DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Clinical Standards and Quality/Survey & Certification Group

October 21, 2015

Linda Krulish, PT, MHS, COS-C
President
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PO Box 2768
Redmond, WA 98073

Dear Ms. Krulish:

Thank you for your letter of October 9, 2015 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 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,

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cc: Theresa M. White
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October 2015 CMS Quarterly OASIS Q&As

Category 4b

M1011

Question 1: M1011 is showing up on our recertification assessments now. Our EMR vendor is telling us this is a required ICD-10 change. Is this true?

Answer 1: With the October 1, 2015 transition from OASIS-C1/ICD-9-CM to OASIS-C1/ICD-10-CM, M1010 - Inpatient Diagnosis was renumbered to M1011 to reflect changes in the wording of the item associated with the new OASIS version. Changes to the new M1011 item include revisions to accommodate the ICD-10-CM code set, including adding space for 7 digit codes, and changing the references from E and V codes (ICD-9-CM) to V, W, X, Y, and Z codes (ICD-10-CM). The wording of the item was also revised from list codes for those conditions "treated" during an inpatient facility stay, to those conditions "actively treated" during an inpatient stay. This wording revision reinforces current guidance that diagnoses listed should be limited to those conditions that during an inpatient stay having a discharge date within the last 14 days, required interventions beyond regularly scheduled medications and treatments. The item language was also revised to clarify that the "14 day" time frame referred to the date of the inpatient discharge, NOT to the date the treatment occurred.

The term "last 14 days" is the two-week period immediately preceding the start/resumption of care date (M0030/M0032) or follow-up date assessment completed (M0090). This means that for purposes of counting the 14-day period, the date of admission/assessment is day 0 and the day immediately prior to the date of admission/assessment is day 1.

M1010 was previously collected at the Start of Care (SOC) and the Resumption of Care (ROC) time points. Effective October 1, 2015 with OASIS-C1/ICD-10, M1011 will be collected at the SOC/ROC AND at the Follow-up time points (RFA 4 recertification and RFA 5 Other Follow-up). On the Follow-up assessments only, the item includes a new "NA" response, to be used when a patient had not been discharged from an inpatient facility.

M1745

Question 2: A question continues to be raised when discussing the two behavioral/emotional/behavioral M items: M1740 – Cognitive, Behavioral and Psychiatric Symptoms, and M1745 – Frequency of Disruptive Behavior Symptoms. In the guidance, it is noted that these behaviors should be associated with a "disorder". Must this disorder be an actual diagnosis, or simply the assessing clinician's observation of symptoms that may be associated with a diagnosis?

Answer 2: The behaviors identified for the purpose of responding to M1740 and M1745 could be determined to be associated with a significant neurological, behavioral or psychiatric disorder either by diagnosis and/or in the assessing clinician's clinical judgment.

M1840

Question 3: If you have a patient that does not have a toilet in his home would he be dependent in toilet transfers?

Answer 3: For M1840 Toilet Transferring, in the absence of a toilet in the home, the assessing clinician would need to determine if the patient is able to use a bedside commode (with or without assistance) (Response 2) or is able to use a bedpan/urinal independently (Response 3). If he is not able to use the bedside commode or a bedpan/urinal as defined in the responses, or if such equipment is not present in the home to allow assessment, then Response 4 – Is totally dependent in toileting would be appropriate.

M1860

Question 4: Patient is wheelchair bound and cannot ambulate but can wheel self. Patient also has advanced dementia or cognitive decline and although the patient can wheel self independently, he/she is unable to do so with any purpose, (i.e., patient could not follow simple instructions to get to another room, or could not self-evacuate in the event of an emergency). What response should be selected?

Answer 4: For M1860 Ambulation/Locomotion Responses 4 and 5, the assessing clinician must consider the non-ambulatory patient's ability to safely use the wheelchair, given the patient's current physical and mental/emotional/cognitive status, activities permitted, and environment. In the scenario cited, the patient's advanced dementia/cognitive decline is noted as a concern because the patient is unable to wheel self with purpose. Other than addressing safety on surfaces the patient would routinely encounter in their environment, CMS guidance does not detail specific criteria regarding patient ambulation or wheelchair use (i.e., how far the patient must walk, or wheel self; of if they use ambulation or

wheelchair mobility with specific purpose, regularity, or efficiency). It is left to the judgment of the assessing clinician to determine the patient's ability (i.e., does the patient's mental status impacted his/her safety?) and select a response accordingly.

M2102

Question 5: We have a patient, who at discharge is able to bathe in the shower with assist of her daughter, however she prefers to sponge bathe at the sink and is able to do so independently now. The clinician has marked response 2 for M1830 to reflect her ability to perform safely. The question is should the clinician answer M2102a (caregiver assistance with ADLs) Response 1, reflecting assistance needed for showering as answered in M1830 or can the clinician choose response 0 – no assistance needed because the patient is able to sponge bathe independently and safely. The patient is able to do all other ADLs independently. The clinician's documentation in the clinical record reports patient's preference with bathing.

Our software system does give a warning if the response for M2102a is not consistent with the M18xx ADL questions/responses. However, it will allow the clinician to mark a different response, I just want to know the correct way to answer the question.

Answer 5: M1830 addresses the patient's ability to bathe in the shower or tub, not actual performance, regardless of where or how the patient currently bathes. Willingness and adherence are not the focus of the item. If assistance is needed to bathe in the shower or tub, then the level of assistance needed must be noted, and Response 1, 2, or 3 should be selected.

M2102 is based on the ability and willingness of the caregiver(s) (other than home health agency staff) to provide the assistance needed by the patient to perform ADLs, including bathing. The item does not specify the bathing must be in the tub or shower. In the scenario cited, the assessing clinician has determined the patient to be independent in all ADLs, including bathing. Therefore, a response of "0" for M2102a. would be appropriate.

M2420

Question 6: For M2420 Discharge Disposition, is personal care provided by the home health agency after discharge from skilled services considered Formal Assistance?

Answer 6: For patients that will receive personal care services from the home health agency following discharge from skilled services, select Response 2 – Patient remained in the community (with formal assistive services). Formal assistive services refers to community-based services provided through organizations or by paid helpers. Therapy services provided in an outpatient setting would not be considered formal assistance.