

DEPARTMENT OF HEALTH & HUMAN SERVICES
Survey and Certification Group
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Survey and Certification Group

October 12, 2007

Linda Krulish, PT, MHS, COS-C
President
OASIS Certificate and Competency Board, Inc
223 East Main Street
New Iberia, LA. 70560

Dear Ms. Krulish:

Thank you for your letter of October 1, 2007 in which you requested review of a number of questions and scenarios related to data collection and accurate scoring of Outcome and Assessment Information Set (OASIS) items. The attached questions and answers have been reviewed by CMS staff and consensus on the responses has been achieved. As deemed valuable for providers, OASIS Education Coordinators and others, we will consider incorporating these questions and answers into future updates to the CMS Q&As posted at <https://www.qtso.com/hhdownload.html>, and/or in future revisions to the OASIS User Manual, Chapter 8, Item-by-item Tips.

You are free to distribute these responses through educational programs for the OASIS Certificate and Competency Board, Inc. (OCCB) or general posting for access by all interested parties. Thank you for your interest in and support for enhancing OASIS accuracy.

Sincerely,

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Nurse Consultant
Survey and Certification Group
Centers for Medicare & Medicaid Services

Cc: Debora A Terkay, RN, MS
Office of Clinical Standards and Quality



CMS OCCB Q&As – October 2007

Category 1 - Applicability

Data Collection Requirement for Pediatric Patients

Question 1: It is my understanding that OASIS collection is not required for Medicare patients under the age of 18. How do you submit a claim with the appropriate HIPPS/HHRG if you do not complete the OASIS assessment? If you do complete an OASIS assessment, can it be submitted to the state? Where would I search on the website for this type of information?

Answer 1: The Conditions of Participation do not require OASIS data collection on pediatric patients. However, if Medicare is the payer, at least the payment OASIS items would have to be collected in order to generate the payer requirement of a HHRG/HIPPS code. This code would be submitted to the Regional Home Health Intermediary (RHHI) for billing purposes only. The data should not be submitted to the State System. The OASIS State System will reject any incomplete assessments or any data submitted for patients younger than 18 years of age.

For further information regarding data submission, contact your OASIS Automation Coordinator (OAC). Contact information is available at http://www.cms.hhs.gov/OASIS/07_AutomationCoord.asp#TopOfPage. For further information about coverage or billing, contact your RHHI.

Category 2 – Comprehensive Assessment

Correct Sequencing of Assessments and Data Collection Requirements when Patient Transferred to Hospital during SOC Visit

Question 2: During the SOC visit, the nurse completed all consents, OASIS, etc and was nearing the end of her visit. The patient developed symptoms which required transport to the ER. The patient was kept overnight for observation and then sent home. Can we count the first visit as the admission, charge for the visit and go on from there or do we have to not charge for the first visit and start new with a new admit and SOC? If we choose not to bill for this type of visit would the OASIS still be required to be completed because the visit was made and consents and skill were involved?

Answer 2: In the scenario presented, you describe a case in which an initial assessment was conducted, it was determined the patient met the payer's eligibility and your agency's admission criteria and a comprehensive assessment was begun, if not completed. If a reimbursable service was provided, it would have established the Start of Care. If the OASIS assessment was not completely finished and the criteria for a Transfer to Inpatient was not met, the same clinician would have up to 5 days after the SOC date to complete the RFA 1, SOC comprehensive assessment. If the same clinician was unable to complete the SOC comprehensive assessment, a second clinician could visit the patient and start and complete a new SOC assessment within 5 days after the SOC date. The SOC date was established when the first reimbursable service was provided.

If no billable service was provided before the patient was transported to the ER, the Start of Care was not established and a new SOC would be completed upon return home from the inpatient facility.

If the patient was admitted to the HHA, the SOC was established, the clinician was unable to

complete the SOC comprehensive assessment, and the patient's stay in the hospital was for 24 hours or longer for reasons other than diagnostic testing, the incomplete SOC assessment (and the transfer assessment) would not be able to be submitted. These documents should be maintained in the clinical record, with documentation explaining the unique circumstances. The agency may complete internal agency discharge paperwork and complete a new SOC when the patient returns home.

If the clinician was able to assess the 24 PPS payment items before the patient was hospitalized, you may contact your Regional Home Health Intermediary (RHHI) to determine if they would allow you to bill for the visit.

Whether you decide to bill or not for this visit does not impact the OASIS data collection requirements. You are not required to collect and submit data on a one-visit only episode. If you do collect the OASIS data voluntarily, submission of the optional data to the state is not required. Questions related to coverage and billing are addressed in the Medicare Policy Benefit Manual which is located at: <http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf> and the Claims Processing Manual located at: <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf>.

Sequencing Assessments after Discharge from Inpatient Facility

Question 3: During a therapy-only episode, the patient had an accidental fall and was hospitalized. An OASIS Transfer without discharge (RFA 6) was completed. Upon return from the hospital, the patient refused to have therapy continued and requested to be discharged from home health. We did the Discharge OASIS instead of a Resumption of Care (ROC) on the 1st day upon return from the inpatient facility but when transmitted, we get a sequencing error message.

Answer 3: The reason you are getting the sequencing error is because you completed a Transfer OASIS and then submitted a Discharge OASIS. When a Transfer OASIS is submitted, the next expected submission would be a Resumption of Care (ROC) - RFA 3. If the patient did not resume services at your agency, then an internal agency discharge (with no OASIS collection) would be expected.

It is not clear whether or not you made a visit when the patient returned home from the hospital. If the patient returned home from the hospital and refused further visits, the Transfer OASIS would be the last OASIS data collection required. You would not need to complete an OASIS Discharge, just your agency's internal agency discharge paperwork.

If the patient returned home from the hospital and you made one visit (the ROC visit) and then the patient refused further visits, you are not required to collect and submit the ROC OASIS data to the state system for one visit episodes (quality episodes). You are required by the Conditions of Participation (484.55) to perform a comprehensive assessment when resuming care of a patient following an inpatient stay of 24 hours or longer for reasons other than diagnostic tests, but OASIS is not required when only one visit is made at the ROC.

Data Collection Requirements for PT One-Visit Episode

Question 4: A patient is ordered and needs only a single Physical Therapy visit (no other disciplines ordered/needed). Is a SOC OASIS required? If the SOC OASIS is required, is a D/C OASIS also required?

Answer 4: Completion of a SOC comprehensive assessment is required, even when the patient is known to only need a single visit in the episode. While there is no requirement to collect OASIS data as part of the comprehensive assessment for a known one-visit episode, some payers (including

Medicare PPS and some private insurers) require OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required by regulation (but collected for payment) for such one-visit episodes, the agency may choose whether or not the data for skilled Medicare/Medicaid patients is transmitted to the State system in these cases. If OASIS data is required for payment by a non-Medicare/non-Medicaid payer [M0150 response does not include Response(s) 1,2,3, or 4], the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State system. Regardless of pay source, no discharge assessment is required, as the patient received only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent OASIS discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however.

OASIS Requirements when Patient Recertified and then Hospitalized Before New Cert Period Begins

Question 5: Our patient's recertification was due August 12th. The nurse completed the recertification assessment on August 8th. Later that night, August 8th, the patient fell, broke her leg and is now in the hospital on her recertification date. Do we submit the recertification assessment and continue on with paperwork including the Transfer OASIS and new Plan of Care or do we keep the Recertification paperwork and complete a Transfer OASIS, and pick back up after the discharge from the inpatient facility as a new referral?

Answer 5: The Conditions of Participation require that a follow-up comprehensive assessment be conducted during last 5 days of every 60 day episode. In your scenario, the follow-up assessment was performed during the required timeframe, but then the patient's condition changed and required what we will assume is a qualifying transfer to an inpatient facility during the recertification assessment timeframe. If your agency completed an RFA 7 - Transfer with Discharge, then regardless of when/if the patient returned to your agency, submission of the Recertification assessment would not be necessary. Therefore, it is acceptable to not submit the Recert assessment to the State system, but rather to maintain the completed Recert assessment in the patient's clinical record, with documentation explaining the situation. It would also be acceptable to submit the Recert assessment to the State system.

If your agency completed an RFA 6 - Transfer without Discharge, then if the patient were to return to your agency on Day 60 or 61, special instructions would apply to determine if the episode is to be considered continuous or not. In order for the episodes to be considered continuous, the HIPPS codes resulting from both the Recertification assessment and the Resumption of Care assessments would need to match, and both assessments would need to be submitted to the State system.

If the conditions required for continuous episodes are not met, it is acceptable to not submit the Recertification assessment to the State system, but rather to maintain the completed Recert assessment in the patient's clinical record, with documentation explaining the situation. In either case, collection and submission of the Transfer assessment would be required.

(More complete details related to this guidance, reference the prior CMS OASIS Q&As Category 2, Questions 53 – 55 and the Medicare Claims Processing Manual, Section 80-Special Billing Situations Involving OASIS Assessments located at <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf>).

OASIS Data Submission Requirement when SOC Completed but Patient Hospitalized before 2nd Visit

Question 6: If we admit a Medicare patient to our home health agency and complete a SOC comprehensive assessment, do we have to submit the OASIS data to the state system if the patient is admitted to the hospital before the second visit? Our understanding of the OASIS regulations is that OASIS data collection and submission is not required when only one visit is made. We will be submitting the data to our RHHI for payment, but do not think we should have to submit it to the state for quality purposes as only one visit was made.

Answer 6: The OASIS data collection instrument was originally developed so that home health agencies could calculate patient outcomes as part of their quality improvement initiatives. In order to produce end result outcomes, patient level data collected at SOC/ROC is compared to the data collected at discharge. When only one visit is made, it is impossible to calculate end result outcomes. Therefore, since the December 2002 OASIS burden reduction initiatives, home health agencies have not been required to collect and/or submit OASIS data for one-visit episodes. If you admit a patient to your home health agency and then become aware that for whatever reason no additional visits will be made after the first visit, you are not required to collect (or submit any already-collected OASIS data) to the State system for that patient episode. You may elect to submit the Home Health Resource Group (HHRG) to your fiscal intermediary/payer in order to obtain payment for the single visit, if eligibility and coverage criteria are met.

Patient under Care of Two Agencies

Question 7: We admit a patient for BID wound care and several days after our SOC, we are made aware by our own staff that it appears that the patient had been open to another home care agency 2 weeks prior to and at the time of our agency's SOC. What are the OASIS requirements for this Medicare patient assuming that our agency is closing?

Answer 7: You are asking which OASIS is required for a patient who is already open under an active plan of care at another home health agency when taken under care by your agency. When more than one agency provides care to a patient simultaneously, one agency is considered primary and is responsible for the billing and OASIS data collection requirements. In your situation, it appears that your agency was not aware that the patient was already open under a primary agency, and that no arrangement existed between your agency and the primary agency. There is no OASIS data collection that will resolve your problem. It is a billing issue and you should refer to the Medicare Claims Processing Manual, Chapter 10, Section 10.1.5.1 - More Than One Agency Furnished Home Health Services, located at

<http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf> and contact your RHHI for guidance.

Category 4a – General OASIS Forms Questions

Question 8: If an agency has excess forms utilizing the 12/2002 version of OASIS, can they continue to use them and attach an addendum with the new or changed M0 Items until their forms supply is used up?

Answer 8: The OASIS-B1 1/2008 data set must be used for follow-up assessments as early as December 27, 2007 and all other assessment time points by January 1, 2008. The Comprehensive Assessment of Patients Condition of Participation requires that “the OASIS data items determined by the Secretary must be incorporated into the HHA’s own assessment”. This standard level requirement means that on the effective date(s), it is expected that agencies will be collecting data using an OASIS-integrated comprehensive assessment that incorporates the current (OASIS-B1 1/2008) data items. The changes to the data set include item additions, item deletions and item revisions. While simply attaching an addendum to the agency’s existing assessment form may be adequate in addressing the data collection for the new items, the data collection issues related to

items that have been deleted or those with language revisions (i.e., skip pattern changes) would not be effectively addressed using an addendum.

Category 4b OASIS Data Set Items

M0090

Question 9: I understand that M0090, Date Assessment Completed, is the day the last information needed to complete the assessment is collected, and at discharge, it is generally the last visit. Due to the new Notice of Provider Non-Coverage which must be given to Medicare recipients two days before discharge, there have been occasions when the notice was not signed at the discharge visit. In order to give the patient the 2 day notice, we hold discharging until after they have had the patient sign the notice, and call them back in two days to confirm the discharge plan, however, the OASIS is completed based on the last visit. When this happens, the system gives us an error when we put in the last visit date versus that last discharge date, even though the assessment is based on the last visit.

Answer 9: M0090, Date Assessment Completed, is the date the clinician gathered the last piece of information necessary to complete the assessment. In most cases, but not all, M0090 is the day of a visit. Sometimes the clinician may gather information off site, such as Therapy Need, or other items that are dependent on a call back from a caregiver or physician or other non-patient assessment data like dates. M0906, Discharge Date, is defined by agency policy. For some agency's it is the date of the last visit, but other agencies may define it to be one or two days or more after the last visit. It is not prescribed by regulation, except that the discharge date cannot occur before the date of the last visit. Regulation requires that the discharge assessment must be completed within two calendar days of the actual discharge date or within two calendar days of learning of the need to discharge in the case of an unplanned or unexpected discharge.

In the case you described, the discharge date (M0906) could be defined by the agency's policy as two days after the last visit to allow for the 2 day notice. The clinician would then have up to two calendar days to complete the assessment (M0090). The bulk of the assessment items could be completed on the visit and then M0906 discharge date and M0090 date assessment completed (the last items you needed to complete the assessment) could be determined 2 days after the date of the last visit, once the discharge was a certainty. Establishing a policy that defines the discharge date in this way prevents the problem with the timing of the data submission and is compliant with the regulation. The problem occurs when you complete the assessment (M0090) before the actual discharge date (M0906).

M0110 and M0826

Question 10: If we determine that we answered M0826, Therapy Need or M0110, Episode Timing, incorrectly at SOC, ROC or Recert, what actions do we have to take?

Answer 10: In the Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Final Rule available at: <http://www.cms.hhs.gov/center/hha.asp> it states:

“The CWF will automatically adjust claims up or down to correct for episode timing (early or later, from M0110) and for therapy need (M0826) when submitted information is found to be incorrect. No canceling and resubmission on the part of HHAs will be required in these instances. Additionally, as the proposed rule noted, providers have the option of using a default answer reflecting an early episode in M0110 in cases where information about episode sequence is not readily available.”

Since medical record documentation standards require a clinician to correct inaccurate information contained in the patient's medical record, if it comes to the clinician's attention that the OASIS response for M0110 - Episode Timing is incorrect, the original assessment may be corrected

following the agency's correction policy. Agencies can make this non-key field change to their records and retransmit the corrected assessment to the State system. For example, if the clinician chose "Early" and during the episode, s/he learned that the patient was in a "Later" episode, M0110 may be corrected. Alternatively, in order to maintain compliance with standard medical record accuracy expectations, the clinician or agency could otherwise document the correction in a narrative correction note, or other format, since CMS is not specifically requiring the correction to be made to the OASIS assessment.

It is quite possible that providers may underestimate or overestimate the number of therapy visits M0826 that will be required in the upcoming episode. Because M0826 is an estimation of an exact number of therapy visits the agency expects to provide and the CWF will automatically adjust claims if the estimation is found to be incorrect, there will be no need to go back to the original OASIS assessment and change the M0826 response and resubmit the data.

The clinician cannot be expected to correct what is unknown to them and since in these specific cases the Common Working File (CWF) will automatically adjust claims found to be incorrect, no extraordinary efforts need to be taken after the original data collection to determine the accuracy of the data specific to M0110 and M0826.

M0150

Question 11: It has come to our attention that we have been answering M0150 incorrectly. How far do we need to go back when correcting our errors?

Answer 11: CMS regulations in the Conditions of Participation 484.20 state the encoded OASIS must be accurate. When errors are identified, follow guidance in the Medicare Conditions of Participation (CoP). The CoPs require your agency to have a policy defining how corrections are made to patient clinical records. The policy must be in compliance with any state and federal laws, and the agency must follow the policy. It should specify who is allowed to make corrections, how the corrections are to be made, and the circumstances under which such corrections can be made. The policy should clarify any differences in procedures to be followed when correcting demographic information versus correcting patient information that the clinician assessed as part of the examination of the patient. The clinical record is a legal document; consequently changes must be made only with very careful consideration. If the correction is to an OASIS item, the correction should be submitted to the state as well as corrected in the clinical record. Data entry/transmission staff should be aware that corrections involving clinical records must be made in accord with these established policies and procedures.

Regarding corrections to OASIS data already submitted to the State, information about correcting the OASIS can be found at <https://www.qtso.com/hhdownload.html>; scroll down the list of available resources and click on the link for HHAcCorrectionPolicy.pdf. Additionally, the State Operations Manual (SOM) and the Conditions of Participation, 484.48, Clinical Record, address the issue of corrections. You can download the SOM at http://cms.hhs.gov/manuals/Downloads/som107ap_b_hha.pdf

If the correction has an impact on billing, you need to correct to submit an accurate claim. There are no time limits on submitting correct claims beyond those contained in the Medicare Claims Processing Manual. If the correction has no billing impact, corrections should be made for at least the last 12 months of data to ensure accurate quality reporting.

M0175

Question 12: We had a client who was admitted to an inpatient facility for less than 24 hours. We did not do a Transfer OASIS because the criteria for it were not met. Two days later the

patient was discharged from our agency and we completed a discharge comprehensive assessment. Approximately 1 week later, the client developed a wound and was readmitted to our agency. When completing the new SOC comprehensive assessment, how do we mark M0175 regarding Inpatient Facility Discharge in the Past 14 Days?

Answer 12: M0175 asks if the patient was discharged from an inpatient facility during the past 14 days. In your scenario, you describe a patient who was admitted and discharged from an inpatient facility during the 14 days prior to the completion of the new RFA 1 SOC comprehensive assessment. The inpatient stay would be reported in M0175.

M0175 does not ask you to only report inpatient facility stays that meet the criteria for the OASIS Transfer, i.e. it does not require that the stay in the inpatient facility is for 24 hours or greater for reasons other than diagnostic test. It simply asks whether the patient was discharged from an inpatient facility during the past 14 days.

M0200

Question 13: Scenario: In the case of an unplanned discharge, how do we calculate the 14 day look back period when responding to M0200?

Answer 13: M0200 is asking if there was a medical or treatment regimen change within the past 14 days. M0200 information in Chapter 8 states "Past 14 days encompasses the two-week period immediately preceding the start/resumption of care or the discharge date." However, in the case of an unplanned discharge, often the discharge assessment visit date is several days prior to the actual discharge date. In the case of an unplanned or unexpected discharge, the assessment data is based on the last visit made by a qualified clinician. In the case of an unplanned discharge, M0200, M0210 and M0220 should be answered based on medical or treatment changes that occurred during the two week period immediately preceding the "last qualified clinician" visit date on which the discharge assessment is based.

M0250

Question 14: For M0250, is Pedialyte, an electrolyte based drink, considered enteral nutrition?

Answer 14: M0250, Response 3 is selected when the patient receives enteral nutrition while in the home. Oral electrolyte maintenance solutions, such as Pedialyte, are administered to prevent dehydration and are not designed to act as nutrition. Response 3 would not be selected unless other forms of enteral nutrition are being administered in the home.

M0445, M0450, M0460 and M0464

Question 15: Has CMS adopted the new 2/2007 NPUAP *Pressure Ulcer Definitions and Stages* as it relates to OASIS data collection, and therefore, should agencies utilize the new definitions when staging a pressure ulcer even though the language will be different on the item itself (per Chapter 8 Item-by-Item Tips)? For instance, if a patient presents with an ulcer that meets the "Unstageable" definition, how should it be reported on OASIS? And if a patient presents with an ulcer that meets the new "Suspected Deep Tissue Injury" wound definition, how should it be reported on the OASIS?

Answer 15: Clinicians should always follow the most current CMS guidance. Agencies may begin to utilize the 2/2007 NPUAP *Pressure Ulcer Definitions and Stages* in the assessment and reporting of pressure ulcers to the extent permitted by current OASIS implementation instructions.

Unstageable

Since the data set does not offer a response of "Unstageable", clinicians should report "Unstageable" pressure ulcers as non observable for M0450 and M0460;

- M0450 - (e) at least one pressure ulcer that is nonobservable
- M0460 - NA

The healing status of an unstageable pressure ulcer should be reported in M0464 as either:

- Response 2 - Early/partial granulation, or
- Response 3 - Not healing

depending on the degree of avascular/necrotic tissue present. See the WOCN OASIS Guidance Document for specific guidelines.

Suspected Deep Tissue Injury

The new pressure ulcer stage of "Suspected Deep Tissue Injury" is not represented in the current OASIS pressure ulcer items. If the physical wound characteristics of the suspected DTI meet the descriptions included in the staging definitions for pressure ulcers currently listed in M0450, then the DTI should be reported.

If the suspected DTI does not meet the descriptions included in the staging definitions currently listed in M0450, it should not be reported in any of the OASIS pressure ulcer items (M0445-M0464) but would be reported in the clinical documentation.

M0450 and M0460

Question 16: In the NPUAP's 2/2007 Pressure Ulcer Stages document , for the description of a Stage IV pressure ulcer it states "Exposed bone/tendon is visible or directly palpable." What does "directly palpable" mean? I can palpate bone through healthy, intact tissue.

Answer 16: Within the context of answering OASIS M0450 and M0460, "directly palpable" means visible.

M0482

Question 17: If a drain was placed post-op and removed prior to admission to home health is the drain site considered a surgical wound upon admission to home care?

Answer 17: A wound with a drain is reported as a surgical wound at M0482. It remains a surgical wound after the drain is pulled until it heals and becomes a scar.

Question 18: If, when reading op reports I find that tissue and/or other structures (mesh, necrotic tissue etc.) were excised when the operation procedure only states I&D, is the resulting wound a surgical wound even though the surgery is labeled I&D?

Answer 18: A simple I&D of an abscess is not a surgical wound for OASIS reporting. A surgical procedure that involves excision of necrotic tissue beyond general debridement (such as excision of a necrotic mass), excision of mesh or other appliances or structures goes beyond a simple I&D and the resulting lesion, until healed, would be reported as a surgical wound for M0482.

Question 19: A patient had a skin cancer lesion removed in a doctor's office with a few sutures to close the wound. Is this considered a surgical wound?

Answer 19: A shave, punch or excisional biopsy utilized to remove and/or diagnose skin lesions does result in a surgical wound, until healed.

M0490

Question 20: Which response for M0490 should be reported for a patient requiring a CPAP (or BiPap) machine at night due to sleep apnea. Since they are apenic at night, would they be considered Response 4 - Short of breath at rest?"

Answer 20: Sleep apnea being treated by CPAP is not the same as dyspnea at rest (response 4 for M0490). M0490 asks about dyspnea (shortness of breath), not sleep apnea (absence of breath during sleep).

The two problems are not the same. Dyspnea refers to shortness of breath, a subjective difficulty or distress in breathing, often associated with heart or lung disease. Dyspnea at rest would be known and described as experienced by the patient. Sleep apnea refers to the absence of breath. People with untreated sleep apnea stop breathing repeatedly during their sleep, though this may not always be known by the individual. If the apnea does not result in dyspnea (or noticeable shortness of breath), then it would not be reported on M0490. If, however, the sleep apnea awakens the patient and results in or is associated with an episode of dyspnea (or noticeable shortness of breath), then response 4 - At rest (during day or night) should be reported.

M0520

Question 21: How do we answer M0520 for patients who have a percutaneous catheter (nephrostomy)? We are coding the primary diagnosis as V53.6 (fitting urinary catheter).

Answer 21: Follow the Response-Specific instructions for M0520 from Chapter 8 of the OASIS Implementation manual, "If the patient has anuria or an ostomy for urinary drainage (e.g., an ileal conduit), mark Response 0". Since your patient has an ostomy for urinary drainage, the nephrostomy, the correct response would be "0". If the patient had the nephrostomy (an ostomy for urinary elimination) and was also incontinent, then Response 1 would be correct.

M0690

Question 22: When scoring M0690, Transferring, the assessment revealed difficulty with transfers. The patient was toe touch weight bearing on the left lower extremity and had pain in the opposite weight bearing hip. The patient had a history of falls and remained at risk due to medication side effects, balance problems, impaired judgment, weakness, unsteady use of device and required assistance to transfer. The concern is the safety of the transfers considering all of the above. Would "2" or "3" be the appropriate response?

Answer 22: Safety is integral to ability, if your patient requires more than minimal human assistance or they need minimal assistance and an assistive device to safely transfer, and can bear weight and pivot safely, Response 2 should be reported. If you determine the bearing weight and pivoting component of the transfer is not safe even with assistance, then the patient is not able to bear weight or pivot and the appropriate selection would be Response 3 – Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

M0780

Question 23: If a patient can't swallow his/her meds but is able to do all the other requirements for oral medication administration, how would you answer M0780, Management of Oral Medications?

Answer 23: M0780 reports the patient's ability to prepare and take (ingest) oral medications reliably and safely at the appropriate dosage and times. On the day of assessment, if the clinician discovers the patient has not been able to swallow prescribed oral medications in the past 24 hours, Response 2 - Unable to take medication unless administered by someone else should be selected, as it is the best response option available. The clinician should explain the patient's inability to take their oral medications in the clinical documentation and why Response 2 was selected.

If it is identified that the route of administration of the medications (which may have originally been prescribed as "oral medications") had been changed to administration "per tube" due to the patient's

inability to swallow, and this has been the patient's usual status on the day of assessment, then response NA - No oral medications prescribed should be selected.

M0810 & M0820

Question 24: Does CPAP apply to items M0810 – Patient Management of Equipment and M0820 – Caregiver Management of Equipment?

Answer 24: CPAP should be considered for M0810 and M0820 only if the patient is receiving oxygen via the CPAP. If the CPAP is not delivering oxygen, then it is not considered in M0810 or M0820.