2026 CAHSAH

2026 ANNUAL
CONFERENCE & EXPO
Celebrating 60 Years
Then. Now. Next.

OASIS Myths

Busted with CMS Guidance

Wednesday, June 24th, 2026 10:45am

1

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

mcbee part of Netsmart

3

Presenters

Lisa Selman-Holman and Annette Lee

2

Myth

Why Waste Time on the GG Items?

They Don't Matter Reality

4

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

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

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	--	2.7039	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

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.

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.
  -

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	

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

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

9

10

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**

11

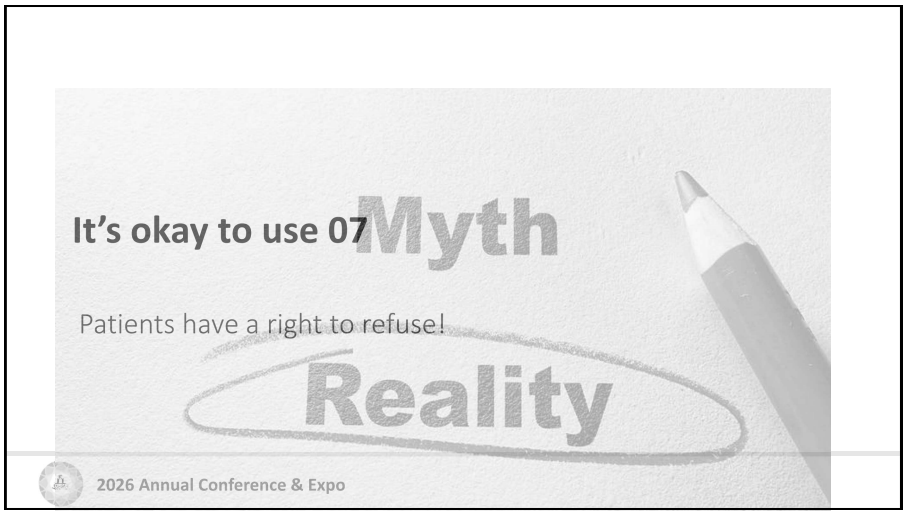
Activity Not Attempted

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**

12

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com



13

07 – Patient Refused

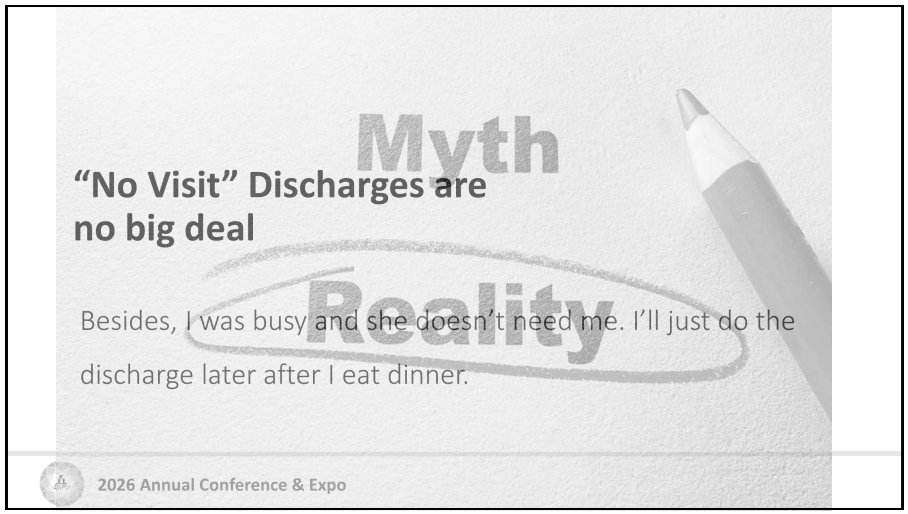
- *The Code of Last Resort*

- 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.

2026 Annual Conference & Expo

14

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com



15

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

2026 Annual Conference & Expo

16

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

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"

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

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)

But he's not SOB!

Myth

Reality

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!

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

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.

Myth

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

Reality

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

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.

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

Data Sources & Considerations

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

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

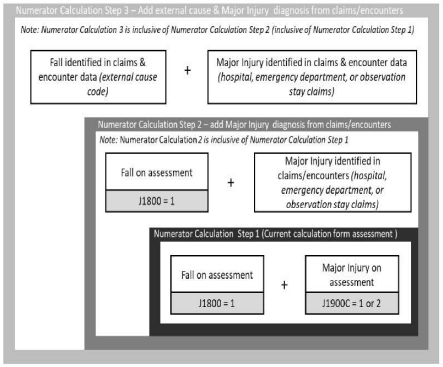
LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

Comparison

Original

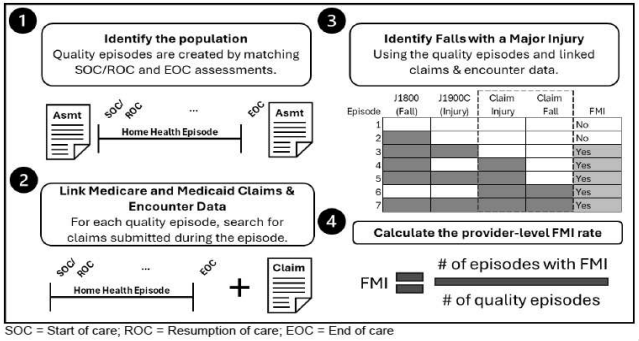
The original version of the measure has been consistent across post-acute care and home health settings, such that an FMI is identified when both a fall and major injury are indicated on the patient assessment (i.e., numerator includes item J1800 identifying that there was a fall indicated on the assessment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

New



25

Detail on Calculation



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

26

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

27

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.

28

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

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

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

Proceed with Caution!

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

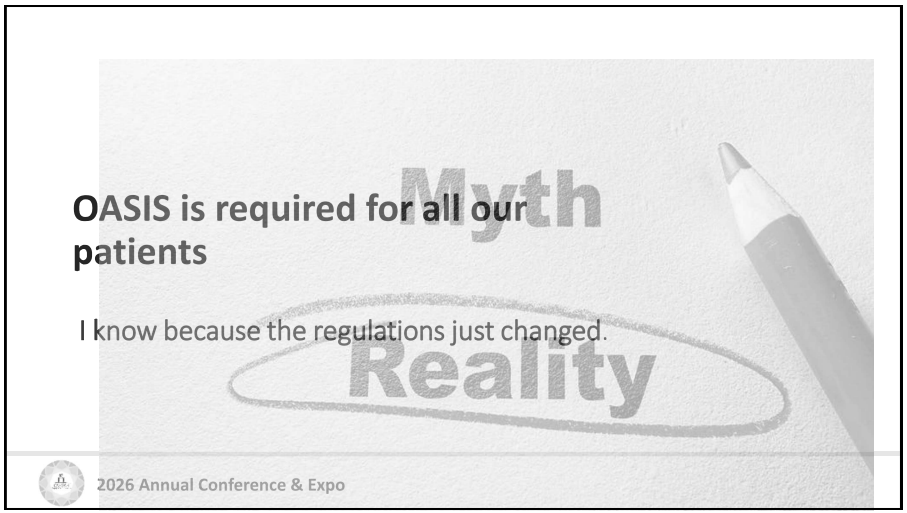
- Question 1: In the draft OASIS-E2 Guidance Manual, Chapter 1 convention #9 stated "An agency's software may not "answer" or "generate" the OASIS response for the assessing clinician."
- Please address the following scenario to clarify what is meant by this convention:
  - A clinician is completing 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?

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."

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com



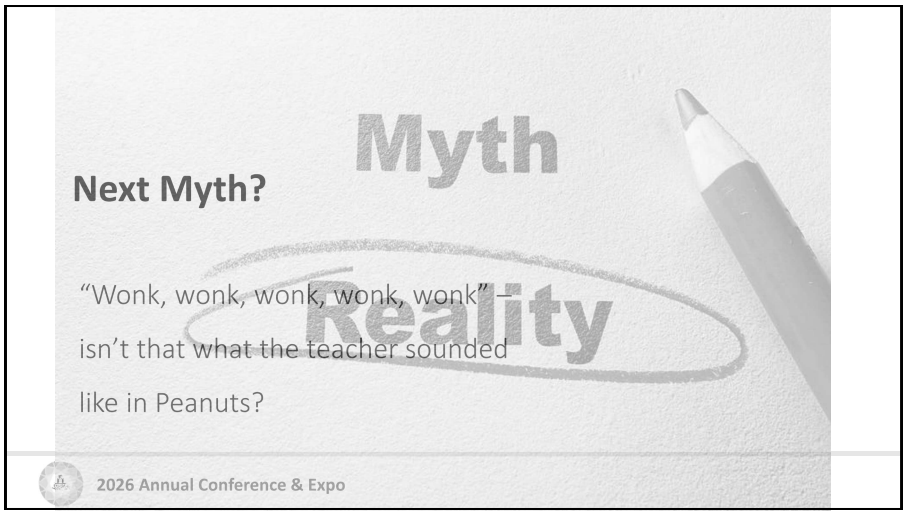
33

OASIS Changes

- *Fact or Fiction?*

- Not so fast! OASIS is included in comprehensive assessments, 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

34



35

References

- OASIS Quarterly Q & As
- OASIS E2 Guidance Manual
- Expanded HHVBP Model: Changes to the Applicable Measure Set Beginning inCY2026
- Home Health Quality Measures

36

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com

Thank You!

LisaSelman-Holman@McBeeAssociates.com

Annette@providerinsights.com

37

LisaSelman-Holman@McBeeAssociates.com
Annette@providerinsights.com