OASIS Documentation Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · September 2026 · Reproduces no item text or response options

The OASIS is the assessment item set CMS requires of Medicare home health agencies, in force as OASIS-E2 since April 1, 2026 and collected at start of care, resumption, recertification, transfer, and discharge. It is a public-domain instrument with coding conventions, not a scored scale: one clinician owns each assessment, the M1800-series items rate ability on the day of assessment, the GG items code usual performance, and eight items set PDGM payment. Defensible charting proves the window with dates, names collaborators and M0090, and supports every response with an observation.

Time point, window, who assessed dates that prove the window
Do: record M0104, M0030, the visit dates, and M0090; name the assessing discipline (M0080) and why it was eligible at SOC.
Pitfall: no referral date, so the 48-hour visit is unprovable; OASIS on the first visit written as a rule.

One clinician, collaboration, M0090 one signature, tracked contributors
Do: one clinician signs; input from patient, caregivers, physician, pharmacist, or staff when policy allows, inside the window; M0090 is the last date gathered.
Pitfall: a therapist's evaluation merged in with no assessor named; M0090 set to the first visit.

Response and supporting narrative every response traces to an observation
Do: write what the patient did, with what help and device, and when; skin and fall items must agree with the clinical notes.
Pitfall: a response coded from the hospital summary; a wound item that disagrees with the wound note.

M1800 series and M1033: ability day of assessment, usual status if it varies
Do: rate what the patient can do safely in the 24 hours before and during the visit; these eight items set PDGM payment.
Pitfall: scored as needing help because a daughter always helps; independent for a transfer nobody watched.

Section GG: usual performance baseline before agency services
Do: code usual performance from attempts at or soon after SOC or ROC; list each attempt; use the not-attempted reason code, never a dash.
Pitfall: GG coded from one assisted walk; the M-item ability judgment copied into GG.

Drug regimen review items M2001, M2003, M2005, N0415, M2020
Do: name the issue, the contact time, and the order time (midnight of the next calendar day); N0415 from the reconciled regimen.
Pitfall: med rec done with no issue or time; an anticoagulant left off N0415 because a dose was skipped.

Plan, QA, correction, transmission close the loop
Do: each need has a plan goal (484.60); QA before lock; transmit within 30 days of M0090; modify or inactivate within 24 months.
Pitfall: a wound order with no skin response; transmitted so it cannot be fixed written into a QA note.

Before the note is signed

- [ ] Window proven with referral, SOC, visit dates
- [ ] Assessing discipline named and eligible
- [ ] Collaborators logged, M0090 last date gathered
- [ ] Every payment item has a dated observation
- [ ] GG coded on usual performance, attempts listed
- [ ] Drug review issue, contact, and order timed
- [ ] Care plan goals answer each identified need

Drafting with AI

Give it the facts: the time point and its dates, the assessing discipline and why it was eligible, each collaborator and date, the observations behind each functional response, the medication review issue with contact and order times, skin and fall findings, QA queries, and the transmission date.

> *"Draft OASIS start of care documentation: referral 09/14, initial visit 09/15, completed 09/17 with PT input 09/16; M0090 09/17; walked 25 feet with rolling walker and contact guard; stairs not attempted for safety; duplicate diuretic found, cardiology order received same day."*

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

Version E2 in force	Eight items pay	Two coding lenses	One clinician signs
effective April 1, 2026	M1800 series plus M1033, not GG	ability on the day, usual performance	collaboration allowed since 2018

OASIS Documentation Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements. Contains no OASIS item text or response options.

Setting: | Patient (initials): | Date: | Clinician:

Time point (SOC / ROC / recert / TRN / DAH / DC): | Assessing discipline + item set version:

Window evidence and eligibility

Referral date (M0104) · ordered start date (M0102) · SOC date (M0030) · visit dates · M0090 date completed · 48-hour visit, 5-day SOC completion, 2-day ROC, transfer, death, discharge windows met · discipline eligible at SOC (RN, PT, SLP, OT with PT or SLP) · late: reason recorded

Collaboration and M0090

Agency policy allows collaboration: yes or no · each contributor, discipline, date, and what was contributed (patient, caregiver, physician, pharmacist, agency staff with direct contact) · input inside the window · M0090 is the last date information was gathered

Responses with supporting observation

For each response a measure or payment can turn on: the task, the help and device, the date and time observed · interviews answered by the patient · skin items agree with the wound note · falls items agree with the fall record · dashes only when no information exists

M1800 series and M1033: ability

Ability to perform safely on the day of assessment (24 hours before the visit plus the visit) · usual status when ability varied, both observations written · caregiver habit and patient choice separated from ability · these eight items set the PDGM functional level

Section GG usual performance

GG0130 self-care and GG0170 mobility coded on usual performance at baseline, before agency services · each attempt listed with the help required · therapy observations through collaboration · not attempted: the item's reason code and the reason, never a dash

Drug regimen review and medication items

M2001 issues found · physician or practitioner contacted: date and time · orders or recommendations received: date and time (midnight of the next calendar day) · N0415 classes in the reconciled regimen even if a dose was missed · M2020 oral medication ability · M2005 at transfer or discharge

Plan of care, QA, correction, transmission

Each identified need has an intervention and a measurable goal in the plan of care (42 CFR 484.60) · QA review date, queries, and resolution before lock · iQIES transmission date within 30 days of M0090 · modification or inactivation record if corrected, within 24 months, per agency correction policy

Clinician (name and credentials): | Signature: | Date: