 0 (zero)*
RFA03	BS160C1.XLS	Required on RFA03: 0=no, 1=yes.
RFA04	BS160C1.XLS	Required on RFA04: 0=no, 1=yes.
RFA05	BS160C1.XLS	Required on RFA05: 0=no, 1=yes.
RFA06	BS160C1.XLS	Required on RFA06: 0=no, 1=yes.
RFA07	BS160C1.XLS	Required on RFA07: 0=no, 1=yes.
RFA08	BS160C1.XLS	Required on RFA08: 0=no, 1=yes.
RFA09	BS160C1.XLS	Required on RFA09: 0=no, 1=yes.
RFA10	BS160C1.XLS	Always 0 (zero)*
RFA_REQ	BS160C1.XLS	List of RFAs for which the field is required (same as "active on RFA" in printed data specs).
RFA_BLANK	BS160C1.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 BS160.XLS will have RFA02=0 and RFA10=0. 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.

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Header Record

The header record has *A1* (capital A followed by one) in the first two bytes. The document **HD160C1.pdf** presents a detailed layout for the header record. The header record contains basic identifying information for the agency submitting the OASIS-B1 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 **HS160C1.pdf**.

Body Record

The body record has *B1* (capital B followed by one) in the first two bytes. The document **BD160C1.pdf** presents a detailed layout for the body record. The body record contains information for a single OASIS-B1 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-B1 assessment, while the data item section contains the OASIS-B1 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-B1. 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 **BS160C1.pdf**.

Inactivation Record

The inactivation record has *X1* (capital X followed by one) in the first two bytes. The document **ID160C1.pdf** presents a detailed layout for the inactivation record. An abbreviated version of the inactivation record layout is presented in the document **IS160C1.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 **TD160C1.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 **TS160C1.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 (e.g., BD160.pdf) 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-B1 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-B1 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.

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- **Active on RFA.** This report element lists the reasons for assessment (RFAs) for which the item is active. For example, for M0290_RSK_OBESITY, the following RFAs are listed: 01, 03, and 09. 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 M0290_RSK_OBESITY, the following RFAs are listed: 04, 05, 06, 07, and 08. 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).
- **Format info.** Provides information about how data must be formatted (e.g., right justified, zero filled, etc.).
- **Consistency required.** Provides information about the logical relationships between the current field and other fields in the layout. The following are some examples of how this report element is used:
 - **Skip patterns.** The response to some OASIS-B1 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-B1 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 *[R1]* may be used to refer to “Revision 1” of the specifications.

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Body Record Date Consistency

The body record contains the following date fields¹:

M0030_START_CARE_DT	Start of care date
M0032_ROC_DATE	Resumption of care date
M0066_PAT_BIRTH_DT	Patient date of birth
M0090_INFO_COMPLETED_DT	Date assessment information completed
M0180_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 not 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. M0180_INP_DISCHARGE_DT
3. M0030_START_CARE_DT
4. M0032_ROC_DT

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.

5. M0903_LAST_HOME_VISIT
6. M0906_DC_TRAN_DTH_DT
7. M0090_INFO_COMPLETED_DT
8. LOCK_DATE

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 M0180_INP_DISCHARGE_DT: M0180_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:

$$0 \leq \text{M0090_INFO_COMPLETED_DT} - \text{M0030_START_CARE_DT} \leq 5$$

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 M0180_INP_DISCHARGE_DT is not blank and if M0100_ASSMT_REASON=01, then the following rule applies:

$$0 \geq \text{M0030_START_CARE_DT} - \text{M0180_INP_DISCHARGE_DT} \leq 14$$

This means that M0030_START_CARE_DT minus M0180_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:

$$0 \leq \text{M0090_INFO_COMPLETED_DT} - \text{M0032_ROC_DATE} \leq 2$$

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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 M0180_INP_DISCHARGE_DT is not blank and if M0100_ASSMT_REASON=03, then the following rule applies:

$$0 \leq M0032_ROC_DT - M0180_INP_DISCHARGE_DT \leq 14$$

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:

$$0 \leq M0090_INFO_COMPLETED_DT - M0906_DC_TRAN_DTH_DT \leq 2$$

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

Prior to Version 1.50, the submission rules were based upon the LOCK_DATE and M0090_INFO_COMPLETED_DT fields. According to those rules, LOCK_DATE had to be within 7 days of M0090_INFO_COMPLETED_DT, and record had to be submitted to the State System by the end of the month following the month of the LOCK_DATE.

Beginning with Version 1.50, these rules have been simplified. The LOCK_DATE requirement has been eliminated and the LOCK_DATE field has been inactivated. Agencies are now required to submit assessments within 30 days of the completion date. Thus, the new rule is as follows:

$$[\text{submission date}] - M0090_INFO_COMPLETED_DT \leq 30$$

A warning will be issued by the State 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.

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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)
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. Check marks 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.

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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				✓	✓	✓	✓	✓	✓	✓
02*	✓	✓								
03				✓	✓	✓	✓	✓	✓	✓
04				✓	✓	✓	✓	✓	✓	
05				✓	✓	✓	✓	✓	✓	
06	✓	✓	✓							
07	✓	✓								
08										
09	✓	✓								
10*	✓	✓								

*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 was 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:

$$\text{SOC} + (60*j) - 5 \leq \text{FCD} \leq \text{SOC} + (60*j) - 1$$

Where $j=1, 2, 3$, etc.

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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). Please refer to the OASIS/PPS web page (<http://cms.hhs.gov/providers/hhapps/default.asp>) for details.

Tightened Data Specifications

Beginning with Version 1.04, many of the data specifications were moved from warnings to fatal edits. In the past, records could violate many of the data specifications and still be accepted by CMS's state system, albeit with warning messages. However, when Version 1.04 was implemented many messages which previously were warnings became fatal errors. Records which violate these standards are rejected.

The data specifications which are related to fatal errors are now marked with asterisks. Some specifications (those not marked with an asterisk) will continue to 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 now 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. For example, the rule stating that the lock date should be within 7 days of the assessment completion date remains a warning. 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, M0220_PRIOR_IMPR_DECSN 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, and 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 blank when the RFA is active. For example, M0220_PRIOR_IMPR_DECSN is an active field when the RFA is 01, 03, or 09. For these RFAs, the field must be blank when certain conditions apply, as noted in the "consistency required" field. 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.

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

Item M0150 is used to identify assessments for patients with Medicare or Medicaid as a payment source. If any option numbered 1 through 4 on M0150 is selected on an assessment (either alone or in combination with another pay source), the assessment is considered a Medicare or Medicaid assessment; all other assessments are considered non-Medicare/non-Medicaid assessments.

More specifically:

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.

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.

As originally published in June, 1999, the OASIS data submission regulations required HHA's to collect and submit Medicare or Medicaid assessments. However, the regulations required HHA's to collect but **not to** submit non-Medicare/non-Medicaid assessments.

It is anticipated that a notice will be published which will require HHA's to submit data for non-Medicare/non-Medicaid patients. However, identifying data for these assessments must be masked to prevent identification of these patients. Until the notice is published, HHA's **will not be required** to submit data for non-Medicare/non-Medicaid patients.

Beginning in late May, 2000, CMS's state system was able to accept masked data for non-Medicare/non-Medicaid patients as described below if submitted by agencies.

Several changes were made to accommodate this change in submission policy:

- Masking was required for the following fields for a non-Medicare/non-Medicaid assessment:
 - M0020_PAT_ID: patient ID number
 - M0040_PAT_FNAME: patient first name
 - M0040_PAT_LNAME: patient last name
 - M0063_MEDICARE_NUM: patient Medicare number
 - M0064_SSN: patient's social security number
 - M0065_MEDICAID_NUM: patient Medicaid number
- Masking was based upon the FIPS SHA-1 secure hash algorithm (see the FIPS publications on the NIST web site are located at <http://csrc.nist.gov/>; the SHA-1 standard is FIPS 180-1). This algorithm takes as input a clear text version of any of the fields listed above and outputs a masked version of the field which has two characteristics: (1) it is extremely difficult to re-create the clear text input from the masked output, and (2) it is extremely unlikely that any two unique clear text inputs will produce the same masked output.
- To facilitate use of the masking algorithm, CMS placed in the public domain a 16-bit and a 32-bit Windows DLL which can be called from most of the popular programming languages. In addition,

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CMS published the source code for these DLL's to assist programmers who must develop masking routines for non-Windows platforms.

- A new field called MASK_VERSION_CD was added to the body record. This field is used to store the version of the masking algorithm which is employed. This field contains the appropriate version designation on records which contain masked fields; it is blank on records with no masking.
- The logic for applying masking is as follows:
 - If M0150 indicates that the assessment is non-Medicare/non-Medicaid, then masking should be applied to the identifying fields listed above and MASK_VERSION_CD should be completed.
 - If M0150 indicates that the assessment is Medicare or Medicaid, then masking should not be applied to the identifying fields listed above and MASK_VERSION_CD should be blank.
- If a field is to be masked but consists entirely of blanks, do not mask the field; submit the blank field instead. For example, if a record is non-Medicare/non-Medicaid and if M0064_SSN is blank, do not mask the field – submit a blank M0064_SSN field instead.

For detailed masking specifications, please refer to the document *Specifications for Software to Mask Identifiers in OASIS Assessment Data for Non-Medicare/Non-Medicaid Patients*. This document is available on CMS's OASIS web site: <http://www.cms.hhs.gov/oasis/default.asp>.

Prospective Payment System

Version 1.10 contained a number of changes to the data specifications which were needed for the implementation of the prospective payment system (PPS) for home health agencies. The changes which were made are summarized below. Please refer to the Version 1.10 change document and the detailed data specifications for more information.

- The response options for item M0170 were changed. The old item was removed from the body record and replaced by filler (bytes 338-342). The new revised item (renamed M0175) was added in bytes 749-754.
- A new data item (M0825_THERAPY_NEED) was added to the body record in bytes 747-748.
- The PPS case mix group code (called HIPPS_CODE) was added to the body record in bytes 1081-1085.
- The PPS grouper version code (called HIPPS_VERSION) was added to the body record in bytes 1091-1095.
- The RFAs for items M0150_CPAY_NONE through M0150_CPAY_OTHER were revised so that these items are now active on all RFAs. This will make it easier to determine whether a patient is non-Medicare/non-Medicaid for the purposes of masking.
- The RFAs for items M0175, M0230, M0240, and M0390 were changed so that these items are now active on RFAs 01 through 05.
- The RFAs for M0220_PRIOR_NOCHG_14D and M0220_PRIOR_UNKNOWN were changed so that these items are now active on RFAs 01 through 05.
- The length of the follow-up period was changed from two months to 60 days. Follow-up assessments must now be completed between days 56 and 60 (inclusive) of each follow-up period.

Grouper software for the home health prospective payment system was made available on CMS's web site. The software and related materials come in a .ZIP file containing a DLL, pseudocode, test cases, and other documentation. The grouper software accepts OASIS assessment data as input and outputs two data elements needed on certain OASIS HAVEN records: the PPS case mix group code (HIPPS_CODE) and the PPS grouper

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version code (HIPPS_VERSION). In general, these two data elements are required on the OASIS HAVEN 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 all data specifications versions up to and including Version 1.04, VERSION_CD2 was used primarily for documentation. Although the value of VERSION_CD2 was edited by the state system, the edits were not fatal – records were not rejected if they contained invalid values in VERSION_CD2. Furthermore, the editing of records was not affected by the value contained in VERSION_CD2. Beginning with Version 1.10 of the data specifications, VERSION_CD2 took on greater importance. Starting with that version, the state system began using the body record's value for VERSION_CD2, in conjunction with the assessment completion date (M0090), to determine what version of the edit engine to apply to the record.

To understand the need for this, we need to briefly review the changes which were implemented each version of the data specifications:

- The purpose of V1.10 of the data specifications was to accommodate changes required for implementation of the PPS regulation. New fields were added to the body record and it was therefore important that the state system edit engine know what version of the data specs was being used in a data submission.
- The primary purpose of V1.20 was to allow submission of inactivation records (described in a later section of this document). There were no significant differences in the editing of body records in V1.20, and we therefore allowed VERSION_CD2 to contain either “01.10” or “01.20” (i.e., the two values were functionally interchangeable).
- The primary purpose of V1.30 was to reduce provider assessment burden by reducing the number of required RFAs and items. The data specifications have been designed to be “upwardly compatible” so that records created using the V1.10 or V1.20 specifications will still be accepted by the state system. This upward compatibility made it unnecessary for providers to upgrade data submission software when the V1.30 specifications were implemented, unless they wished to do so.
- The primary purpose of V1.40 is to change the formatting of the M0230 and M0240 diagnosis codes and to add the new M0245 diagnosis codes.
- The primary purpose of V150 was to deactivate the LOCK_DATE field and to accommodate the new submission timing rule (whereby assessments must be submitted within 30 days of the completion date).
- The purpose of V160 (the current version) is to replace some existing fields and add some new fields to support a new version of the HHRG grouper.

To accommodate these changes, we established the following rules for the use of VERSION_CD2:

1. All assessments which have a completion date (M0090) on or before **August 31, 2000** (before the beginning of the PPS transition period) must have a value of “1.04 “ (left-justified, blank filled) in VERSION_CD2.
2. All assessments which have a completion date (M0090) during **September, 2000** (during the PPS transition period) may have a value of “01.10”, “01.20”, or another value in VERSION_CD2. The state system software will examine the VERSION_CD2 field to determine whether to apply the V1.10/V1.20 edits or

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the V1.04 edits to the record. If the field is equal to "01.10" or "01.20", then the V1.10/V1.20 edits are applied. Otherwise, the V1.04 edits are applied.

3. All assessments which have a completion date (M0090) on or after **October 1, 2000** (after the PPS transition period) and on or before **December 15, 2002** must have value of "01.10" or "01.20" in VERSION_CD2 (i.e., either value will be accepted and the choice of value will not affect the editing of the record by the state system).
4. All assessments which have a completion date (M0090) on or after **December 16, 2002** and on or before **September 30, 2003** must have a value of "01.10", "01.20", or "01.30" in VERSION_CD2. If VERSION_CD2 contains any of these three values, the state system software applies the V1.30 edits to the record. *Any record which would pass the V1.20 edits without errors or warnings will also pass the V1.30 edits without requiring any changes*
5. All assessments which have a completion date (M0090) on or after **October 1, 2003** and on or before **June 20, 2006** must have a value of "01.40".
6. All assessments which have a reason for assessment (M0100) of 04 or 05 and a completion date on or after **June 21, 2006** and on or before **December 26, 2007** must have a value of "01.40" or "01.50".
7. All assessments which have a reason for assessment (M0100) of 01, 03, 06, 07, 08, or 09 and a completion date on or after **June 21, 2006** and on or before **December 31, 2007** must have a value of "01.40" or "01.50".
8. All assessments which have a reason for assessment (M0100) of 04 or 05 and a completion date on or after **December 27, 2007** must have a value of "01.60".
9. All assessments which have a reason for assessment (M0100) of 01, 03, 06, 07, 08, or 09 and a completion date on or after **January 1, 2008** must have a value of "01.60".

There is one exception to the rules above: *on or after December 16, 2002, any record with RFA 02 or 10 will be rejected, regardless of its completion date and regardless of the data specs version under which it is submitted.* Please refer to the section on "Burden Reduction" below for details.

Note that beginning with Version 1.10 we changed the formatting of VERSION_CD2. Up to and including Version 1.04, the version code was a four-byte string, submitted as follows: "1.04 " (left justified, blank filled). Beginning with Version 1.10, we changed the field so that the version number is zero filled (e.g., "01.10", or "01.20").

The following table summarizes the formatting and usage of VERSION_CD2.

Value of M0090	Value of VERSION_CD2	State System Results
Before PPS transition period (through 8/31/2000)	"1.04 " (left justified, blank filled)	V1.04 edit engine applied, record accepted, no warning issued.
	Anything other than "1.04 "	V1.04 edit engine applied, record accepted, warning issued.
PPS transition period (9/1/2000 through 9/30/2000)	"01.10" or "01.20"	V1.10/V1.20 edit engine applied, record accepted. Choice of value ("01.10" vs. "01.20") doesn't affect editing of record.
	"1.04 " (left justified, blank filled)	V1.04 edit engine applied, record accepted, no warning issued.

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Value of M0090	Value of VERSION_CD2	State System Results
	Anything other than "01.10", "01.20", or "1.04 " (left justified, blank filled)	V1.04 edit engine applied, record accepted, warning issued.
After PPS transition period (between 10/1/2000 and 12/15/2002, inclusive)	"01.10" or "01.20"	V1.10/V1.20 edit engine applied, record accepted. Choice of value doesn't affect editing of record.
	Anything other than "01.10" or "01.20"	V1.10/V1.20 edit engine applied, record rejected
After implementation of burden reduction (between 12/16/2002 and 09/30/2003, inclusive)	"01.10", "01.20", or "01.30"	V1.30 edit engine applied. Choice of value doesn't affect editing of record. Any record which would pass the V1.20 edits without errors or warnings will also pass the V1.30 edits without requiring any changes. Existing submission software can therefore continue to be used once V1.30 is implemented on the state system.
	Anything other than "01.10", "01.20", or "01.30"	V1.30 edit engine applied, record rejected.
Between 10/01/2003 and 06/20/2006, inclusive	"01.40"	V1.40 edit engine applied. Values other than "01.40" will result in a warning message.
Between 06/21/2006 and 12/26/2007, inclusive, for RFA 04 and 05	"01.50" or "01.40".	V1.50 edit engine applied. Values other than "01.50" or "01.40" will result in a warning message.
Between 06/21/2006 and 12/31/2007, inclusive, for RFA 01, 03, 06, 07, 08, and 09	"01.50" or "01.40".	V1.50 edit engine applied. Values other than "01.50" or "01.40" will result in a warning message.
On or after 12/27/2007 for RFA 04 and 05	"01.60"	V1.60 edit engine applied, record accepted, no warning issued.
	Anything other than "01.60"	V1.60 edit engine applied, record rejected.
On or after 1/1/2008 for RFA 01, 03, 06, 07, 08, and 09	"01.60"	V1.60 edit engine applied, record accepted, no warning issued.
	Anything other than "01.60"	V1.60 edit engine applied, record rejected.
All dates	All versions	Beginning on December 16, 2002, all records with RFA 02 or 10 will be rejected, regardless of the values in M0090 and in VERSION_CD2.

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Note that the date used to determine which edit engine to apply is the completion date (M0090) in each assessment record, NOT the submission date (except for RFA 02 or 10, as noted above).

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. These procedures were changed in V1.20 of the data specifications.

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_DATE (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
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.*

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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 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 active table; all other, corrected versions are retained in a history table. Most state system 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.
4. If an assessment has been submitted in unmasked format and it is subsequently determined that the assessment should have been masked, ***inactivation is not sufficient*** to remove the assessment from the state'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 the database in unmasked format. Therefore, an unmasked non-Medicare/non-Medicaid assessment must be manually deleted from the database. When such a deletion is necessary, the HHA can submit a request to the state which will convey the request to the Iowa Foundation for Medical Care.
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 assessment 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

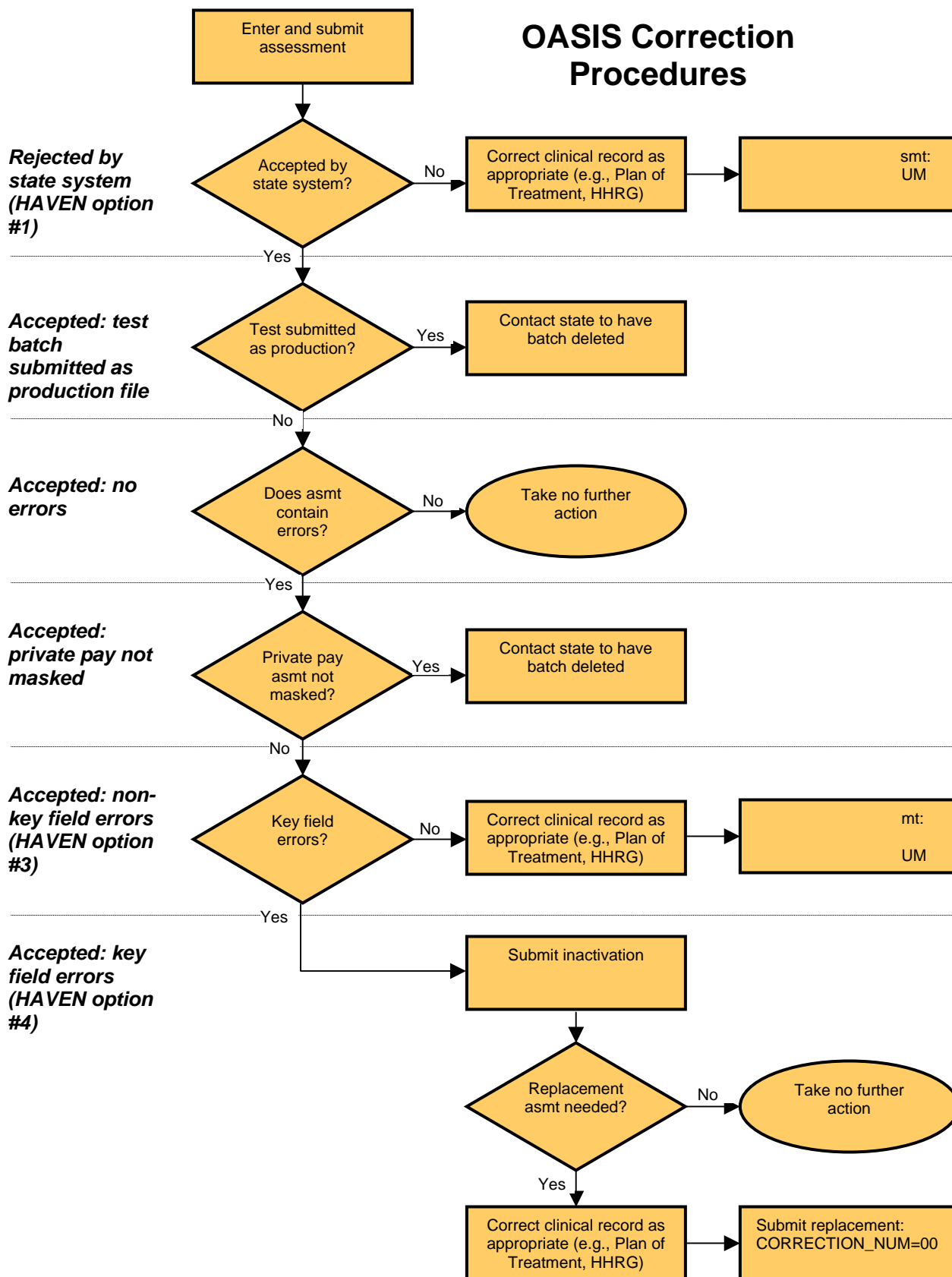
Previous versions of the OASIS data specifications and of the state system did not allow an automated way to correct an assessment with erroneous information in key fields (such as M0100_ASSMT_REASON) or to remove an assessment which was submitted in error (i.e., it should never have been submitted). Until now, the only way to fix such problem records was for an HHA to ask state staff to manually delete such records from the state's

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database. The HHA could then re-submit a corrected record, if appropriate. However, making such manual deletions is time-consuming and prone to error and many deletion requests have not been fulfilled.

Starting with Version 1.20 of the data specs, users were able to remove such erroneous records using an automated methodology called *inactivation*. By including inactivation request records in their submission files, as described below, users will be able to 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.



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We have created a new type of submission record which will allow users to submit automated inactivation requests. Prior to Version 1.20, the data specs allowed three types of records (as indicated by the contents of the REC_ID field in each record): header records (REC_ID = "A1"), body records (REC_ID="B1"), and trailer records (REC_ID="Z1"). Every submission file was required to have one header record, followed by one or more body records, followed by one trailer record.

Beginning with version 1.20, users could submit a new type of record, the inactivation record, designated 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. Under version 1.20, 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.

Prior to Version 1.50, LOCK_DATE was an active field on inactivation records. Beginning with Version 1.50, LOCK_DATE has been made into an inactive field because it is no longer in use.

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.

Burden Reduction

CMS has reduced the number of required OASIS data items in order to reduce the assessment burden for providers. The primary purpose of V1.30 of the data specifications is to accommodate this reduced data set. This has been accomplished by making the following changes in the data specifications:

- RFAs 02 and 10 were eliminated.

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- Assessment items which are not required by the PPS grouper were eliminated from RFA 04 and 05.
- Five assessment items were eliminated from all RFAs (M0160, M0310, M0320, M0330, and M0600).

Note that CMS's burden reduction initiative also includes the establishment of a patient tracking sheet which contains certain identifying and demographic items. This tracking sheet is completed at start of care and does not need to be updated unless one or more items change. This represents a change in assessment procedures, but does not involve any changes to the data specifications since all of the items on the tracking sheet are submitted on every assessment record.

V1.30 is scheduled for implementation on the state system on December 16, 2002. It is CMS's intention to make providers' adoption of the burden reduction measures optional. That is, if an agency wishes to begin using the reduced-burden data set on December 16, it may do so. But if it wishes to continue using the full OASIS data set and the current version of its data submission software on or after that date, it will have that option.

To accommodate this, we have designed the data specs to be "upwardly compatible," so that records created using the V1.20 specifications will still be accepted by the state system even after V1.30 has been implemented. This upward compatibility makes it unnecessary for providers to upgrade data submission software when the V1.30 specifications are implemented, unless they wish to do so.

There is one exception to this. ***Beginning on December 16, 2002, the state system will reject any record with RFA 02 or 10.*** This includes records with a completion date (M0090) before December 16, 2002 as well as corrections or inactivations of such records.

Diagnosis Codes

In order to insure that home health agencies can report ICD-9-CM diagnosis codes to be compliant with HIPAA, certain changes were made in V1.40 regarding the collection and encoding of diagnosis codes. These changes are planned for October 1, 2003. The table below summarizes the data specification changes which have been made.

Data Item	Data Specs Version 1.30	Changes in Data Specs Version 1.40
M0190	No E-codes or V-codes allowed (first character of code must be a space).	No change.
M0210	No E-codes or V-codes allowed (first character of code must be a space).	No change.
M0230	No E-codes or V-codes allowed (first character of code must be a space).	V-codes allowed (E-codes still not allowed).
M0240	No E-codes or V-codes allowed (first character of code must be a space).	V-codes and E-codes allowed.
M0245	Item added to printed copies of data set to illustrate how this new item will be used. Not added to data specs.	Added to data specs. No E-codes or V-codes allowed (first character of code must be a space).

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. Prior to version 1.40 of the OASIS data specifications, these fields were optional and could be blank. Even when reported by the HHA, there was no standardized numbering system for branches so the information was not useful.

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In August, 2002, CMS's Survey and Certification group issued a memo announcing that CMS would assign identification numbers to every existing branch belonging to a home health agency (HHA) or subunit. The identification system is being implemented nationally and will uniquely identify every branch of every HHA and subunit certified to participate in the Medicare home health program. It will also link 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 ID assignment process is scheduled for completion by 12/31/2003.

Version 1.40 of the data specifications accommodates the reporting of branch ID. For assessments with completion dates (M0090) on or before 12/31/2003, the field will continue to be optional. However, for assessments completed on or after 1/1/2004, these branch ID will be required and will be validated. The following edits will be applied:

1. If M0090 is on or before 12/31/2003, then the following edits apply:
 - a. M0014 can be blank, but if it is non-blank it must contain a valid state code.
 - b. M0016 can be blank or may contain any alphanumeric characters.
2. If M0090 is on or after 1/1/2004, then the following edits apply:
 - a. M0014 can be blank, but if it is non-blank it must contain a valid state code. It is recommended that M0014 be completed when the branch is located in a state which is different from the home office of the HHA or subunit, although this will not be checked by the state system. The only edit which will be applied to M0014 is that it must contain either blanks or a valid state code.
 - b. 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.
 - c. 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).
 - d. 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.
 - e. If M0016 does not contain a standard branch ID, "N ", or "P ", a fatal error will result and the record will be rejected.
 - f. 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

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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).

Implementation of Version 1.40

All assessments with completion dates (M0090) between 10/01/2003 and 06/20/2006 (inclusive) must conform to the version 1.40 specifications. Assessments with completion dates on or before 9/30/2003 must conform to the version 1.30 specifications (or to previous versions, if appropriate).

What's New: Version 1.50

We have developed a new version of the OASIS data specifications which will be version 1.50. This new version incorporates changes that were mandated by the OASIS rule that was published in the Federal Register on December 23, 2005. It also incorporates several additional changes as described below.

Summary of Changes

Version 1.50 incorporates the following changes:

- LOCK_DATE is no longer used and has been replaced with filler in both the body record and the inactivation record.
- The submission requirement for original assessments has been changed. Records must now be submitted within 30 days of the completion date (M0090).
- A new field has been added to accommodate the National Provider ID. This field, NATL_PROV_ID, is in both the header record (bytes 575-584) and in the body record (bytes 769-778). In Version 1.50 of the data specs, this field is voluntary and may be left blank.
- A new consistency check has been added to the primary diagnosis severity code (M0230_PRIMARY_DIAG_SEVERITY). A warning will now be issued if this field contains a value of "00" (zero). This warning will not prevent the record from being accepted, however.
- New consistency checks have been added to two pressure ulcer fields (M0460 and M0464).
- New consistency checks have been added to the stasis ulcer fields (M0468 through M0476).
- New consistency checks have been added to the surgical wound fields (M0482 through M0488).
- A consistency check between M0012_MEDICAID_ID in the body record and ST_ID in the header record has been changed from a fatal edit to a warning. This has been done to make the submission process easier for agencies with branches in more than one state.
- A new value ("01.50") has been added to VERSION_CD2 to accommodate the new version of the data specs.

Changes in Final Version

A draft of the Version 1.50 specifications was published on January 23, 2006. Several corrections have been made for the current (final) version:

- In the draft release, consistency check #2 for M0012_MEDICAID_ID in the body record was changed from a fatal edit to a warning. This consistency check looks for a match between M0012_MEDICAID_ID in the body record and ST_ID in the header record. However, in the draft specifications a parallel change to the consistency checks for ST_ID was inadvertently omitted. In the current release, consistency check #2 under ST_ID has been changed from a fatal edit to a warning.
- In the draft release, the specifications for VERSION_CD2 were updated to reflect the number that identifies the current version of the data specifications ("01.50"). However, the specifications for consistency check #1 were not updated. This has been fixed in the current release.

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Implementation of Version 1.50

All assessments with completion dates (M0090) on or after 06/21/2006 must conform to the Version 1.50 specifications. Assessments with completion dates on or before 06/20/2006 must conform to the Version 1.40 specifications (or to previous versions, if appropriate).

What's New: Version 1.60

The primary purpose of Version 1.60 is to replace and add fields that are needed to support a new version of the HHRG grouper. The specific changes are as follows:

- Item M0110_EPISODE_TIMING was added.
- Item M0825_THERAPY_NEED was removed and replaced by M0826_THER_NEED_NUM and M0826_THER_NEED_NA.
- Items M0245_PMT_ICD1 and M0245_PMT_ICD2 were removed. They were replaced by the following fields:
 - M0246_PMT_DIAG_ICD_A3
 - M0246_PMT_DIAG_ICD_B3
 - M0246_PMT_DIAG_ICD_C3
 - M0246_PMT_DIAG_ICD_D3
 - M0246_PMT_DIAG_ICD_E3
 - M0246_PMT_DIAG_ICD_F3
 - M0246_PMT_DIAG_ICD_A4
 - M0246_PMT_DIAG_ICD_B4
 - M0246_PMT_DIAG_ICD_C4
 - M0246_PMT_DIAG_ICD_D4
 - M0246_PMT_DIAG_ICD_E4
 - M0246_PMT_DIAG_ICD_F4
- The consistency checks for the HIPPS_CODE field were modified to accommodate the new fields.
- Several fields that were previously required by the grouper on RFA 04 and 05 are no longer required. These fields are no longer active on RFA 04 or 05.
- Several fields that were not previously required by the grouper on RFA 04 or 05 are now required. These fields were made active on RFA 04 and 05.
- A new value ("01.60") has been added to VERSION_CD2 to accommodate the new version of the data specs.

Implementation of V1.60

The implementation of V1.60 is contingent upon the reason for assessment (the value of M0100):

- All assessments with a reason for assessment of 04 or 05 and completion dates (M0090) on or after 12/27/2007 must conform to the Version 1.60 specifications. Assessments with a reason for assessment of

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04 or 05 and completion dates on or before 12/26/2007 must conform to the Version 1.50 specifications (or to previous versions, if appropriate).

- All assessments with a reason for assessment of 01, 03, 06, 07, 08, or 09 and completion dates (M0090) on or after 01/01/2008 must conform to the Version 1.60 specifications. Assessments with a reason for assessment of 01, 03, 06, 07, 08, or 09 and completion dates on or before 12/31/2007 must conform to the Version 1.50 specifications (or to previous versions, if appropriate).

Note that implementation of V1.60 will make software upgrades mandatory. Because new OASIS items and a new HHRG grouper will become active for assessments completed on or after the dates listed above, the State System edit engine will reject records that should have the new format but are submitted with the old format.

Revisions to Draft Version of Version 1.60 Specifications

A draft version of the Version 1.60 data specifications was released on June 1, 2007. Subsequent to that release, three errors were identified which have been fixed in this final version of the specifications. The following three changes were made to the specification for the body record:

- M0530_UR_INCONT_OCCURS. Consistency note #3 was removed. Consistency note #3 eliminated consistency checks between M0520_UR_INCONT and M0530_UR_INCONT_OCCURS when the reason for assessment was 04 or 05. In previous versions, M0520 was inactive for RFA 04 and 05, so the consistency checks did not apply. However, beginning with the current version M0520 is active for RFA 04 and 05, so the consistency checks do apply.
- M0246_PMT_DIAG_ICD_F4. In the draft version of the V1.60 specs, this field was incorrectly listed as active on RFA 01, 03, 04, 05, and 06. It is not active on RFA 06. The specs were therefore fixed to show this field as active only on RFA 01, 03, 04, and 05.
- M0474_UNOBS_STASULC. In the draft version of the V1.60 specs, this field was incorrectly listed as active on RFA 01, 03, and 09. It is also active on RFA 04 and 05. The specs were therefore fixed to show this field as active on RFA 01, 03, 04, 05, and 09.

These changes are identified with the notation [R1] (which stands for “Revision 1”) in the “version notes” field of bd160c1.pdf (the body detail specs) and in the “changes” column in bc160c1.pdf (the change document for the body specs).

Correction to Final Version of Version 1.60 Specifications

A final version of the Version 1.60 data specifications was released on September 18, 2007. Subsequent to that release, one error was identified which has been fixed in the correction that is now being released. The only change that has been made was as follows in the body record.

- VERSION_CD1. The prior version of the specifications failed to list a new form version code: B1-0108. This new code has been added to the list of allowable values. Consistency note #1 was also changed to accommodate the new code. Note that prior version codes (B1-1098, B1-0800, B1-1202) will continue to be accepted. If the value “B1-1098” is submitted, a warning will be issued, but the other values will be accepted without warning. Despite the fact that older version codes will be accepted, home health agencies must use the new version of OASIS once it is implemented. The data specs allow the old version codes in order to avoid rejecting a record that is otherwise correct simply because an incorrect form version code is included on the submission record.

This change is identified with the notation [R2] (which stands for “Revision 2”, indicating that this is the second revision since the initial release of the data specs) in the “version notes” field of bd160c1.pdf (the body detail specs) and in the “changes” column in bc160c1.pdf (the change document for the body specs). All of the file names associated with the data specs have “c1” in their name to indicate that they belong to “Correction 1” of the final data specs. For example, the body detail specs are contained in the file that is named “bd160c1.pdf”.

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