Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

57th Annual Meeting

Wednesday, September 2, 2026
Republic ABC Room
1:30pm-2:30pm

2a. Igniting the Truth: Top OASIS Myths That Burn Outcomes

Presented by:

Lisa Selman-Holman, JD, BSN, RN, VP Clinical Services, McBee
Annette Lee RN, MS, HCS-D, COS-C, CEO & Founder of Provider Insights, Inc.

Thank you to our Partners:

Vesta®
HHAeXchange
MAC LEGACY
KanTime How better happens.
United Healthcare Community Plan
AXXESS

Igniting the Truth:

Top OASIS Myths that Burn Outcomes

mcbee part of Netsmart

1

Presenters

Lisa Selman-Holman and Annette Lee

2026 McBee and Provider Insights

mcbee part of Netsmart

2

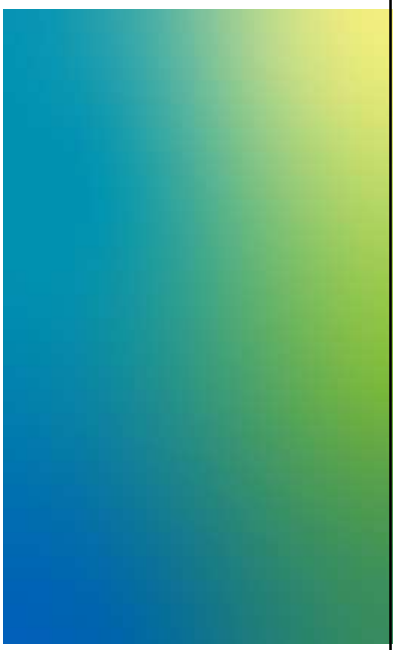
Objectives

1. Identify the most prevalent OASIS myths that negatively influence data integrity, quality outcomes, and reimbursement.
2. Apply CMS-aligned guidance to replace common misconceptions with accurate OASIS decision-making.
3. Strengthen clinician education and internal auditing efforts by addressing persistent myth-based errors at the bedside and in review processes.

3

The OASIS is an interview tool

Or, the OASIS is a “to-do” list…



4

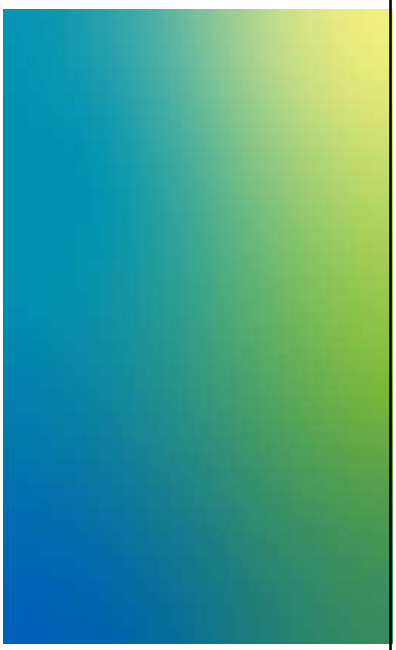
Which is it then?

- CMS states throughout the OASIS Guidance Manual that the OASIS is a data collection tool and is part of the comprehensive assessment. Collecting and coding is multifaceted
  - Interview: This information should be partly collected by combining interview (some items mandate direct interview of the patient, such as BIMS or the social determinants of health items)
  - Observation: The clinician should observe the harder tasks to incorporate a more thorough assessment
  - Caregiver input
  - Medical record
  - Clinical judgement

5

Why Waste Time on the GG Items?

They Don't Matter



6

Discharge Function (DCF) Coefficients

Green Lowered Expectation, Red Raised Expectation

Covariate	GG0130A1	GG0130B1	GG0130C1	GG0170A1	GG0170C1	GG0170D1	GG0170E1	GG0170F1	Locomotion 1 Walk (GG0170I1)	Locomotion 2 Walk (GG0170J1)	Locomotion 1 Wheel (GG0170R1)
Prior Functioning: Self-Care — Dependent	-0.1549	-0.1695	-0.1569	-0.0648	-0.1969	0.0853	-0.1892	-0.0296	0.3177	0.0982	-0.0477
Prior Functioning: Self-Care — Some Help	-0.0497	-0.0405	-0.0156	0.0452	-0.0165	0.0491	0.0102	0.0723	0.1083	0.0302	0.0208
Prior Functioning: Indoor Ambulation — Dependent	-0.2327	0.1388	-0.0680	-0.1494	-0.0797	-0.2342	-0.1070	-0.1680	-0.7771	-0.3103	-0.0719
Prior Functioning: Indoor Ambulation — Some Help	-0.2010	0.0727	-0.0102	-0.0884	-0.0604	-0.0086	0.0177	-0.0737	-0.1949	-0.1616	-0.0756
Prior Functioning: Stair Negotiation — Dependent	0.1414	-0.0681	-0.0042	0.0697	0.0287	-0.0276	0.0030	0.0368	0.0568	-0.0317	0.1210
Prior Functioning: Stair Negotiation — Some Help	0.0195	-0.0181	-0.0123	0.0112	-0.0137	-0.0129	-0.0275	0.0194	0.0704	-0.0222	0.0042
Stage 2 Pressure Ulcer	0.0446	0.0512	-0.1073	-0.0560	-0.0762	-0.0356	-0.0344	-0.0052	0.0152	0.0045	-0.0609
Stage 3, 4, or Unstageable Pressure Ulcer/Injury	0.0125	0.0128	-0.0971	-0.0726	-0.0656	-0.0684	-0.0174	-0.0094	-0.0193	-0.0049	-0.0153
Cognitive Function: Moderately Impaired	-0.0512	-0.0721	-0.0476	0.0191	-0.0179	0.0160	-0.0059	0.0312	0.0205	-0.0278	-0.1410
Cognitive Function: Severely Impaired	-0.1483	-0.3148	-0.1353	0.0107	-0.0002	0.0733	0.0071	0.0260	0.0665	0.0290	-0.3983
Bladder Incontinence: Incontinent	0.0208	-0.0097	-0.1052	0.0198	-0.0416	-0.0028	-0.0046	-0.0128	0.0131	-0.0295	-0.0762
Bladder Incontinence: Catheter	0.0144	0.0448	-0.2371	0.0045	-0.0487	-0.0213	0.0150	-0.0237	0.0096	-0.0337	0.1624
Bowel Continence: Always Incontinent	-0.0892	0.0079	-0.3712	-0.0371	-0.0844	-0.0358	-0.0243	-0.0639	-0.0083	-0.0058	-0.1581
Bowel Continence: Incontinent Less than Daily	-0.0545	0.0105	-0.1383	0.0072	-0.0454	-0.0013	0.0313	-0.0277	0.0159	-0.0132	-0.0720

7

Effect of Not Attempted Codes

Impacting Risk Adjustment Matters

Covariate	GG0130A1	GG0130B1	GG0130C1	GG0170A1	GG0170C1	GG0170D1	GG0170E1	GG0170F1	Locomotion 1 Walk (GG0170I1)	Locomotion 2 Walk (GG0170J1)	Locomotion 1 Wheel (GG0170R1)
Toileting Hygiene (GG0130C1) - Skip Pattern	.	.	--	.	.	.	.	.	.	.	.
Shower/bathe Self (GG0130E1) - Valid Score	-0.0314	0.0483	0.3514	-0.0491	0.0037	0.0293	0.0854	0.0806	0.0278	0.0579	0.0749
Shower/bathe Self (GG0130E1) - Not Attempted	0.0104	0.0619	1.1634	-0.1097	0.0915	0.0610	0.2463	0.2358	0.0897	0.3064	0.1073
Shower/bathe Self (GG0130E1) - Skip Pattern	.	.	.	.	.	.	.	.	.	.	.
Upper Body Dressing (GG0130F1) - Valid Score	0.0941	0.2974	0.2971	0.1629	0.0612	0.0262	0.0439	0.0834	0.1525	0.0087	0.1200
Upper Body Dressing (GG0130F1) - Not Attempted	0.0608	0.7398	1.3173	0.6909	0.7433	0.5556	0.3978	0.4270	0.7223	0.5248	0.2376
Upper Body Dressing (GG0130F1) - Skip Pattern	.	.	.	.	.	.	.	.	.	.	.
Lower Body Dressing (GG0130G1) - Valid Score	-0.0415	-0.0515	0.3424	-0.0239	0.0234	0.0441	0.0641	0.0906	0.0024	0.0205	-0.0376
Lower Body Dressing (GG0130G1) - Not Attempted	-0.0482	-0.0811	0.8998	0.0918	0.1038	0.3885	0.1491	0.1777	0.0429	0.2690	-0.0773
Lower Body Dressing (GG0130G1) - Skip Pattern	.	.	.	.	.	.	.	.	.	.	.
Put On/Take Off Footware (GG0130H1) - Valid Score	-0.0283	-0.0022	0.0803	-0.0166	0.0909	0.0107	0.0081	0.0003	-0.0629	0.0632	0.0485
Put On/Take Off Footware (GG0130H1) - Not Attempted	-0.2038	0.0771	0.1346	0.0238	0.1516	-0.0366	0.1967	-0.0049	-0.2382	-0.1868	0.1406
Put On/Take Off Footware (GG0130H1) - Skip Pattern	.	.	.	.	.	.	.	.	.	.	.
Roll Left and Right (GG0170A1) - Valid Score	0.2275	0.0206	0.0409	--	0.2315	0.0155	0.0104	0.0276	0.0862	-0.0114	0.0347
Roll Left and Right (GG0170A1) - Not Attempted	1.0995	0.0882	0.3298	--	0.8730	0.2560	0.2169	0.3489	0.4896	0.1827	0.2988
Roll Left and Right (GG0170A1) - Skip Pattern	.	.	.	--	.	.	.	.	.	.	.
Sit to Lying (GG0170B1) - Valid Score	-0.0322	0.0916	-0.0135	1.2957	1.7650	0.0630	0.0538	0.0227	0.0900	-0.1055	0.0258
Sit to Lying (GG0170B1) - Not Attempted	-0.0354	0.2795	0.0292	2.7826	5.6797	0.0582	0.4030	0.1103	0.3128	-0.4857	0.0955
Sit to Lying (GG0170B1) - Skip Pattern	.	.	.	.	.	.	.	.	.	.	.
Lying to Sitting on Side of Bed (GG0170C1) - Valid Score	0.0262	-0.0525	0.0723	0.2995	--	0.4518	0.1906	0.0018	-0.1636	0.1201	0.0414
Lying to Sitting on Side of Bed (GG0170C1) - Not Attempted	-0.0082	-0.1582	0.1657	0.6546	--	1.8197	0.3610	-0.0345	-0.5331	0.5199	0.1043
Lying to Sitting on Side of Bed (GG0170C1) - Skip Pattern	.	.	.	.	--	.	.	.	.	.	.
Sit to Stand (GG0170D1) - Valid Score	-0.0117	0.0184	0.0136	0.0084	0.4829	--	1.4939	0.4625	0.4188	0.0190	0.0193
Sit to Stand (GG0170D1) - Not Attempted	-0.0653	0.0916	-0.1607	-0.1179	0.8937	--	2.7639	0.5205	0.8522	-0.0473	0.0569
Sit to Stand (GG0170D1) - Skip Pattern	.	.	.	.	.	--	.	.	.	.	.
Chair/Bed-to-Chair Transfer (GG0170E1) - Valid Score	-0.0274	-0.0028	-0.0148	-0.0192	0.2346	1.6055	--	1.2057	0.2774	0.2413	0.1266
Chair/Bed-to-Chair Transfer (GG0170E1) - Not Attempted	-0.0419	0.0296	0.0408	0.0442	0.6640	5.3664	--	3.9540	1.2109	0.9515	0.0679
Chair/Bed-to-Chair Transfer (GG0170E1) - Skip Pattern	.	.	.	.	.	.	--	.	.	.	.
Toilet Transfer (GG0170F1) - Valid Score	0.0357	-0.0048	0.5210	0.0253	-0.0041	0.4351	1.0618	--	0.3891	0.0885	0.0376
Toilet Transfer (GG0170F1) - Not Attempted	0.0408	-0.0532	1.0126	0.0261	-0.2754	0.8344	2.0088	--	1.2445	0.3635	-0.0574

8

Risk Adjustment

Why It Matters

- The purpose of risk adjustment is to account for differences across home health patients that affect their functional status.
- Risk adjustment individualizes the **expected discharge function score** for each quality episode by controlling for patient SOC/ROC functional status, age, and clinical characteristics.
- This ensures that each quality episode is measured against an expectation that is calibrated to the patient's individual circumstances when determining the numerator for each agency.

9

Outcomes

End Result Outcomes

- Discharge Function Score
  - The percentage of home health patients who achieve or exceed a risk-adjusted expected function score at discharge.
  - Functional status evaluates a patient's capacity to perform daily activities related to some selfcare (GG0130) and mobility (GG0170).

GG ITEMS & ACTIVITIES USED IN THE MEASURE		
GG0130 Self-Care	GG0170. Mobility	GG0170. Mobility (cont)
GG0130A. Eating	GG0170A. Roll left and right	GG0170I. Walk 10 feet
GG0130B. Oral hygiene	GG0170C. Lying to sitting on side of bed	GG0170J. Walk 50 feet with two turns
GG0130C. Toileting hygiene	GG0170D. Sit to stand	GG0170R. Wheel 50 feet with two turns/GG0170S. Wheel 150 feet in a corridor or similar space (both used in place of walking activities for patients who don't walk at both SOC/ROC and discharge)
	GG0170E. Bed-to-chair transfer	
	GG0170F. Toilet transfer	

  - Results also posted in Care Compare

10

Home Health Value Based Purchasing

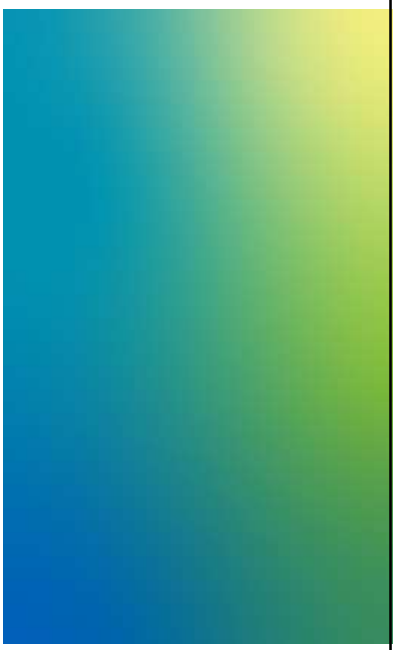
Discharge Function

- OASIS contributes 40% to your Total Performance Score in HHVBP if you're in the Larger-Volume Cohort.
  - There are only 6 measures included in the OASIS-Based Measures.
  - Of that 40%, the DC Function score now contributes 15%.
  - That is the single largest percentage of the OASIS measures, meaning its contribution to HHVBP is substantial.
  - Getting this right is an investment in your agency's financial future.
- In conclusion: GG items DO Matter! They contribute to risk adjustment, quality outcomes, and reimbursement.

11

Education

The Antidote for the Misinformed



12

Performance Codes

06 – Independent	Patient does **everything alone**	**06 = No assist in the mix**
05 – Setup or Clean-up Assist	Helper helps **before or after**, not during	**05 = Prep to Thrive**
04 – Supervision or Touching Assist	Helper provides **verbal cues**, **steadying**, or **light touch**	**04 = Watch the Chore**
03 – Partial / Mod Assist	Helper does **less than half**	**Less of Me = the score is 3**
02 – Substantial / Max Assist	Helper does **more than half**	**Needs More = 2 is the score**
01 – Dependent	Helper does **all** the effort OR **2 helpers** needed	**01 = 2 to get it done**

13

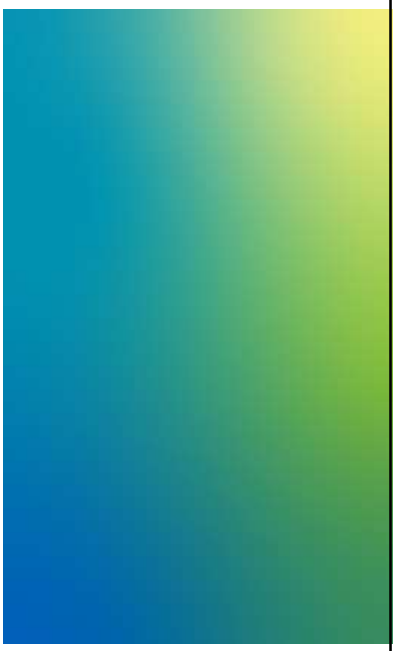
Activity Not Attempted

09 – Not applicable / Baseline unable	Patient can't do it now **or before**	**09 = Baseline**
88 – Not attempted due to medical or safety concerns	Can't do it now but **could before**	**88 = Brand New State**
10 – Not attempted due to environmental limitations	Not attempted due to environment or lack of equipment	**10 = Blocked Again**
07 – Patient Refused	Patient refused and no other activity or not attempted code applies	**07 = Nope Not Steppin**
Dash	No information available	**Dash is Trash**

14

It's okay to use 07

Patients have a right to refuse!



15

07 – Patient Refused

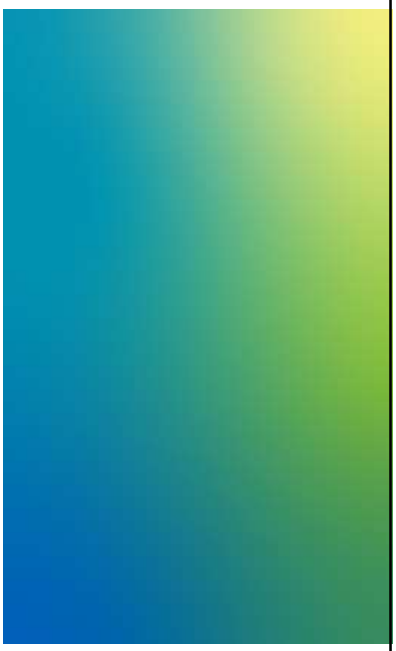
The Code of Last Resort

- Patient refused and no other activity or not attempted code applies – really?!?!
  - Watch the patient perform a similar activity – flex your clinical judgment muscles
  - Ask the patient or caregiver about the activity in question – it is okay to ask
    - Example: Car transfer – How did that go? How much help did you need?
- Unlike the other Activity Not Attempted (Assessed) Codes the use of 07 and 10 should be limited.
  - 09 and 88 have specific meaning and should be used when appropriate.

16

I was told that CMS doesn't like "88" or "09"

And doesn't want us to use them anymore.



17

Activity not Attempted Codes are Valid Responses

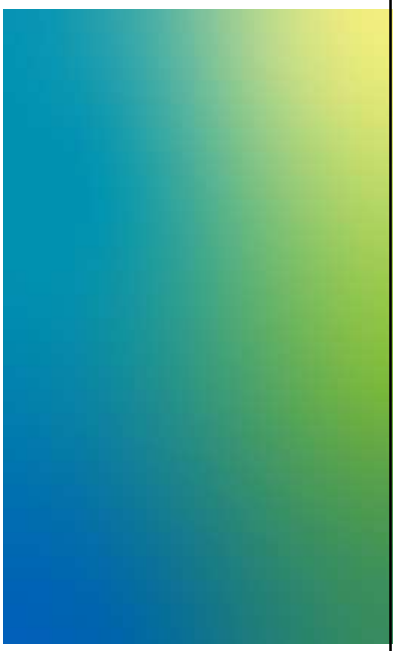
They should be used when they are the most accurate description of the patient's current status/condition

- "88" and "09" **were provided by CMS** to explain why the patient is unable to safely perform the task in question. Either code indicates that the task was not attempted because:
  - There are medical conditions or safe concerns for the patient (88) or
  - The patient did not perform this activity prior the current illness, injury or exacerbation (09)
- Unlike the weighted performance codes, these response options have no numeric values and requires CMS to use statistical imputation to guess their likely value(s.)
  - There is no official guidance to suggest that CMS doesn't like them, but this rumor reminds me of the "telephone game" we played as kids

18

The GG items are supposed to match the M1800s

Our OASIS scrubber keeps sending me notices to change my responses to make them match.



19

No Equality Between M1800s and GG Items

Each functional group/items has its own unique guidance

- Each OASIS item should be considered individually and coded based on guidance provided for that item.
- Similarly titled tasks are not necessarily the same in the both worlds
  - Inclusions/exclusions
  - Duration of assist (intermittent, constant) vs. effort of patient/caregiver
- Assistive devices do not impact GGs – it's all about assistance
- Majority of tasks only applies to the M1800s

20

No Equality Between M1800s and GG Items

Each functional group/items has its own unique guidance

- CMS created a document on February 2019 based on an OASIS Q & A to "provide clarification that the intention is not for the codes on the GG and M items to be duplicative or always "match."

Question 1: Should we expect to see consistency between a patient's OASIS "M" and "GG" function codes?

Answer 1: Not necessarily. There are differences between items that have the same or similar names. Coding differences may be a result of:

- what is included or excluded in the activity, or
- what coding instructions apply to the activity.

Each OASIS item should be considered individually and coded based on guidance specific to that item.

21

Coding difference due to inclusion/exclusion guidance

Also considered in M1800s are frequency and majority of task performance

EXAMPLE: Patient can brush teeth and wash hands without assistance or set up, but requires some assistance with hair care, washing face, shaving and trimming nails.

(M1800)	**Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code **2**	0 Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1 Grooming utensils must be placed within reach before able to complete grooming activities. 2 Someone must assist the patient to groom self. 3 Patient depends entirely upon someone else for grooming needs.

GG0130B	
0 6	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

06. Independent – Patient completes the activity by him/herself with no assistance from a helper.

22

Coding difference due to consideration of assistive devices

EXAMPLE: Patient is able to walk distance up to 20 feet with a walker and no human assistance.

(M1860)	**Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
Enter Code [2]	0 Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device). 1 With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. 2 Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 3 Able to walk only with the supervision or assistance of another person at all times. 4 Chairfast, unable to ambulate but is able to wheel self independently. 5 Chairfast, unable to ambulate and is unable to wheel self. 6 Bedfast, unable to ambulate or be up in a chair.

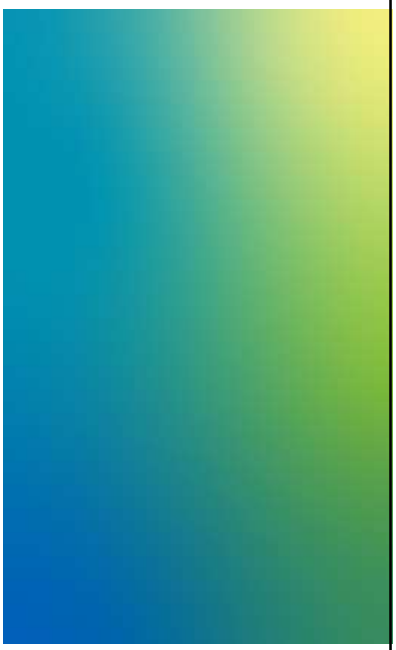
GG0170I	
[0][6]	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb)*

06. Independent – Patient completes the activity by him/herself with no assistance from a helper.

mcbee part of Netsmart

23

M0102 Date of Physician ordered SOC should ***always*** be the same as M0030 Start of Care Date

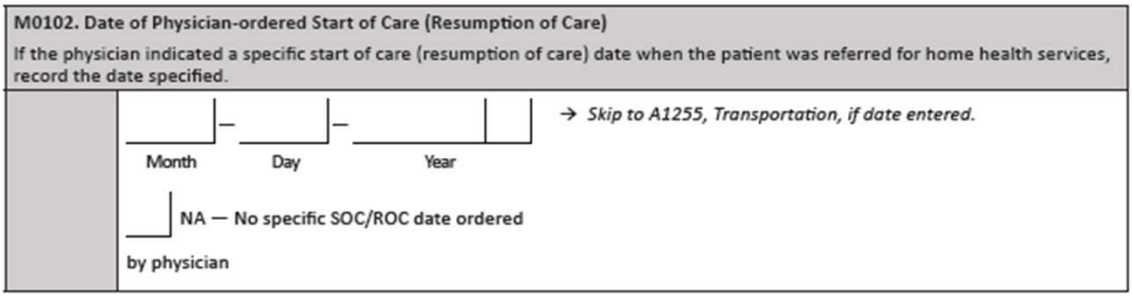


24

Do not phone a friend!

Become familiar with the official CMS guidance

M0102: Date of Physician-ordered Start of Care (Resumption of Care)



Item Intent

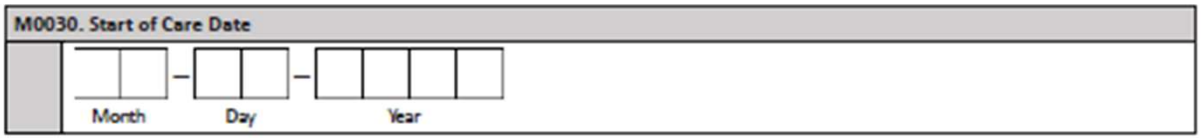
The date specified by a physician/allowed practitioner order to start home care services (that is, provide the first covered service), or resume home care services (that is provide the first visit) regardless of the type of services ordered (for example, therapy only).

25

For the bonus round

Let's talk about SOC date = first reimbursable service

M0030: Start of Care Date



Item Intent

Specifies the start of care date, which is the date that the first reimbursable service is delivered.

26

Our RNs do the "starts" for our therapists

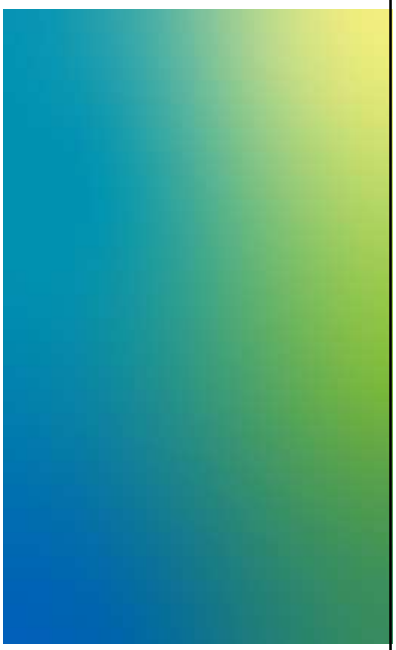
Isn't collection of the OASIS data considered skilled & a billable service?

- Q36.1. I understand the comprehensive assessment cannot be completed before the Start of Care (SOC) date. Does that mean it's OK to start it at the initial assessment as long as it is not completed until on or after the SOC date?
- Excerpts from A36.1 …If agency policy is for the RN to perform the initial assessment during a non-billable visit to meet the Condition of Participation (§484.55) time requirement of 48 hours for the completion of the initial assessment, and the RN does not provide a billable service, the SOC is not yet established. If the PT does not visit that same day, the date of the RN's initial assessment visit is not the SOC date.
  - Further a compliance statement from Home Health Quality Reporting Requirements states, "CMS requires OASIS completion as part of the home health comprehensive assessment and quality reporting requirement. OASIS documentation itself is not separately billable to Medicare; it is an administrative/regulatory requirement that supports payment determination, quality reporting, and compliance."
    - Home Health Quality Reporting Requirements | CMS

27

"No Visit" Discharges are no big deal

Besides, I was busy and she doesn't need me. I'll just do the discharge later after I eat dinner.



28

What's the CMS Requirement?

- Discharge from agency services requires an *in person visit* to complete the assessment.
- A Discharge (DC) OASIS is required within 2 days of discharge.
  - Agency policy may dictate the date of discharge, e.g., date of the last visit or, 2 days after last visit in the case of a required notice of discharge to the patient or request for discharge.
- CMS does NOT recognize a routine "non-visit" discharge
  - These are unplanned or unexpected discharges (not a convenience option for busy clinicians)
  - Routine use of "non-billable discharge" workflow pose a survey risk
- It's important to set the expectation that the patient will be seen in-person all the way end of their care.
  - DC planning should begin at the SOC

29

How to Compliantly Handle a Discharge Without a Visit

In the case of an unplanned discharge, CMS still requires the DC OASIS to be **based on an assessment.**

The discharge OASIS must be completed **by the last qualified clinician who saw the patient**

Included should be the **findings from that last visit** (existing clinical information) without using "administrative" assumptions

This information may be **augmented by documentation from any other agency staff who visited the patient within the last 5 days** that the patient received visits defined as "the date of the last visit, plus the four preceding calendar days"

30

Risk/Impact of No Visit Discharge

- No real discharge plan
- Were goals met? Was the patient set up for success?
- Discharged to Community DTC
  - You are responsible for that patient for 31 days after their discharge from your care,
  - You need to keep them out of the hospital (ACH and LTCH) **and** alive.
- Medicare Spending Per Beneficiary MSPB
  - Counts most inpatient admissions **and** observation stays within 30 days of DC

mcbee part of Netsmart

31

Benefits of Completing a Compliant DC OASIS

An accurate discharge OASIS assessment and a timely discharge are essential to keeping that patient safe at home.

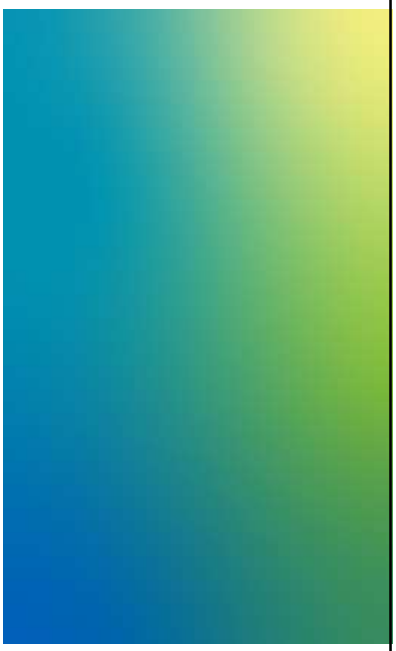
An effective discharge is even more important with the Discharged to Community—Post Acute Care VBP claims-based outcome (and impacts MSPB, too).

You need a real end timepoint for the outcomes (Improvement in Oral Med Management, Improvement in Dyspnea, DC Function)

32

But he's **not** SOB!

I was with him for over two hours and he was never short of breath. Not once. And no, I didn't stand him up. He weighs over 300 pounds!



33

M1400

*When is the patient dyspneic or noticeably **Short of Breath?***

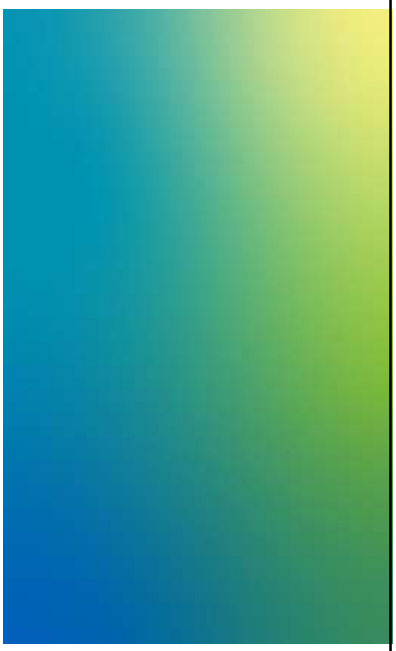
M1400. When is the patient dyspneic or noticeably Short of Breath?	
Enter Code ☐	0. **Patient is not short of breath** 1. **When walking more than 20 feet, climbing stairs** 2. **With moderate exertion** (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3. **With minimal exertion** (for example, while eating, talking, or performing other ADLs) **or with agitation** 4. **At rest** (during day or night)

- The key word is **when!**
- Consider **– What** makes the patient dyspneic or noticeably short of breath
  - Did that activity occur within the assessment timeframe?
- This item is included in our outcome measures, posted on Care Compare and is one of the OASIS-based measures for HHVBP.

34

I don't *think* she's fallen since SOC.

She can't remember and her husband is worse. What's the big deal? I said "no."



35

Key Findings from the OIG

- Home health agencies are underreporting falls
- ***55% of falls*** with major injuries and hospitalization among Medicare home health patients ***were not reported in OASIS assessments*** as required.
- These assessments are used by CMS to calculate fall rates and inform the public on the Care Compare website.

J1800. Any Falls Since SOC/ROC, whichever is more recent	
Enter Code ☐	Has the patient **had any falls since SOC/ROC**, whichever is more recent? 0. No → *Skip to M1400, Short of Breath at DC; Skip to M2005, Medication Intervention at TRN and DAH* 1. Yes → Continue to J1900, Number of Falls Since SOC/ROC

36

Data Sources & Considerations Risk Adjustment

OASIS	Medicare fee-for-service (FFS) claims	Medicare Advantage encounter data
Medicaid claims and encounter data	No risk adjustment!	Only typical OASIS exclusions: • Under 18 • Maternity • Unskilled care only

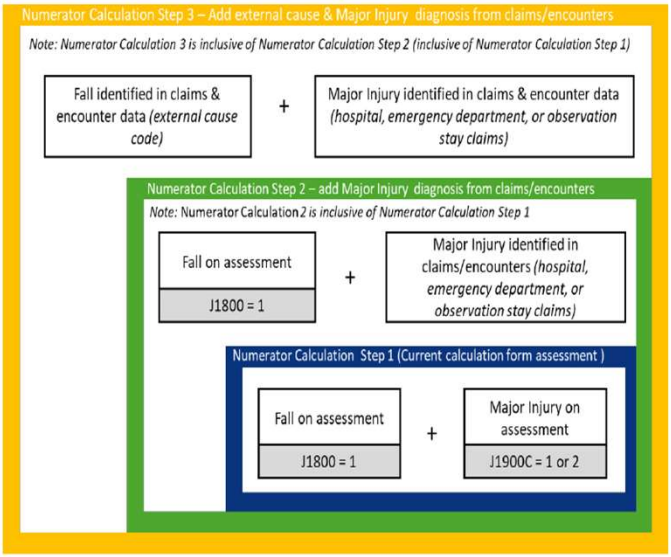
37

Comparison of Discovery Process

Original

The original version of the measure has been consistent across post-acute care and home health settings, such that an FMI is identified when both a fall and major injury are indicated on the patient assessment (i.e., numerator includes item J1800 identifying that there was a fall and item J1900C identifying that there was a major injury - both indicated on the assessment).

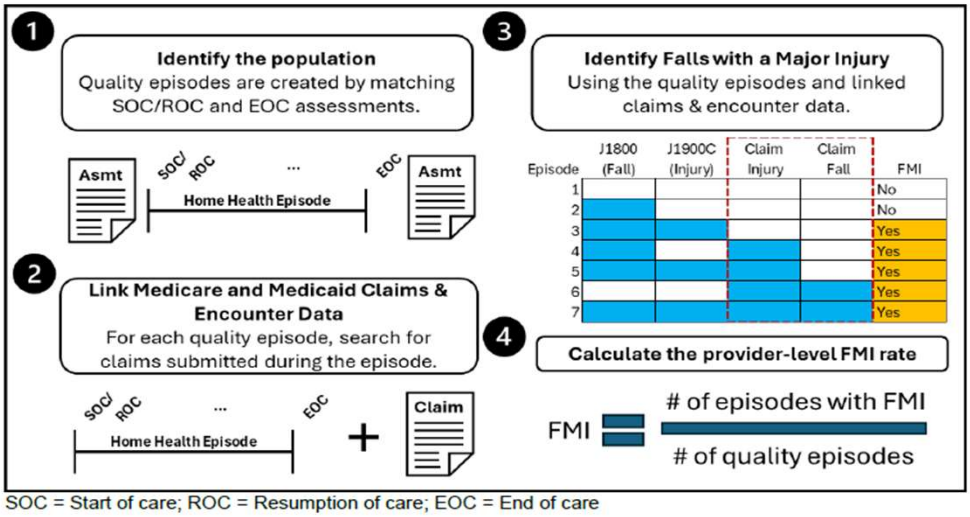
New



mcbee part of Netsmart

38

Detail on Calculation



SOC = Start of care; ROC = Resumption of care; EOC = End of care

mcbee part of Netsmart

39

New Definitions of a Fall

- Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground.
- A fall due to an overwhelming external force (e.g., a patient pushes another patient) is considered a fall.
- An intercepted fall is considered a fall. An intercepted fall occurs when the patient would have fallen if they had not caught themselves or had not been intercepted by another person. However, an anticipated loss of balance resulting from a supervised therapeutic intervention where the patient's balance is being intentionally challenged during balance training is not considered an intercepted fall.
  - An exception is if a major injury results from a fall or intercepted fall that occurs when a clinician is intentionally challenging a patient's balance, during balance training. This would be reported as both a fall and a major injury in J1800 Any Falls Since SOC/ROC and J1900 Number of Falls Since SOC/ROC.

40

Preventing Falls With Major Injury

Clinical Focus Areas

- **Medication Review:** Evaluate medications that impact balance, cognition, sedation, or blood pressure (e.g., antihypertensives, opioids, psychotropics, diuretics).
- **Orthostatic Hypotension:** Routinely assess for orthostatic changes and address symptomatic drops in blood pressure.
- **Visual Impairment**: Identify vision deficits that limit hazard recognition and depth perception, increasing fall risk.
- **Mobility & Strength Deficits:** Assess for muscle weakness, gait instability, impaired coordination and limited endurance that compromise safe ambulation.
- **Risk-Taking & Unsafe Behaviors:** Address behaviors such as rushing, improper footwear, refusal or misuse of assistive devices, and nonadherence to safety recommendations.

41

What to Do

Ensure Clinicians Know/Do the Following:

New Definitions of Fall

Balance challenge with major injury counts as a fall

Assess the risk

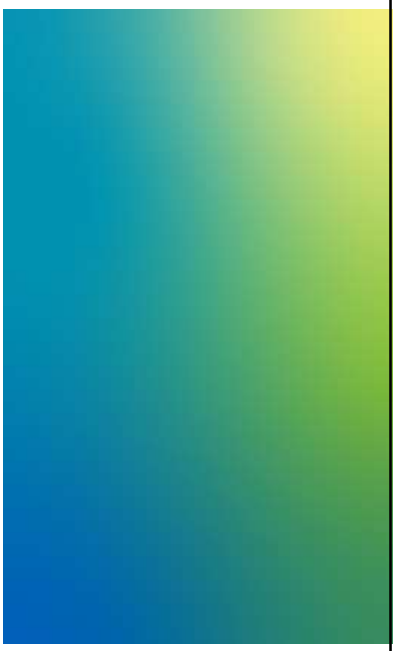
Make appropriate referrals

Safety teaching

42

I don't have to complete the OASIS anymore!

My new tablet does is for me!
How great is that?



43

Proceed with Caution!

*It is still the **clinician's responsibility** to ensure the appropriate OASIS responses are chosen*

- Question 1: In the draft OASIS-E2 Guidance Manual, Chapter 1 convention #9 stated "An agency's software may not "answer" or "generate" the OASIS response for the assessing clinician."
- Please address the following scenario to clarify what is meant by this convention:
  - A clinician is completing a Start of Care assessment. Their iPad uses an ambient listening AI platform, with the patient's consent, that populates some of the OASIS responses while the assessment is being conducted. After completing the assessment, the clinician reviews the OASIS items one by one, making corrections on any items they feel were incorrectly coded by the AI platform.
- Is this scenario compliant with convention #9?

44

And the Answer Is…

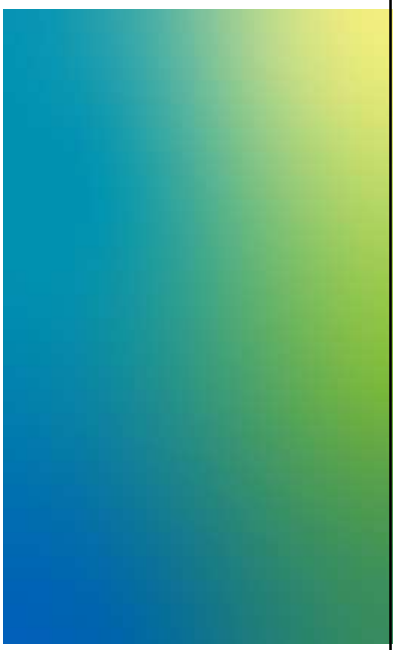
No! Clinicians cannot abdicate this responsibility to AI's Ambient Listening feature

- Answer 1:
  - As stated in the final version of the OASIS-E2 Guidance Manual, "an agency's software may not "answer" or "generate" a final code for the OASIS items.
  - Following agency policies, the assessing clinician is responsible for considering available information and ensuring the appropriate OASIS item response(s) were selected, within the appropriate timeframe and consistent with data collection guidance."

45

OASIS is required for all our patients

I know because the regulations just changed.



46

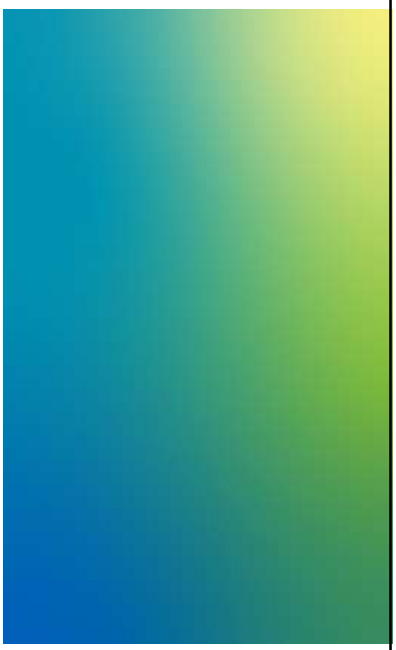
OASIS Changes
Fact or Fiction?

- Not so fast! OASIS is included in comprehensive assessment for all payers – but only if OASIS is "not exempt"
- Exemptions include:
  - One visit in a quality episode
  - Under 18 years old
  - Maternity care
  - If not "Skilled" care per Chapter 7 definition

47

Next Myth?

"Wonk, wonk, wonk, wonk, wonk" – isn't that what the teacher sounded like in Peanuts?



48

References

- OASIS Quarterly Q & As
  https://qtso.cms.gov/system/files/qtso/CMS_OAI_Qtr_1_2026_QAs_April_2026_508c.pdf
- OASIS E2 Guidance Manual
  https://www.cms.gov/files/document/final-oasis-e2-manual-04-01-2026.pdf
- Expanded HHVBP Model: Changes to the Applicable Measure Set Beginning inCY2026
  https://rainmakerssolutions.com/postacutecaretraining/ExpandedHHVBPModelCY26/#/
- Home Health Quality Measures
  https://www.cms.gov/files/document/home-health-outcome-measures-table-oasis-e2025.pdf
- Understanding OASIS Function M & GG Item Coding
  https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/homehealthqualityinits/downloads/understanding-oasis-function-m-gg-item-coding_fact-sheet.pdf

49

Questions?

Annette@providerinsights.com

PROVIDERINSIGHTS

STAY CONNECTED

@McBee
@McBeeassociates

mcbee part of Netsmart

50