## General OASIS Item Conventions

1. Understand the time period under consideration for each item. Report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance. Day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home.
2. If the patient's ability or status varies on the day of the assessment, report the patient's "usual status" or what is true greater than 50% of the assessment timeframe, **unless** the item specifies differently (e.g., for M2020 Management of Oral Medications, M2030 Management of Injectable Medications, and M2100e Management of Equipment, instead of "usual status" or "greater than 50% of the time," consider the medication or equipment for which the most assistance is needed).
3. Minimize the use of NA and Unknown responses.
4. Responses to items documenting a patient's current status should be based on independent observation of the patient's condition and ability at the time of the assessment without referring back to prior assessments unless collection of the item includes review of the care episode (e.g., process items). For OASIS items that require review of the episode, "since the previous OASIS assessment" should be interpreted to mean "at the time of the last OASIS assessment. These instructions are included in item guidance for the relevant OASIS questions.
5. Combine observation, interview, and other relevant strategies to complete OASIS data items as needed (e.g., it is acceptable to review the hospital discharge summary to identify inpatient procedures and diagnoses at Start of Care, or to examine the care notes to determine if a physician-ordered intervention was implemented at Transfer or Discharge). However, when assessing physiologic or functional health status, direct observation is the preferred strategy.
6. When an OASIS item refers to assistance, this means assistance from another person unless otherwise specified within the item. Assistance is not limited to physical contact and includes both verbal cues and supervision.
7. Complete OASIS items accurately and comprehensively, and adhere to skip patterns.
8. Understand what tasks are included and excluded in each item and score item based only on what is included.
9. Consider medical restrictions when determining ability. For example, if the physician has ordered activity restrictions, these should be considered when selecting the best response to functional items related to ambulation, transferring, etc.
10. Understand the definitions of words as used in the OASIS.
11. Follow rules included in the Item Specific Guidance.
12. Stay current with evolving CMS OASIS guidance updates.
13. Only one clinician takes responsibility for accurately completing a comprehensive assessment, although for selected items, collaboration is appropriate (e.g., Medication items M2000 – M2004). These exceptions are noted in the Item Specific Guidance.
14. When the OASIS item includes language specifying "one calendar day" (e.g., M2002 Medication Follow-up), this means until the end of the next calendar day.
15. The use of i.e., means "only in these circumstances" or "that is" and scoring of the item should be limited to the examples listed. The use of e.g., means "for example" and the clinician may consider other relevant examples when scoring this item.

## ADL/IADL Item-Specific Conventions

1. Report the patient's ability, not actual performance or willingness, to perform a task. While the presence or absence of a caregiver may impact actual performance of activities, it does not impact the patient's **ability** to perform a task.
2. The level of ability refers to the patient's ability to **safely** complete specified activities.
3. If the patient's ability varies between the different tasks included in a multi-task item, report what is true in a majority of the included tasks, giving more weight to tasks that are more frequently performed.

# New Numbering System

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| Tracking Items | M0010 – M0150 |
| Clinical Record Items | M0080 – M0110 |
| Patient History and Diagnoses | M1000s |
| Living Arrangements | M1100s |
| Sensory Status | M1200s |
| Integumentary Status | M1300s |
| Respiratory Status | M1400s |
| Cardiac Status | M1500s |
| Elimination Status | M1600s |
| Neuro/Emotional/Behavioral Status | M1700s |
| ADLs/IADLs | M1800s + M1900s |
| Medications | M2000s |
| Care Management | M2100s |
| Therapy Need and Plan of Care | M2200 |
| Emergent Care | M2300 |
| Data Collected at TF/DC | M2400s, M0903+M0906 |