

Survey and Certification Group

July 10, 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 in which you presented a compilation 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's Manual, Chapter 8, Item-by-item Tips.

In the meanwhile, you may use these CMS-approved responses in educational programs for the OASIS Certificate and Competency, Board, Inc. (OCCB) and for general distribution and posting. Thank you for your interest and support for standardization of OASIS data collection.

Sincerely,

Patricia Sevast, BSN, RN
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Survey and Certification Group
Centers for Medicare & Medicaid Services



CMS OCCB Q&As – July 2007

Category 2 – Comprehensive Assessment

Timing of SOC Assessment When Payer Changes

Question 1: If a patient converts to a payer requiring a new SOC, is it OK to do the SOC OASIS on next visit (under the new pay source) even if that visit isn't scheduled for up to a week after the last visit under the old payer?

Answer 1: When a patient is changing pay sources to a payer which requires a new SOC, then the agency must provide an initial assessment visit within 48 hours of the time of referral or on the physician's ordered Start of Care date. If the orders for the new episode are for SN to begin on a date a week away, then the initial assessment visit and SOC Comprehensive Assessment may be completed one week after the discharge visit under the old pay source, if that meets the physician's ordered start of care date. Alternatively, the agency may have completed the initial assessment requirements (determined immediate care and support needs, and eligibility for the home health benefit if appropriate) at the last visit under the old pay source, in which case the SOC comprehensive assessment may still be conducted at the next visit (in a week), noting that if the patient were to develop problems and require services in between the visits, the SOC may need to be completed sooner.

RN Completion of Assessment for Therapy Only Case

Question 2: Has there been any regulatory changes that prohibit a nurse from doing the initial SOC OASIS if only therapy is ordered?

Answer 2: There have not been any regulatory changes to the Condition of Participation (CoPs), 484.55, Comprehensive Assessment of Patient Standard (a) Initial assessment of patients. But the Standard does not prohibit a nurse from performing the initial assessment visit when there are therapy only orders. It states that the RN must complete the initial assessment visit when nursing orders exist at SOC. If there are therapy only orders, no nursing at all, the appropriate therapist may complete the initial assessment visit. Agencies are at liberty to develop policies that are more restrictive than the CoPs (e.g., policies that allow or require the RN to perform the initial assessment visit during a non-billable visit when there are no nursing orders at SOC).

Hospitalization During Recert Window

Question 3: In the new Q&As that were posted in May 2007 it states that if an agency has done a recert and then the patient goes to the hospital and the agency does a transfer without dc, then when the patient comes back the clinician does the comprehensive assessment. Depending on the HIPPS code would depend on if they did a ROC or a SOC. But what if the agency had not done the recert and the patient went to the hospital on day 58. When the patient comes out would they do a new SOC? (Since there is no HIPPS code to match up with).

Answer 3: If a patient is transferred to the hospital on day 58, before the recertification assessment was completed, and the stay in the inpatient facility met the criteria for a Transfer, the agency would complete a Transfer OASIS. When the patient returns home, if it is on 59 or 60 and they have not been discharged from the home care agency, a Resumption of Care (RFA 3) assessment would be completed, and would satisfy both the ROC and the recertification requirements. If the patient's stay extends beyond the end of the current certification period, a SOC would be completed. The agency would also need to perform a "paper" discharge from the previous episode, (no OASIS DC required).

One Visit Only at ROC

Question 4: Medicare patient goes to hospital, agency completes RFA 6, Transfer, patient not discharged. Patient returns home with orders for one PT visit to evaluate new equipment. PT does eval and determines no further visits are necessary. Should HHA complete ROC, even though no further visits are going to be provided? And if the HHA completes the ROC, would they complete a DC on the same day?

Answer 4: In responding to the question, it will be assumed that the single PT visit conducted at the resumption of care was a skilled and covered visit, that the resumption of care visit occurred within the existing 60-day episode, and that we are discussing a Medicare PPS patient.

A comprehensive assessment must be completed when the patient returns home from an inpatient stay of 24 hours or greater for any reason other than diagnostic tests, even though there will only be the one PT visit. The Conditions of Participation 484.55 Comprehensive Assessment of Patients, Standard (d) states: The comprehensive assessment must be updated and revised within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.

However, since 2002, OASIS is not a required part of the comprehensive assessment for known one-visit patient episodes. CMS Q&A Cat 2 Q43 clarifies that a ROC comprehensive assessment is required, even if it is the only visit conducted after the inpatient discharge, but that the assessment should be treated like a one-visit only episode at the start of care (i.e., comprehensive assessment is required, but OASIS data collection is not required). While there is not a regulatory requirement to collect OASIS as part of these assessments, there may be a reimbursement requirement by the payer to do so.

No discharge comprehensive assessment or OASIS is required when only one visit is made. The agency would complete their own internal discharge paperwork.

Category 4b OASIS Data Set Items

M0250

Question 5: We have been admitting patients status post lumpectomy for breast cancer. After the surgery, they are discharged with an eclipse (bulb) that has Marcaine or Lidocaine that infuses pain medication into the wound bed. After 48 hours the bulb can be removed. If the patient still has this bulb on at start of care, should Response 1 be marked for M0250?

Answer 5: When a patient is receiving an infusion at home, M0250 should be marked with Response 1-Intravenous or infusion therapy. If the patient you describe is receiving a local anesthetic via an infusion device while in the home, M0250 would be marked "1" at SOC.

M0390

Question 6: If a patient has a physical deficit, such as a neck injury, limiting his range of motion, which affects his field of vision and ability to see obstacles in his path, how is M0390, Vision to be answered? Is the physical impairment to be considered? Visual acuity has not been affected.

Answer 6: When selecting the correct response for M0390, Vision, the clinician is assessing the patient's functional vision, not conducting a formal vision screen or distance vision exam to determine if the patient has 20/20 vision. Therefore physical

deficits or impairments that limit the patient's ability to use their existing vision in a functional way would be considered. If a patient sustained an injury that limits neck movement, the patient may not be able to see obstacles in their path. A patient who has sustained a facial injury may have orbital swelling that makes it impossible for them to see and they must locate objects by hearing or touching them. Conversely, it is possible for a patient to be blind in one eye (technically not "normal vision"), but still be appropriately scored a "0" on M0390 if with the patient's existing vision, they are able to see adequately in most situations and can see medication labels or newsprint.

M0450, M0460

Question 7: I have reviewed the new 2/07 NPUAP pressure ulcer staging document and it states that a pressure ulcer with slough or eschar can be staged if the necrotic tissue does not obscure the wound bed preventing visualization of tissue loss. There is a CMS OCCB Q&A dated 7/06 that states you cannot stage a pressure ulcer when any amount of eschar or slough is present, even when the bone is visible. Can I stage a pressure ulcer when eschar or slough is present as long as the wound bed is visible?

Answer 7: Yes, you can stage a pressure ulcer when some eschar or slough is present as long as the wound bed is visible and you can see the extent of tissue involved. In response to the latest National Pressure Ulcer Advisory Panel (NPUAP) guidance, we are retracting the CMS OCCB Q&A #24 dated 7/06 that states "any pressure ulcer with any amount of eschar or slough present, even an ulcer with bone visible, would be considered non-observable and therefore could not be staged."

In the latest NPUAP staging document, the Stage III pressure ulcer definition states "Slough may be present but does not obscure the depth of tissue loss." The Stage IV pressure ulcer definition states "Slough or eschar may be present on some parts of the wound bed." An Unstageable pressure ulcer has "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and therefore stage, cannot be determined."

The new NPUAP staging document is also consistent with the latest (7/06) WOCN guidance on OASIS skin and wound status M0 items in which the Stage III pressure ulcer definition includes the statement that: "Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia." and that a Stage IV pressure ulcer includes: "Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule)." These definitions state that Stage III and IV pressure ulcers can have necrotic tissue present and therefore are NOT unstageable. The WOCN does go on to explain that a non-observable pressure ulcer is a "Wound unable to be visualized due to an orthopedic device, dressing, etc. A pressure ulcer cannot be accurately staged until the deepest viable tissue layer is visible; this means that wounds covered with eschar and /or slough cannot be staged, and should be documented as non-observable." which again is supported by the NPUAP 2/07 document.

These new definitions are consistent with the Chapter 8 guidance for M0450, Current Number of Pressure Ulcers at Each Stage that states "A pressure ulcer cover by eschar or a nonremoveable cast or dressing cannot be staged...", "The bed of the ulcer must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar), it cannot be staged until the necrotic tissue is removed." and "Consult published guidelines of NPUAP (www.npuap.org) for additional clarification and/or resources for training."

The 2/07 NPUAP's Pressure Ulcer Staging document can be accessed at www.npuap.org. The WOCN's Guidance on OASIS Skin and Wound Status M0 Items document can be accessed at www.wocn.org.

M0482

Question 8: If a surgical wound is completely covered with steri-strips is it considered non observable?

Answer 8: Chapter 8 of the OASIS Implementation Manual states, "A [surgical] wound is not observable if it is covered by a dressing (or cast) which is not to be removed, per physician's orders." Although unusual, if the steri-strip placement did not allow sufficient visualization of the incision, and if the physician provided specific orders for the steri-strips to not be removed, then the wound would be considered not observable. However, a surgical wound with steri-strips should be considered observable in the absence of physician orders to not remove strips for assessment, or if usual placement allows sufficient visualization of the surgical incision to allow observation of clinical features necessary to determine the surgical wound's healing status (e.g., incisional approximation, degree of epithelialization, incisional necrosis (scab), and/or signs or symptoms of infection).

M0482

Question 9: Is a heart cath site (femoral) considered a surgical wound? If not, what if a stent is placed?

Answer 9: 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. The fact that a stent was placed does not have an impact.

M0488

Question 10: Is it true that the status of a new surgical incision that is closed, with no signs or symptoms of infection present, well approximated, but with a small scab, should be evaluated at 3 - Not healing, even though the scab is normal part of incision healing? Since this potentially impacts reimbursement, we want to ensure we are doing it right.

Answer 10: In order to determine the healing status of a surgical wound, clinicians are directed to rely on the "WOCN Guidance on OASIS Skin and Wound Status M0 Items" document available at www.wocn.org. This document provides guidance specific for determining the healing status for surgical wounds healing by primary intention, and separate guidance for wounds healing by secondary intention. A typical routine surgical incision as you describe would be considered healing by primary intention. Referencing the WOCN guidelines, it is noted that a wound that demonstrates incisional necrosis (of any amount for primary intention), is considered "Not Healing".

Note that if we were discussing a dehisced wound, we would be assessing a wound healing by secondary intention, and would follow different guidelines which take into consideration the amount of avascular tissue in determining the healing status (e.g. $\geq 25\%$ = not healing).

For further clarification, review the CMS OCCB Q&A's (07/2006), Question #30 at www.oasiscertificate.org which confirms that a scab equates to avascular tissue, which the WOCN Document Glossary equates to necrotic tissue.

M0488

Question 11: We are having a discussion as to whether a mediport is a "Not healing" or "Early/partial granulation" wound in M0488 when the needle is present in the wound. And if the needle has just been removed within the last 24 hrs how would it be scored; or if the site has not been accessed for several months and

there is no open area visible how is it to be scored? We are assuming that this is a wound that is healing by secondary intention.

Answer 11: The assessing clinician must determine the healing status of a wound following guidance in Chapter 8 of the OASIS User's Manual and the latest version of the WOCN's OASIS Guidance Document.

Some sites, because they are being held open by a line or needle, may not reach a "fully granulating" state while the line or needle is in place.

Once the needle is removed before a scab has formed, the wound bed may be clean but non-granulating. Based on the WOCN Guidance, the wound would be reported as Response 3 – Not healing for M0488. Or if the venous access device is routinely accessed and upon assessment has a scab at the puncture site, assuming there are no signs or symptoms of infection, a wound with greater than or equal to 25% avascular tissue is considered "non-healing". Therefore a venous access puncture site which is covered by a scab (avascular tissue) would also be classified on M0488 as Response 3 – not healing.

If the site has not been accessed for months, then guidance from CMS OASIS Q&As Category 4b Q106 assists in determining the healing status of an implanted vascular access device by suggesting that to answer M0488, the healing status of a wound can only be determined by a skilled assessment (in person). It is possible for such a wound to be considered "fully granulating" (the best level the wound could attain on this particular item) for long periods of time, but it is also possible for such wounds to be considered "early/partial granulation," or "not healing" if the site becomes infected. These sites would not be considered as "non-healing" unless the signs of not healing are apparent.

M0490

Question 12: What is the correct response to M0490, Dyspnea, if a patient uses a CPAP or BiPAP machine during sleep as treatment for obstructive sleep apnea?

Answer 12: 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.

M0490

Question 13: Patient currently sleeps in the recliner or currently sleeps with 2 pillows to keep from being SOB. They are currently not SOB because they have already taken measures to abate it. Would you mark M0490, #4 At Rest or 0 Never SOB?

Answer 13: M0490 reports what is true at the time of the assessment (the 24 hours immediately preceding the visit and what is observed during the assessment). If the patient has not demonstrated or reported shortness of breath during that timeframe, the correct response would be "0-Never" even though the environment or patient activities were modified in order to avoid shortness of breath.

M0500

Question 14: If patient is on a ventilator, do you mark O2 & ventilator or is the O2 inclusive with the ventilator in this question?

Answer 14: M0500 instructs the assessor to mark all that apply. As it is possible for a patient to be ventilated with entrained room air and thus be on a ventilator without oxygen therapy, it would be accurate to mark both Responses 1-Oxygen and 2-Ventilator when the patient is receiving oxygen through the ventilator.

M0690

Question 15: How do you select a score for M0690 – Transferring, for the patient who is not really safe at response 1, but moving to response 2 seems a bit aggressive? Response 1 uses the word "or" NOT "and". If a patient requires both human assist AND an assistive device, does this move them to a 2, especially if they are not safe? It seems these patients can do more than bear weight and pivot--but it is the next best option. If they require human assist AND an assistive device, should we automatically move the patient to a "2", whether they are safe or not?

Answer 15: If the patient is able to safely transfer with either minimal human assistance (but no device), or with the use of an assistive device (but no human assistance) then they should be reported as a "1-Transfers with minimal human assistance or with use of an assistive device". If they are not safe in transferring with either of the above circumstances, (e.g., they transfer with only an assistive device but not safely, minimal assistance only is not adequate for safe transferring, or they require both minimal human assistance and an assistive device to transfer safely), then the patient would be scored a "2-Unable to transfer self but is able to bear weight and pivot during the transfer process"(assuming the patient could bear weight and pivot). Safety is integral to ability. If the patient is not safe when transferring with just minimal human assistance or with just an assistive device, they cannot be considered functioning at the level of response "1".

For the purposes of Response 1 – Minimal human assistance could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance, where the level of assistance required from someone else is equal to or less than 25% of the total effort to transfer and the patient is able to provide >75% of the total effort to complete the task. Examples of environmental set-up as it relates to transferring would be a patient who requires someone else to position the wheelchair by the bed and apply the wheelchair locks in order to safely transfer from the bed to the chair, or a patient who requires someone else to place the elevated commode seat over the toilet before the patient is able to safely transfer onto the commode.

M0690

Question 16: The patient is severely disabled with MS, is obese, cannot support her weight and the spouse is able to use a Hoyer lift to transfer her to a chair. Because of her size, she is not able to use a bedside commode. The bathroom entrance and layout does not allow for the Hoyer to pass through, so the patient is unable to be transferred to the bathroom toilet or into the shower. She can only do one of the three transfers via lift. She is not "confined to the bed" because she is able to be lifted to a chair. When in bed, she needs help turning and positioning. Is she a response 3 or a 5? Which principles apply and how would the transfer question be scored in this instance?

Answer 16: When selecting the correct response to a multi-task item like Transferring, you must first determine if your patient is bedfast or not. If the patient is bedfast, the response will be 4 or 5. If the patient is not bedfast and their ability varies between the three transfers, determine what is true in a majority of the more frequently performed transfers. Bedfast means that a patient is unable to tolerate being out of the bed. They are confined to the bed. You state that your patient is transferred out of bed via the

Hoyer lift and sits in a chair, so she is not bedfast. Even though the patient is only able to perform one of the three transfers, due to environmental and physical barriers, Response 3 best describes this patient. In the most frequently performed transfer, she is unable to transfer self and is unable to bear weight or pivot when transferred by another person.

M0780

Question 17: A patient is typically independent in managing her own oral medications. At the time of assessment, the patient's daughter and grandchildren have moved in to help care for the patient, and the daughter has placed the meds out of reach for safety. This now requires someone to assist the patient to retrieve the medications. How should M0780 be answered?

Answer 17: M0780 assesses the patient's ability to prepare and take oral medications reliably and safely. Preparation includes ability to read the label (correct medication), open the container, select the pill/tablet or milliliters of liquid (correct dosage), and orally ingest at the prescribed time (take). In some cases, a patient lives in an environment where the facility or caregiver may impose a barrier that limits the patient's ability to access or prepare their medications, e.g. an Assisted Living Facility that keeps all medications in a medication room or a family that keeps the medications out of the reach of children for the child's safety - not the patient's. In these cases, the clinician will assess the patient's vision, strength and manual dexterity in the hands and fingers, as well as their cognitive status to determine the patient's ability to prepare and take their oral medications despite access barriers imposed by family or facility caregivers.

M0780

Question 18: The patient with schizophrenia is not compliant with his medication regimen when he must pour his oral medications from bottles. The nurse discovers that if the pharmacist prepares the medications in bubble packs, the patient is less paranoid, is able to open the pack and will safely and reliably take the majority of his medication doses at the correct time. Since the patient is able to manage the medications once they are in the home in a bubble pack is he considered independent (Response 0) in medication management or is the special packaging requirement considered a type of assistance and is response 1 the correct answer?

Answer 18: M0780 is asking if the patient has the ability to prepare and take oral medications reliably and safely - the correct dosage at the correct times. Preparation includes the ability to read the label (or otherwise identify the medication correctly, e.g. illiterate patients may place a special mark or character on the label to distinguish between medications), open the container, select the pill/tablet or milliliters of liquid and orally ingest it at the correct times. Some patients may require medications to be dispensed in bottles with easy-open lids, while others may not. Arranging to have medications dispensed in bubble packs is an excellent strategy that may enable a patient to become independent in the management of their oral medications. Because a patient utilizes a special method or mechanism in order to take the correct medication, in the correct dose, at the correct time, does not necessarily make them dependent in the management of their oral medications. All patients are dependent on their pharmacist to dispense their medications in containers appropriate to their needs. Once in the home, if the patient requires someone else to prepare individual doses, or fill a pill box or planner, or create a diary or med list in order to take the correct med in the correct dose at the correct time, the patient would be scored a "1" indicating they require someone's else's assistance.

M0840

Question 19: I have a question about how to complete a Transfer OASIS when a client has a fall outside of the home. If they go to the doctor's office for care and falls there, should the answer to M0840 – Emergent Care Reason be #3 – Injury caused by fall or accident at home or #9 – Other than above reason (since the fall/accident did not occur in the home)?

Answer 19: M0840 Response 3 would be selected for an injury caused by a fall or accident at home. If a patient sought emergent care for an injury that occurred while away from home, the correct response to M0840 would be 9-Other than above reasons.