DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

October 8, 2014

Linda Krulish, PT, MHS, COS-C
President
OASIS Answers, Inc.
PO Box 2768
Redmond, WA 98073

Dear Ms. Krulish:

Thank you for your letter of October 1, 2014 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 accompanying questions and answers have been reviewed by CMS staff, selected content experts and contractors, and consensus on the responses has been achieved.

As deemed valuable for providers, OASIS Education Coordinators and others, CMS will consider incorporating these questions and answers into current OASIS-C preparation and education activities, and may include them in future updates to the CMS Q&As posted at https://www.qtso.com/hhatrain.html, and/or in future releases of item-by-item tips.

In the meantime, you are free and encouraged to distribute these responses through educational offerings sponsored by OASIS Answers, Inc. (OAI) or general posting for access by all interested parties. Thank you for your interest in and support for enhancing OASIS accuracy.

Sincerely,

Patricia A. Sevast, BSN, RN
Nurse Consultant
Survey and Certification Group
Centers for Medicare & Medicaid Services

cc: Caroline D. Gallaher, JD, BSN, RN
Centers for Clinical Standards & Quality
Division of Chronic & Post-Acute Care
Centers for Medicare & Medicaid Services

October 2014 CMS Quarterly Q&As

(Note, when guidance applies only to the OASIS-C1/ICD/9 version of the data set, it will be indicated by the inclusion of a C1/ICD-9 notation.)

Category 2

QUESTION 1: We received an order for nursing and PT. The nurse conducted the initial assessment visit and determined that the patient did not have any justifiable nursing need, but did have a need for PT services. Because there was an order for nursing present with the original orders, is the RN required to complete the SOC comprehensive assessment? Or since nursing services are not necessary, can the PT complete the SOC comprehensive assessment on or within 5 days after the PT establishes the start of care?

ANSWER 1: Since an order for nursing existed at the time of the initial referral, the RN must complete the initial assessment visit. If it is determined during the initial assessment visit, that the patient either did not have a need for nursing services and/or the patient declined all nursing services, the SOC will not be established by that visit. The RN can notify the physician that nursing will not be involved in the patient's care, and either continue on to complete the SOC comprehensive assessment (if the PT will be establishing the SOC that day), OR have the PT complete the SOC comprehensive assessment on or within 5 days after the PT establishes the start of care.

Category 4b

M0104

QUESTION 2: As outlined in the Conditions of Participation, the initial assessment visit must be conducted "within 48 hours of referral", and the referral date should be reported in M0104 – Date of Referral. What constitutes a "valid referral" for the purposes of considering that we, in fact, have an actionable referral to initiate home care services?

Sometimes we get a home care referral from a hospitalist who will NOT be giving orders or signing the plan of care. Sometimes we get a referral that contains only the patient's name without any contact information (no phone number or address). Sometimes we get a general order to "Evaluate for Home Health Services". If/when we try to follow up with the patient's primary care physician, or with the referral source to get patient contact information or clarify orders, we don't hear back the same day, and wonder how/if this impacts our M0104 - Date of Referral and initial assessment visit compliance?

ANSWER 2: In order to be eligible for the Medicare Home Health benefit, a patient must be "Under the care of a physician". When an agency receives an initial "referral" or contact about a patient who needs service, the HHA must ensure this physician, or another physician will provide for the plan of care and ongoing orders. If a physician is willing to follow the patient,

and provides adequate information (name, address/contact info, and diagnosis and/or general home care needs) regarding the patient, this is considered a valid referral. In cases where the referring physician is not going to provide orders and follow the patient, this is not a valid "referral" for M0104. In the example of a hospitalist who will not be providing an ongoing plan of care for the patient, the HHA must contact an alternate, or attending physician, and upon agreement from this following physician, for referral and/or further orders, the HHA will note this as the Referral date in M0104 (unless referral details are later updated or revised).

If a general order to "Evaluate for Home Care services" (no discipline(s) specified) is received from a physician who will be following the patient, this constitutes a valid order, and per CoPs §484.55 the RN must conduct the initial assessment visit to determine immediate care and support needs and eligibility for the Home Health benefit for Medicare patients.

M1024

QUESTION 3: I have a patient with distal radial and ulnar styloid fractures. Both of these codes go with V54.12 (aftercare following lower arm fracture). If I report the V54.12 aftercare code as the primary diagnosis in M1020, and report one of the fracture codes (813.42) in M1024 column 3, should I report the other fracture code (813.43) in M1024 column 4?

ANSWER 3: While unable to offer guidance regarding exact diagnosis and code selection, your question does raise an important OASIS data collection issue regarding completion of M1024. When a single aftercare code is applicable to two different fractured bones, only one of the codes for the acute fractures may be reported in Column 3 of M1024. Both acute fractures may not be reported in Columns 3 and 4, as Columns 3 and 4 may only be completed when a V code is replacing an etiology/manifestation pair. In that case the etiology would be reported in Column 3 and the manifestation would be reported in Column 4. Since fracture codes are not part of an etiology/manifestation pair, only one of the two may be reported in Column 3. There is no need or reason to report the second fracture code in the M1024, but it would be appropriate to describe both fractures in the clinical narrative of the comprehensive assessment.

M1306-M1350

QUESTION 4: Is the WOCN's Guidance Document on OASIS-C1 copyrighted? And can we use it for education?

ANSWER 4: The WOCN has copyrighted the *Wound, Ostomy and Continence Nurses Society's Guidance on OASIS-C1 Integumentary Items: Best Practices for Clinicians* document. Reuse for education is permitted by the WOCN, as long as the document is in its complete, unabridged form including the copyright notice. Contact the WOCN (wocn.org) with questions. The Chapter 3 Response specific instructions for M1320 Status of Pressure Ulcer, M1334 Status of Stasis Ulcer, and M1342 Status of Surgical Wound also contain the same guidance for healing status, verbatim, for your convenience.

M1306-M1324, M1340

QUESTION 5: If a Pressure Ulcer is replaced with a muscle flap, and before the muscle flap suture line healed completely, pressure caused new break down within the flap area (not along the suture line). Is this considered a non-healing surgical wound? Or a new Pressure ulcer?

ANSWER 5: If a pressure ulcer is closed with a muscle flap, and before the muscle flap suture line heals completely, pressure causes new breakdown within the flap area (not along the suture line), this would be considered a new pressure ulcer, and until the muscle flap suture site is completely epithelialized for approximately 30 days, the flap site would remain a surgical wound. In this scenario, the patient would have both a new pressure ulcer and a surgical wound simultaneously.

M1308

QUESTION 6: If a patient has an unstageable pressure ulcer due to black stable eschar at SOC and during the episode it peels off and leaves an area of newly epithelialized tissue, how should this be staged at Discharge on M1308?

ANSWER 6: If unable to obtain any documentation that would support the most advanced stage, an assumption would be allowed that this wound is at least a Stage III, and reported in M1308 as such. Stage I and II ulcers do not form eschar or slough. Due to the presence of this avascular tissue, the assumption is allowed for the less advanced stage of a Stage III. See CMS Q&A Category 4b, Q 89.5 for additional detail.

M1320

QUESTION 7: If pressure ulcer presents with hypergranulation (growth of granulation tissue above the area of surrounding tissue in all or part of the wound bed), what healing status should be reported in M1320?

ANSWER 7: Since the growth of granulation tissue above the skin plane causes delayed healing due to obstructed epithelialization, the presence of any hypergranulation in a pressure ulcer should be reported as response 3 - Not healing.

M1340, M1350

QUESTION 8: The OASIS-C Guidance Manual (December 2012) and the OASIS-C1/ICD-9 Guidance Manual (June 2014), contain conflicting instruction regarding ileostomies. Chapter 3 guidance for M1340 – Surgical Wounds, excludes all ostomies (included bowel ostomies) as surgical wounds for M1340. Under the 9th bullet of M1340 Response-Specific Instruction it lists various ostomies that are excluded as surgical wounds:

> "Examples include cystostomy, urostomy, thoracostomy, tracheostomy, **ileostomy**, gastrostomy, etc. These may be reported in M1350 if the home health agency is providing intervention specific to the ostomy."

This suggests that ileostomies could be considered as lesions for M1350 - Skin Lesion or Open Wound, even though M1350 language specifically excludes bowel ostomies. Please clarify.

ANSWER 8: An ileostomy is a bowel elimination ostomy, and should not be reported in M1350, as the response specific instructions mistakenly state in M1340. This inconsistency will be passed along to those responsible for updating the guidance manual.

M1342

QUESTION 9: If a patient is receiving antibiotics for a surgical site infection, but at the time of assessment, the patient no longer exhibits any signs or symptoms of infection, would the surgical wound be considered "not healing"? In other words, is treatment for an infection, in the absence of current symptoms of infection, considered a sign/symptom of infection?

ANSWER 9: M1342 is reporting healing status based on the clinician's assessment of the patient and visualization of the wound. Since the patient could be at the point in the course of the antibiotic regimen where the infection has resolved, ongoing treatment for an infection should not be the sole basis for selecting 3 - Not healing, unless signs and symptoms of infection are currently present.

M1630

QUESTION 10: Is an A.C.E. considered an ostomy for the bowel elimination for M1630 – Ostomy for Bowel Elimination?

ANSWER 10: The Antegrade Colonic Enema therapy is provided by a catheter through an ostomy, but is not considered a "bowel elimination ostomy". M1630 refers specifically to the presence of an ostomy for bowel elimination. In A.C.E., the bowel is flushed through the catheter via the ostomy, but bowel elimination is not happening through this ostomy.

This ostomy could be reported in M1350, Skin Lesions or Open Wounds, if the home health agency was providing intervention, because it is not considered a "bowel elimination ostomy".

M2002

QUESTION 11: Related to M2002 – Medication Follow-up, the new OASIS C1/ICD-9 Guidance Manual states: "If a medication related problem is identified and resolved by the agency staff without physician involvement by the time the assessment is completed, the problem does not need to be reported as an existing clinically significant problem."

Is the addition of the phrase "without physician involvement" intended to change guidance which currently states that if the problem is identified and resolved by the time the assessment is completed, the problem does not need to be reported. In other words, does physician involvement require that the problem be reported in M2002?

ANSWER 11: No, the inclusion of the phrase "without physician involvement" is provided as an example, and is not a change in guidance. You are not required to report a clinically significant medication issue that was resolved (with or without physician involvement) before the assessment was completed. An example would be family delivering medications that were not in the home at the time of the initial visit. Note that by not reporting it, your agency would miss the positive impact to your process measure adherence rate.

M2010, M2015

QUESTION 12: When scoring M2010 - Patient/Caregiver High Risk Drug Education, does the clinician need to follow up a response of "1-Yes" with a list of all high risk medications he/she educated the patient/caregiver on, or is it acceptable to score this item as "1-Yes" either with "all" listed or is any additional documentation required at all?

ANSWER 12: It would be expected that there would be documentation in the clinical record to support that instruction on all high risk medications occurred. Supporting documentation would also be expected related to M2015 – Patient/Caregiver Drug Education Intervention, as it is a "look back" item, where a review of the medical record should show evidence that education was provided for all medications, "at, or since the last OASIS Assessment".

M2430

QUESTION 13: I have reviewed the OASIS guidance and cannot seem to find a listing of what exactly fits into each of the reason choices in M2430 "Reason for Hospitalization." Please provide additional guidance or a listing of applicable diagnoses?

ANSWER 13: M2340 offers a wide variety of responses to report the specific condition(s) necessitating hospitalization. The assessing clinician should report all response(s) that reflect (a) reason(s) why the patient was admitted and treated in the acute setting. CMS does not provide a list of diagnoses for each category. The clinician is to use his/her clinical judgment to determine if the patient's condition (for instance; "hypertension", or "change in mental status") resulting in hospitalization, fits into the categories/conditions reflected in the various M2430 responses (for instance; "Other heart disease", or "Acute mental/behavioral health problem"). If the clinician finds that none of the categories represent the reason(s) why the patient was hospitalized, then "Other" is the correct response. The clinician could provide more information for agency use in a narrative within the comprehensive assessment.