

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

May 11, 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 April 9, 2007 in which you presented a number of questions and scenarios seeking clarification on accurate responses to Outcome and Assessment Information Set (OASIS) items. The attached questions and answers have been reviewed by CMS staff and we have achieved consensus on the responses. 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 may use these responses in educational programs for the OASIS Certificate and Competency, Board, Inc. (OCCB). Thank you for your interest and support for standardization of OASIS data collection.

Sincerely,

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

Cc: Mary Weakland, RN, MS, COS-C
Office of Clinical Standards and Quality



CMS OCCB Q&As – May 2007

Category 1 - Applicability

Maternity

Question 1: Do we need to collect OASIS on a patient admitted to home health with post-partum complications? If we open a patient 2-3 months after a C-section for infection of the wound, do we collect OASIS, or do we consider this "maternity"? What is the definition of "maternity" and when do we collect OASIS on these patients?

Answer 1: In the OASIS User's manual, Chapter 4, Section C, it clarifies that the Conditions of Participation do not require OASIS data collection for patients receiving only maternity-related services.

Post-partum complications and a wound infection in the C-section incision are only possible in maternity patients. You are not required to collect OASIS on maternity patients unless the payer requires the data collection for payment. Maternity patients are patients who are currently or were recently pregnant and are receiving treatment as a direct result of the pregnancy.

Category 2 – Comprehensive Assessment

Sequence of Visits at SOC

Question 2: Start of Care visit - If both nursing and therapy are ordered at SOC, does the RN have to visit the patient before the therapist? If this is required and the PT visits before the RN, what is the impact on the agency?

Answer 2: The Condition of Participation, 484.55, Comprehensive Assessment of Patients found at www.access.gpo.gov/su_docs/fedreg/a990125c.html stipulates that a registered nurse must conduct the initial assessment unless it is a therapy only case. Since "initial" means first, when nursing orders exist at Start of Care, the RN must be the first person to see the patient and complete the initial assessment requirements.

The Conditions also require that if nursing orders exist at SOC, the RN must complete the SOC comprehensive assessment including the OASIS. This does not necessarily mean that the SOC comprehensive assessment must be completed by the RN on the SOC date or that the initiation of therapy must be delayed until the RN completes the comprehensive assessment. Federal guidelines state the SOC comprehensive assessment including the OASIS must be completed within 5 days after the SOC date. (See the OASIS Assessment Reference Sheet, www.cms.hhs.gov/apps/hha/hharefch.asp). Of course, if your agency policies are more restrictive (e.g., require earlier completion), you must follow your policy.

You also asked what is the impact to the agency if the PT visits the patient before the RN when both nursing and PT are ordered at SOC. Your agency will be out of compliance with the Medicare Conditions of Participation when you allow the therapist to make the initial assessment visit when there are also nursing orders.

Assessment Collaboration Between Disciplines

Question 3: First scenario: A home care agency receives an order for RN and PT for a patient. The SN does the SOC OASIS assessment on the first billable visit of 1/1/07. The Physical therapist does his initial eval on 1/3/07 and upon review of the RN's SOC OASIS documentation, it is discovered that the patient's functional status documented on the OASIS differs from the PT evaluation.

Should the PT discuss his findings with the RN and, if agreed upon, make changes to the SOC OASIS completed on 01/01/07? Does another visit have to occur jointly? Is there a certain time frame this can happen?

Answer 3: While the comprehensive assessment must be completed by only one clinician, it is an excellent idea for all the disciplines caring for a patient to discuss assessment findings and their plans of care. The RN who performs the SOC comprehensive assessment on the SOC date, 1/1/07, has up to 5 days after the SOC (the date of the first billable visit) to complete the SOC OASIS assessment. When conferring with the PT regarding his 1/3/07 visit assessment findings, the RN may discover the SOC OASIS responses chosen do not reflect the assessment findings of the therapist. The RN and PT should further discuss the patient's status to determine if:

1) The differences noted in the patient's status or ability would be considered **normal progression of disease or recovery based on the time that lapsed** between the two assessments, (e.g. the RN noted the patient required assistance of another at all times to ambulate on 1/1/07 due to weakness after hospital discharge. The PT conducted his evaluation on 1/3/07 and the patient's weakness had greatly improved and only needed supervision of another to ambulate at night when she was tired.) In this case, the differences noted can be attributed to normal progression of recovery and do not indicate that the 1/1/07 findings were necessarily inaccurate.

2) The differences noted in the patient's status were due to a **misunderstanding of the OASIS scoring guidance**, (e.g. the RN believed that M0680 Toileting included the patient's ability to transfer on and off the toilet and clothing management.) After discussion, if the RN believes her original score was inaccurate because she inappropriately applied her assessment findings when selecting an OASIS response, changing her response to M0680 within the 5 day time period allowed for completing the assessment is acceptable. The M0090 date will be changed to reflect the date the assessment was completed.

3) The differences noted were due to a **difference in the interpretation of assessment findings**, (e.g. The RN observed the patient ambulating while holding onto furniture and walls and believed the patient was independent and needed no assistance. The PT made the same observation but understood the walls and furniture represented the patient's need for assistance for safe ambulation.) If after discussion, the RN believes her original score was inaccurate because she inappropriately interpreted her assessment findings, changing her response to M0700 within the 5 day time period allowed for completing the assessment is acceptable. The M0090 date will be changed to reflect the date the assessment was completed.

4) The differences noted were due to a **difference (or adequacy) in the assessment approach**, (e.g. The RN asked the patient if he could dress himself. The PT asked the patient to demonstrate gathering his clothes and putting on and removing select clothing

items.) The RN should not base or change her assessment scores based solely on the assessment of the PT, if such assessment findings were not observed by the RN. If after discussion the RN questions the accuracy of her score because she believes she may not have gathered sufficient information necessary to determine the patient's ability to dress, the RN may choose to make another visit during the 5 day assessment time frame and further observe and assess the patient. The RN may determine that her original OASIS response is accurate and leave the assessment as originally completed. Or, the RN may select a different score based on the subsequent visit findings and report the new score as part of the SOC assessment. If the subsequent visit provides any information that is used to complete the comprehensive assessment, then the M0090 date should be changed to reflect the date the assessment was completed.

5) The differences, after discussion, **cannot be reconciled**. The RN's observations are not consistent with the PT's evaluation. The RN may choose to make another visit during the 5 day assessment time frame and further observe and assess the patient. The RN may determine that her original OASIS response is accurate and leave the assessment as originally completed. Or, the RN may select a different score based on the subsequent visit findings and report the new score as part of the SOC assessment. If the subsequent visit provides any information that is used to complete the comprehensive assessment, then the M0090 date should be changed to reflect the date the assessment was completed.

ROC on Day 60 or 61

Question 4: A patient is recertified on 2/21/07 for a new cert period starting 2/26/07. The patient goes into the hospital on 2/23/07 and is discharged from the hospital on 2/26/07. We go back out to see her on 1st day of new episode 2/26/07. Would she require a ROC or a SOC OASIS?

Answer 4: Special guidance applies when the patient returns home from the inpatient facility on day 60 or 61. You will need to complete the ROC assessment and then make a decision based on the HIPPS code. If it did not change from the recert assessment, then you submit the ROC, as it is considered a continuous episode. If the HIPPS code did change from the recert assessment, home care would not be considered continuous and you would perform a "paper billing" discharge and then submit the assessment as a SOC. More details related to this guidance can be found in the Medicare Claims Processing Manual, Section 80-Special Billing Situations Involving OASIS Assessments located at <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf> (see excerpt below)

"2. Beneficiary is Discharged From the Hospital on Day 60 or Day 61

A hospital discharge may occur on day 60 or day 61 and the HHA performs a Resumption of Care assessment which DOES NOT change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this case, home care would be considered continuous if the HHA did not discharge the patient during the previous episode. (Medicare claims processing systems permit "same-day transfers" among providers.) The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates in FL 6 reflected day 61. The RAP would not report a new admission date in FL 17. The HIPPS code submitted on the RAP would reflect the recertification OASIS assessment performed before the beneficiary's admission to the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key

in FL 63. This OASIS assessment would be submitted to the State Agency, as would the Resumption of Care assessment.

A hospital discharge may occur on day 60 or day 61 and the HHA performs a Resumption of Care assessment which DOES change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this case, home care would not be considered continuous and HHAs must discharge the beneficiary from home care for Medicare billing purposes. The RAP for the episode beginning after the hospital discharge would be submitted with claim "from" and "through" dates in FL 6 that reflected the first date of service provided after the hospital discharge. The RAP would also report a new admission date in FL 17. The HIPPS code submitted on the RAP would reflect the OASIS assessment performed after the patient returned from the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key in FL 63. This OASIS assessment would be changed to indicate a Start of Care assessment prior to submission to the State Agency."

ROC as the First Visit in a new Certification Period

Question 5: For a Medicare patient, a recert visit is done April 16th, which was the last day of the first cert period. The patient is hospitalized on April 18th, the second day of the new cert. No home care visits were provided in the new cert period before the hospitalization. Which assessments should be completed and is discharge required?"

Answer 5: If the Medicare PPS patient had a recertification assessment visit during the last five days of the episode, and then experiences a qualifying hospitalization in the new episode, the agency should complete a transfer assessment. This is true whether or not any home care visits have been made in the new episode. The agency may select RFA 6 or 7, depending on agency policy and practice.

If the agency selects RFA 7, then when the patient returns to home care services, a new SOC should be completed.

If the agency selects RFA 6, then when the patient returns to home care services within the episode, a SOC/ROC comprehensive assessment should be completed. In order to determine if this assessment should be reported as a SOC or a ROC, the HHRG/HIPPS code resulting from the assessment responses should be determined. If the resulting HHRG/HIPPS code is the same as from the recertification assessment performed in the last 5 days of the previous episode, then the two episodes are considered continuous. In this case the assessment should be reported as a ROC, no discharge is required, and the care continues on under the original certification periods. This is an example of a situation in which the first visit in a new certification period could be the Resumption of Care visit.

If the resulting HHRG/HIPPS code is not the same as from the recertification assessment performed in the last 5 days of the previous episode, then the two episodes would not be considered continuous. In this case the patient should be discharged through completion of agency discharge paperwork or process, and the new assessment should be reported as a SOC, establishing a new episode with a new certification period. All assessments completed (the SOC and recertification assessments completed in the previous episode, the transfer, and the SOC or ROC assessment in the next episode) should be transmitted to the State

Agency. A discharge OASIS assessment under the previous episode is not required, and if the home health agency completed an RFA 6 upon transfer and the episodes were eventually determined to not be continuous (under the conditions explained above), the agency does not need to “correct” the RFA 6, (by changing to an RFA 7, indicating discharge). The submission of the assessment sequence (SOC RFA 1, Recert RFA 4, Transfer RFA 6, SOC RFA 1...) will be accepted by the State Agency, and the documentation contained within the clinical record(s) should clarify the events.

More details related to this guidance can be found in the Medicare Claims Processing Manual, Section 80-Special Billing Situations Involving OASIS Assessments located at <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf>, (see excerpt below)

3. Beneficiary is Admitted to Hospital on Day 61 Prior to Delivery of Services in the Episode

A beneficiary may be hospitalized in the first days of an episode, prior to receiving home health services in the new episode. These cases are handled for billing and OASIS identically to cases in which the beneficiary was discharged on days 60 or 61. If the HIPPS code resulting from the Resumption of Care OASIS assessment is the same as the HIPPS code resulting from the recertification assessment, the episode may be billed as continuous care. If the HIPPS code changes, the episode may not be billed as continuous care. The basic principle underlying these examples is that the key to determining if episodes of care are considered continuous is whether or not services are provided in the later episode under the recertification assessment performed at the close of the earlier episode.

Category 3 – Follow-Up Assessments

Use of RFA 5 - Other Follow-up

Question 6: I am trying to find clarification on how to use RFA 5 for decline or improvement. When I review the OASIS time points, it lists RFA 5 as a SCIC with or without hospitalization. Does the RFA 5 only have to be done when payment is affected? If the patient improved, I would think we would be discharging, thus RFA 9. I don't understand what RFA 5 is used for.

Answer 6: When the patient experiences an event that meets your agency's definition of a major decline or improvement in the patient's health status, you are required to complete the RFA 5, the Other Follow-up assessment, in order to be compliant with the Medicare Conditions of Participation – Section 484.55(d). In the preamble to the comprehensive assessment regulation, 484.55, it is noted that a comprehensive assessment (with OASIS data collection, if applicable) is required when there is a major decline or improvement in health status. CMS encouraged each agency to develop its own guidelines and policies for this type of assessment and did not provide written requirements about what constitutes a significant decline or improvement.

This requirement to complete an RFA 5 for a patient experiencing a major decline or improvement in health status should not be confused with the Significant Change in Condition (SCIC) payment adjustment which was introduced in the initial Home Health Prospective Pay System (PPS) model. Regardless of the pay source or impact, current regulations require that any patient experiencing a major decline or improvement (as defined

by your agency) is expected to receive a follow-up comprehensive assessment. Following agency policy, if the clinician identifies that there has been a major decline or improvement, the clinician will complete the assessment and evaluate the plan of care and modify as needed.

You stated that if a patient had a major improvement, you would discharge, but that may not be true if the patient had continuing home care needs. For example, if your patient had a CVA and at SOC and subsequently experienced a significant resolution of neurological symptoms, this patient may meet the criteria for your agency's definition of a major improvement. If the patient continued to have nursing needs related to medication management, you may not discharge until those goals were met. The RFA 5 would serve as the vehicle to reassessment the patient's status after the major change in status.

Category 4b OASIS Data Set Items

M0030

Question 7: Related to M0030, the 06/06 revisions to Chapter 8 of the OASIS Implementation Manual, have redefined the SOC date to be the day of the first skilled visit. The revisions substituted "skilled" for "reimbursable". Does this mean that once need and eligibility is established, aide visits provided before the first skilled visit are not included in the episode of care? For instance, if PT and HHA are ordered, and a registered nurse does a non-billable initial assessment visit to establish needs and eligibility for a therapy only patient, can't the home health aide make a "reimbursable" visit prior to the day the therapist makes the first "skilled" visit for a Medicare patient? And wouldn't the aide's visit establish the SOC?

Answer 7: CMS Q&A, Category 2, Question 36 clarifies that the "start of care" is defined as the first billable visit. The change in language found on page 8.18 of the 06/06 revision to Chapter 8 of the OASIS Implementation Manual, where the word "reimbursable" was replaced with "skilled" was unintentional and providers are instructed to continue to define the Start of Care as the date the first covered or reimbursable service is provided.

It is possible that the visit that establishes the SOC is not skilled, as in the scenario presented in the question above where the aide's visit is both reimbursable and establishes the start of care for the episode. The Conditions of Participation 484.55, Comprehensive Assessment of Patients Interpretive Guidelines states "For all practical purposes, the start of care date is the first billable home visit. For payers other than Medicare, the first billable visit might be a visit made by a home health aide." More recent instruction in the Medicare Benefits Manual (Chapter 7, Sequence of Qualifying Services) does state that now, even for Medicare, the first billable visit might be a visit made by a home health aide, once the need and eligibility has been established.

M0010 & M0072

Question 8:

- 1. As of May 23, 2007, should M0010 Agency Medicare Provider Number report the six-digit Medicare Provider Number, as in the past, or the agency's NPI number?**
- 2. And should M0072 Primary Referring Physician ID report the six-digit UPIN, as in the past, or the ten-digit NPI number for the referring physician?**

Answer 8: M0010 will not report the new agency NPI number, but will continue to report the Agency Medicare Provider Number (now called Centers for Medicare and Medicaid Services Certification Number or “CCN”). M0010 is a six-digit field and would not accommodate the ten-digit NPI number. The agency NPI number will not be collected anywhere in the OASIS data set, although, after set up, it will be imbedded in the header and body of the transmission file.

Beginning May 23, 2007, home health agencies may begin entering the physician's NPI number in M0072 Primary Referring Physician ID. To accomplish this, agencies will need to collect NPI numbers from referring physicians to be entered into OASIS item M0072 for any assessment completed on or after May 23, 2007. Agencies should also be working with their software vendors to determine if any changes are required to accommodate this. The OASIS Data Specifications Version 1.50 and HAVEN 7.1 currently provide 10 spaces for this OASIS item. This space is sufficient to accommodate the Physician's NPI number.

If by May 23, 2007, the agency is unable to comply with the instruction to enter the physician's NPI number in M0072, they should continue to enter the UPIN number and at least initially assessments will not be rejected. Mandatory collection of the physician's NPI number on the OASIS data set is not required under the HIPAA National Privacy Rule (NPI) Rule, but CMS may be required NPI collection on the OASIS in the future. Since it is not currently required, there will not be an integrity check. The file will not be rejected if M0072 is filled with the UPIN number.

Since the agency must collect and use this number to comply with the NPI Rule, it is recommended that as they attain compliance with collection and use of the physician's NPI number for required functions, they simultaneously use it to report the Primary Referring Physician ID in M0072.

M0100

Question 9: For the purposes of determining if a hospital admission was for reasons “other than diagnostic tests” how is “diagnostic testing” defined? I understand plain x-rays, UGI, CT scans, etc. would be diagnostic tests. What about cardiac catheterization, an EGD, or colonoscopy? (A patient does receive some type of anesthesia for these). Does the fact that the patient gets any anesthesia make it surgical versus diagnostic?

Answer 9: Diagnostic testing refers to tests, scans and procedures utilized to yield a diagnosis. Cardiac catheterization is often used as a diagnostic test to determine the presence or status of coronary artery disease (CAD). However, a cardiac catheterization may also be used for treatment, once other testing has established a definitive CAD diagnosis. Each case must be considered individually by the clinician without making assumptions. The fact that the procedure requires anesthesia does not determine whether or not the procedure is purely diagnostic or not. Utilizing the definition of diagnostic testing, a clinician will be able to determine whether or not a certain procedure or test is a diagnostic test.

M0100 & M0855

Question 10: HHAs are providing services for psychiatric/mental health patients. The physician admits the patient to the hospital for "observation & medication review" to

determine the need to adjust medications. These admissions can occur as often as every 2-4 weeks. The patient(s) are admitted to the hospital floor under inpatient services (not in ER or under “observation status”). The patient(s) are observed and may receive some lab work. They are typically discharged back to home care services within 3-7 days. Most patients DO NOT receive any treatment protocol (i.e. no medications were added/stopped or adjusted, no counseling services provided) while they were in the hospital. Is this considered a hospitalization? How do you answer M0100 & M0855?

Answer 10: In order to qualify for the Transfer to Inpatient Facility OASIS assessment time point, the patient must meet 3 criteria:

- 1) Be admitted to the inpatient facility (not the ER, not an observation bed in the ER)
- 2) Reside as an inpatient for 24 hours or longer (does not include time spent in the ER)
- 3) Be admitted for reasons other than diagnostic testing only

In your scenario, you are describing a patient that is admitted to the inpatient facility, and stays for 24 hours or longer for reasons other than diagnostic testing. An admission to an inpatient facility for observation is not an admission for diagnostic testing only. This is considered a hospitalization. The correct M0100 response would be either 6-Transfer to an Inpatient Facility, patient not discharged or 7-Transfer to an Inpatient Facility, patient discharged, depending on agency policy. M0855 would be answered with Response 1- Hospital as you state the patient was admitted to a hospital.

M0100, M0830

Question 11: Observation Status/Beds - A patient is held for several days in an observation bed (referred to as a “Patient Observation” or “PO” bed) in the emergency or other outpatient department of a hospital to determine if the patient will be admitted to the hospital or sent back home. While under observation, the hospital did not admit the patient as an inpatient, but billed as an outpatient under Medicare Part B. Is this Emergent Care? Should we complete a transfer, discharge the patient, or keep seeing the patient. Can we bill if we continue to provide services?

Answer 11: For purposes of OASIS (M0830) Emergent Care - the status of a patient who is a being held in an emergency department for outpatient observation services is response 1 - hospital emergency department (whether or not they are ever admitted to the inpatient facility). If they are held for observation in a hospital outpatient department, response 3 should be reported for M0830.

If from observation status the patient is eventually admitted to the hospital as an inpatient (assuming the transfer criteria are met), then this would trigger the Transfer OASIS assessment, and the agency would complete RFA 6 or RFA 7 data collection, depending on whether the agency chose to place the patient on hold or discharge from home care.

During the period the patient is receiving outpatient observation care, the patient is not admitted to a hospital. Regardless of how long the patient is cared for in outpatient observation, the home care provider may not provide Medicare billable visits to the patient at the ER/outpatient department site, as the home health benefit requires covered services be provided in the patient's place of residence. Outpatient therapy services provided during the period of observation would be included under consolidated billing and should be managed

as such. The HHA should always inform the patient of consolidated billing at the time of admission to avoid non-payment of services to the outpatient facility.

If the patient is not admitted to the hospital, but returns home from the emergency department, based on physician orders and patient need, the home health agency may continue with the previous or a modified plan of care. An Other Follow-up OASIS assessment (RFA 5) may be required based on the agency's Other Follow-up policy criteria. The home health agency would bill for this patient as they would for any patient who was seen in an emergency room and returned home without admission to the inpatient facility following guidance in the Medicare Claims Processing manual.

The CMS Manual System Publication, 100-04 Medicare Claims Processing: Transmittal 787 - the *January 2006 Update of the Hospital Outpatient Prospective Payment System Manual Instruction for Changes to Coding and Payment for Observation* provides guidance for the use of two new G-codes to be used for hospital outpatient departments to use to report observation services and direct admission for observation care. Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

M0100

Question 12: An HHA has a patient who has returned home from a hospital stay and they have scheduled the nurse to go in to do the Resumption of Care visit within 48 hours. However, this patient receives both nursing and physical therapy and the PT cannot go in on the 2nd day (tomorrow) and would like to go in today. I have found the standard for an initial assessment visit must be done by a registered nurse unless they receive therapy only. Is this the same case for resumption? Is it inappropriate for the PT to go in the day before and resume PT services and the nurse then to go in the next day and do the ROC assessment update?

Answer 12: The requirement for the RN to complete an initial assessment visit prior to therapy visits in multidisciplinary cases is limited to the SOC time point. At subsequent time points, including the ROC, either discipline (the RN or PT in the given scenario) could complete the ROC assessment. While the assessment must be completed within 48 hours of the patient's return home from the inpatient facility, there is no requirement that other services be delayed until the assessment is completed. Therefore, assuming compliance with your agency-specific policies and other regulatory requirements, there is no specific restriction preventing the PT from resuming services prior to the RN's completion of the ROC assessment.

M0230/M0240

Question 13: Is it true that you can never change M0230 or M0240 from the original POC (cert) until the next certification?

Answer 13: Guidance in Chapter 8 of the OASIS User's manual, pg. 8.42 and 8.145, states the primary diagnosis is the chief reason the agency is providing home care, the condition most related to the plan of care. Secondary diagnoses are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care." "In general, M0240 should include not only conditions actively addressed in the patient's plan of care but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself."

M0230, Primary Diagnosis and M0240, Other Diagnoses are reported at Start of Care, Resumption of Care and Follow-up/Recertification. At each time point, after completing a comprehensive assessment of the patient and receiving input from the physician, the clinician will report the patient's current primary and secondary diagnoses. Diagnoses may change following an inpatient facility stay - the Resumption of Care and following a major change in the patient's health status - the Other Follow up. The chief reason an agency is caring for a patient may change. The focus of the care may change. At each required time point the clinician will assess and report what is true at the time of the assessment.

M0250

Question 14: If a patient's appetite is poor and he/she has a g-tube and the physician orders Ensure prn through the g-tube? Does this count as enteral nutrition for this item?"

Answer 14: If a PRN order exists and the patient meets the parameters for administration of the feeding based on the findings from the comprehensive assessment, or has met such parameters and/or received enteral nutrition at home in the past 24 hours, the assessing clinician would mark Response 3. The clinician could not mark response 3 automatically when a PRN order exists at SOC because it is unknown if the patient will ever receive the enteral nutrition.

M0340

Question 15: What if paid help lives with the patient Monday through Friday, would we still score, in this section, 1-lives alone? My understanding is that this section is not asking about what kind of help the patient receives.

Answer 15: You are describing paid help that lives with the patient intermittently, Monday through Friday. Intermittent (e.g., a few hours each day, one or two days a week, etc.) paid help is not classified as help the patient "lives with." The correct response for M0340, in this case, would be 1-Lives alone.

M0340 is asking with whom the patient is living with at the time of the assessment, even if the arrangement is temporary. Subsequent items will capture information about the primary caregiver and the type and quantity of assistance s/he provides.

M0340 & M0350

Question 16: What are the correct responses for M0340 and M0350 in the situation where family members that live outside the home are staying around the clock with a patient (caregivers are taking turns with each other)? If the patient has 24 hour supervision from people outside the home, is the patient living alone?

Answer 16: Chapter 8, Page 8.51 of the OASIS Implementation Manual (www.cms.hhs.gov/OASIS/05_UserManual.asp) instructs that M0340 should identify whomever the patient is living with at the time of the assessment, even if the arrangement is temporary. It does not simply ask if the patient has 24 hour companionship or supervision, but who the patient lives with.

In situations where multiple caregivers/family members stay with the patient for a number of hours each day, if each of the caregivers comes and goes to their own residences outside of the patient's home, then they do not live with the patient, even if the cumulative "coverage" equates to 24 hour supervision/companionship. The patient is living alone and M0340 should be reported as response 1 - Lives alone. These caregivers should be considered when reporting assisting persons for M0350 (unless they are home care agency staff), and response 1 - relatives, friends or neighbors living outside the home, should be reported.

M0482

Question 17: I understand that a simple I&D of an abscess is not a surgical wound. Does it make a difference if a drain is inserted after the I&D? Is it a surgical wound if the abscess is removed?

Answer 17: For purposes of scoring the OASIS integumentary items, a typical incision and drainage procedure does not result in a surgical wound. The procedure would be reported as a surgical wound if a drain was placed following the procedure.

Also, if the abscess was surgically excised, the abscess no longer exists and the patient would have a surgical wound, until healed.

M0482

Question 18: A patient, who has a paracentesis, has a stab wound to access the abdominal fluid. Is this a surgical wound?

Answer 18: When a surgical procedure creates a wound in which a drain is placed (e.g., an incision or stab wound), the presence of the drain (or drain wound site until healed) should be reported as a surgical wound. If a needle was inserted to aspirate abdominal fluid and then removed (no drain left in place), it should not be reported as a surgical wound.

M0482

Question 19: Does a cardiac cath site qualify as a surgical wound for M0482?

Answer 19: If a cardiac catheterization was performed via a puncture with a needle into the femoral artery, the catheter insertion site is not reported as a surgical wound for M0482.

M0482

Question 20: Does a patient have a surgical wound if they have a traumatic laceration and it requires plastic surgery to repair the laceration?

Answer 20: Simply suturing a traumatic laceration does not create a surgical wound. A traumatic wound that required surgery to repair the injury would be considered a surgical wound (e.g., repair of a torn tendon, repair of a ruptured abdominal organ, or repair of other

internal damage), and the correct response to M0482 for this type of wound would be "1-Yes."

M0482

Question 21: Is a PICC placed by a physician under fluoroscopy and sutured in place considered a surgical wound? It would seem that placement by this procedure is similar to other central lines and would be considered a surgical wound.

Answer 21: Even though the physician utilized fluoroscopy to insert the peripherally inserted central catheter (PICC) and sutured it in place, it is not a surgical wound, as PICC lines are excluded as surgical wounds for OASIS data collection purposes.

M0440 – M0488

Question 22: Do CMS OASIS instructions supersede a clinical wound nurse training program?

Answer 22: CMS references, not clinical training programs should be used to guide OASIS scoring decisions. While CMS utilizes the expert resources of organizations like the Wound Ostomy Continence Nurses Society and the National Pressure Ulcer Advisory Panel to help suggest assessment strategies to support scoring of the integumentary items, in some cases, the OASIS scoring instructions are unique to OASIS and may not always coincide or be supported by general clinical references or standards. While CMS provides specific instructions on how OASIS data should be classified and reported, OASIS scoring guidelines are not intended to direct or limit appropriate clinical care planning by the nurse or therapist. For instance, even though for OASIS data collection purposes a gastrostomy is excluded as a skin lesion or open wound, such data collection exclusion does not suggest that the clinician should not assess, document and include in the care plan findings and interventions related to the gastrostomy.

M0520

Question 23: How long would a patient need to be continent of urine in order to qualify as being continent?

Answer 23: Utilize clinical judgment and current clinical guidelines and assessment findings to determine if the cause of the incontinence has been resolved, resulting in a patient no longer being incontinent of urine. There are no specific time frames that apply to all patients in all situations.

M0640 – M0800

Question 24: I know it is imperative that the assessing clinician be accurate on answering what the patient's status was on the "14th day prior to". Can you explain to me the importance of that 14th day? What bearing this has on their outcomes/payment? If we mark "unknown", does it hurt the agency?

Answer 24: Prior status contributes to the Case Mix Report categories of "ADL Status Prior to SOC" and "IADL Status Prior to SOC" and is utilized in risk adjustment for some of the outcome measures. The "prior status" variables have proven to be particularly useful in risk adjustment for the OBQI reports, as they indicate the chronicity of a functional impairment (thus impacting the patient's expected ability to improve in a specific outcome of interest).

The 14th day prior to SOC/ROC serves as a proxy for the patient's prior functional status. While it may not represent the "true" prior functional status, it allows the data collection of thousands of assessors to be standardized. General OASIS conventions state that data collectors should minimize the use of "unknown" as a response option, and to limit its use to situations where no other response is possible or appropriate. Under the current reimbursement for Medicare home care services, the "14 days prior" responses do not affect payment. However, since the responses from the prior status items do currently contribute to risk adjustment, it is possible that they may have a reimbursement impact in the future, depending on the parameters used to determine payment under the home health benefit and other programs.

M0650/M0660

Question 25: In the dressing items, how do you answer if a disabled person has everything in their home adapted for them; for instance, closet shelves & hanger racks have been lowered to be accessed from a wheelchair. Is the patient independent with dressing?

Answer 25: M0650 & M0660, Upper and Lower Body Dressing, Response 0 indicates a patient is able to safely access clothes and put them on and remove them (with or without dressing aids). Because in these specific OASIS items, the use of special equipment does not impact the score selection, at the assessment time point, if the patient is able to safely access clothes, and safely dress, then Response 0 would be appropriate even if the patient is using adaptive equipment and/or an adapted environment to promote independence.

M0650, M0660, M0780

Question 26: For M0650 & M0660, we know you count things like prostheses & TED hose as part of the clothing. But the interpretation is that they have to only be independent with the "majority" of the dressing items & then they are considered independent. Because of the importance of being able to put a prostheses on and for a diabetic being able to put shoes & socks on, clinicians want to mark a patient who can do all their dressing except those items NOT independent. However, does this fit the criteria of "majority"?

The same issue can exist for medication compliance.....if a patient can take the majority of their meds (Vitamins, stool softeners, etc.) but cannot remember their digoxin....does that make them independent with the majority even though we know how important the digoxin is?"

Answer 26: Your understanding of the majority rule is correct. If a patient's ability varies among the tasks included in a single OASIS item (like M0660 lower body dressing, or M0780 Oral Medications), select the response that represents the patient's status in a "majority" of the tasks. The concerns of clinicians focus on critical issues that need to be addressed in the plan of care. It may help to remember that the OASIS is a standardized data set designed to measure patient outcomes. In order to standardize the data collected, there must be objective rules that apply to the data collection (e.g. the percentage of medications a patient can independently take). Less objective criteria, like which medications are more important, or which lower body dressing items are more important than others, have limitations in consistency in which a similar situation would likely be

interpreted differently between various data collectors from one agency to the next. While these rules may cause the assessing clinician to pick an item response that lacks the detail or specificity that may be observable when assessing a given patient, as long as the clinician is abiding by scoring guidelines, he/she is scoring the OASIS accurately and the agency's outcome data will be a standardized comparison between other agencies. In any situation where the clinician is concerned that the OASIS score does not present as detailed or accurate representation as is possible, the clinician is encouraged to provide explanatory documentation in the patient's clinical record, adding the necessary detail which is required for a comprehensive patient assessment.

M0670

Question 27: For M0670 even the normal person requires a long-handled sponge or brush to wash their back. However, the July 27 CMS OCCB Q & A's # 36 indicates that if a patient can do everything except wash their back & requires a long-handled sponge or brush they would be marked a "1". Is this correct?

Answer 27: Assistive devices promote greater independence for the user by enabling them to perform tasks they were previously unable to, or had great difficulty safely performing. The intention of the use of the term "devices" in the response 1 for M0670 is to differentiate a patient who is capable of washing his entire body in the tub/shower independently (response 0), from that patient who is capable of washing his entire body in the tub/shower only with the use of (a) device(s). This differentiation allows a level of sensitivity to change to allow outcome measurement to capture when a patient improves from requiring one or more assistive devices for bathing, to a level of independent function without devices. Individuals with typical functional ability (e.g. functional range of motion, strength, balance, etc.) do not "require" special devices to wash their body. An individual may choose to use a device (e.g., a long-handled brush or sponge) to make the task of washing the back or feet easier. If the patient's use of a device is optional (e.g., it is their preference, but not required to complete the task safely), then the score selected should represent the patient's ability to bathe without the device. If the patient requires the use of the device in order to safely bathe, then the need for the device should be considered when selecting the appropriate score. CMS has not identified a specific list of equipment that defines "devices" for the scoring of M0670. The clinician should assess the patient's ability to wash their entire body and use their judgment to determine if a device, assistance, or both is required for safe completion of the included bathing tasks.

M0670

Question 28: If a patient uses the tub/shower for storage, is this an environmental barrier? Is the patient marked a "4" in M0670?"

Answer 28: Upon discovering the patient is bathing at the sink, the clinician should evaluate the patient in attempts to determine why he/she is not bathing in the tub/shower. If it is the patient's personal preference to bathe at the sink (e.g. "I don't get that dirty." "I like using the sink."), but they are physically and cognitively able to bathe in the tub/shower; the clinician will pick the response option that best reflects the patient's ability to bathe in the tub/shower. If the patient no longer bathes in the tub/shower due to personal preference and has since begun using the tub/shower as a storage area, the patient would be scored based on their ability to bathe in the tub/shower when it was empty. If the patient has a physical or cognitive/emotional barrier that prevents them from bathing in the tub/shower and therefore

has since starting using the tub/shower as a storage area, the clinician will score the patient as “4 –“Unable to use the shower or tub and is bathed in bed or bedside chair.”, unless they are a “5”, unable to participate in bathing and is totally bathed by another person. Note that the response of “4” (or “5”) is due to the patient’s inability to safely bathe in the tub/shower (even with help) due to the physical and/or cognitive barrier, not due to the alternative use of the tub for storage.

M0690

Question 29: A quadriplegic is totally dependent, cannot even turn self in bed, however, he does get up to a gerichair by Hoyer lift. For M0690, is the patient considered bedfast?

Answer 29: A patient who can tolerate being out of bed is not “bedfast.” If a patient is able to be transferred to a chair using a Hoyer lift, response 3 is the option that most closely resembles the patient’s circumstance; the patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast (“confined to the bed”) even though he cannot help with the transfer. Responses 4 and 5 do not apply for the patient who is not bedfast. The frequency of the transfers does not change the response, only the patient’s ability to be transferred and tolerate being out of bed.

M0700

Question 30: For M0700, does able to walk “on even and uneven surfaces” mean inside the home or outside the home or both? If the patient is scored a 0, does this mean the patient is a safe community ambulator and therefore is not homebound?

Answer 30: “Even and uneven surfaces” refers to the typical variety of surfaces that the particular home care patient would routinely encounter in his environment. Based on the individual residence, this could include evaluating the patient’s ability to navigate carpeting or rugs, bare floors (wood, linoleum, tile, etc.), transitions from one type or level of flooring to another, stairs, sidewalks, and uneven surfaces (such as a graveled area, uneven ground, uneven sidewalk, grass, etc.).

To determine the best response, consider the activities permitted, the patient’s current environment and its impact on the patient’s normal routine activities. If, on the day of assessment, the patient’s ability to safely ambulate varies among the various surfaces he must encounter, determine if the patient needs some level of assistance at all times (Response 2), needs no human assistance or assistive device on any of the encountered surfaces (Response 0), or needs some human assistance and/or equipment at times but not constantly (Response 1).

Response 0, Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e. needs no human assistance or assistive device), is not intended to be used as a definitive indicator of homebound status. Some patients are homebound due to medical restrictions, behavioral/emotional impairments and other barriers, even though they may be independent in ambulation.

Refer to the Medicare Coverage Guidelines for further discussion of homebound criteria at <http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf>.

M0810

Question 31: Is dialysis thru a central line considered for this question?

Answer 31: Dialysis through a central line is included in M0810 as long as the dialysis occurs in the home. M0810 reports the patient's ability to manage the equipment used for the delivery of oxygen, IV/infusion therapy or enteral/parenteral nutrition. Dialysis is an infusion therapy.

If the patient were receiving such therapy outside the home, (e.g. at a dialysis center), then M0810 should be marked "NA – No equipment of this type used in care", assuming the patient care did not include use of any other included services at home (oxygen, enteral nutrition, etc.).

M0820

Question 32: Is it true that nebulizers are not considered when answering M0810 & 820 unless they are given with oxygen? M0820 Response 3 states Caregiver is only able to complete small portions of task (e.g., administer nebulizer treatment). Are nebulizers considered in these OASIS items?

Answer 32: M0810 and M0820 are restricted to the management of oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment and supplies. A nebulizer utilizing oxygen in the treatment is considered for these items but a nebulizer without oxygen is not.

M0825

Question 33: If a RAP is cancelled and resubmitted because therapy visits do go over 10, must you correct the OASIS document where you answered "No" to M0825?

Answer 33: At times, providers may simply underestimate the number of therapy visits that will be required in the upcoming episode. If the adjustment to the patient's case mix is due solely to the correction of the therapy visits estimated at SOC and there is no clinical change in the patient's health status, no follow up assessment is required. However, there should be concurrent OASIS correction and clinical record documentation recording the difference between therapy originally estimated and therapy actually delivered. It is necessary to correct the original assessment at M0825 that will update the HHRG. Agencies can make this non-key field change to their records and retransmit the corrected assessment.

M0825

Question 34: A patient is recerted with knowledge that the patient will be admitted to a rehab facility in next few weeks. On the Recert OASIS, the RN answers M0825 "No". The patient receives less than 10 therapy visits before being transferred (RFA 6) to rehab. The patient is discharged home during the open episode and a Resumption of Care is performed. RN answers M0825 "Yes" and the patient does receive more than 10 therapy visits in the remainder of the episode. Should the Recert Oasis be unlocked and M0825 changed to "Yes"?

Answer 34: When the Resumption of Care (RFA 3) is completed, if M0825-Therapy Need is the only payment item that changes from the Recertification (RFA 4) assessment, then the agency may take necessary action to change the M0825 response on the Recertification assessments from "0 = No" to "1 = Yes" and cancel and resubmit the RAP with the

corrected HHRG. Bear in mind that this will involve making a change in the clinical record (electronic or hard copy, as appropriate to the agency) as well as in the data submission files. The agency must follow the applicable laws, regulations, and agency policies when making a change to any clinical record, which is a legal document. When a change is made to a clinical record, the agency must carefully consider the reason for making that change and document the reason in the record.

M0855

Question 35: When a patient is transferred to a hospital ER and dies while in the ER, I understand a Transfer OASIS would be completed and not a Death at Home OASIS. At M0855, on a Transfer OASIS there are 4 options. There is no N/A option, as there would be on a Discharge OASIS. It does not seem appropriate to select Option 1 (hospital) since the patient was not admitted to the hospital, but we cannot transmit the OASIS without entering some type of response.

Answer 35: When a patient dies in the ER, the Transfer to an Inpatient Facility OASIS is completed. In this unique situation, clinicians are directed to mark Response "1-Hospital" for M0855, even though the patient was not admitted to the inpatient facility (hospital).

M0906

Question 36: How do you answer M0906 on a Transfer OASIS when a patient is transferred to an inpatient facility (hospital) during the evening of 1/24/07 but doesn't get admitted to the inpatient facility until 1/25/07?

Answer 36: Transfer is not defined as the date the patient was transported to the inpatient facility, or the date that the patient was transported and/or treated in the emergency department. Assuming the patient's inpatient admission lasted 24 or more hours, and included care/services other than diagnostic testing, the Transfer date would be the actual date the patient was admitted to the inpatient facility. If, as in your example, the transportation occurred during the evening of 1/24/07, but the inpatient facility admission did not occur until 1/25/07, M0906 Transfer/Discharge/Death Date would be 1/25/07.