

CMS OASIS Q&As: CATEGORY 4 - OASIS DATA SET: FORMS and ITEMS

Category 4A - General OASIS forms questions.

Q1. [Q&A RETIRED 09/09; Outdated]

Q2. When integrating the OASIS data items into an HHA's assessment system, can the OASIS data items be inserted in an order that best suits the agency's needs, i.e., can they be added in any order, or must they remain in the order presented on the OASIS form?

[Q&A EDITED 06/14]

A2. Integrating the OASIS items into the HHA's own assessment system in the order presented on the OASIS data set would facilitate data entry of the items into the data collection and reporting software. However, it is not mandatory that agencies do this. Agencies may integrate the items in such a way that best suits their assessment system. Some agencies may wish to electronically collect their OASIS data and upload it for transmission to the OASIS system. As long as the agency can format the required CMS data submission file for transmission to the OASIS system, it doesn't matter in what order the data are collected.

Q3. Are agencies allowed to modify skip patterns through alternative sequencing of OASIS data items? [Q&A EDITED 10/16; 06/14]

A3. While we encourage HHAs to integrate the OASIS data items into their own assessment instrument in the sequence presented on the OASIS data set for efficiency in data entry, we are not precluding them from doing so in a sequence other than that presented on the OASIS data set. Agencies collecting data in hard copy or electronic form must incorporate the OASIS data items into their own assessment instrument using the exact language of the items from the current data set. Agencies must carefully consider any skip instructions contained within the questions in the assessment categories and may modify the skip language of the skip pattern as long as the resulting data collection complies with the original and intended skip logic. When agencies encode the OASIS data they have collected, data MUST be transmitted in the sequence presented on the OASIS data set. The software that CMS has developed for this function (HAVEN) prompts the user to enter data in a format that will correctly sequence the item responses and ultimately be acceptable for transmission. HAVEN includes certain editing functions that flag the user when there is missing information or a question as to the accuracy or validity of the response. Agencies may choose to use software other than HAVEN to report their data so as long as the data are ultimately transmitted to the OASIS system in the required CMS data submission format found on the CMS Website at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/DataSpecifications.html>. This file contains the OASIS data items in the same order as contained on the OASIS data set.

Q4. Are any quality assurance tools available to help us verify that our staff is using the OASIS correctly? [Q&A EDITED 06/14]

A4. We are not aware of any standardized quality assurance tool that exists to verify that clinical staff members are using OASIS correctly. A variety of audit approaches might be used by an agency to validate the appropriate responses to OASIS items. For example, case conferences can routinely incorporate OASIS items as part of the discussion. Multi-discipline cases with visits by two disciplines on adjacent days can contribute to discussion of specific items. (Note

that only one assessment is reported as the 'OASIS assessment.') Supervisory (or peer) evaluation visits can include OASIS data collection by two clinicians, followed by comparison of responses and discussion of any differences. Other approaches to data quality monitoring are included in the current OASIS Guidance Manual, Appendix B available at http://www.cms.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp under "Downloads".

Q5. How do I cut and paste the OASIS questions on the website into our HHA's own assessment? [Q&A EDITED 09/09]

A5. CMS will post the OASIS data set in both .PDF format, i.e., read only format, and Word format on the OASIS Data Sets page at http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage

Q6. Do you have anything available that would help us integrate the OASIS items into our own assessment? [Q&A EDITED 06/14]

A6. The most current version of OASIS will be found on the CMS OASIS website. HHAs are required to incorporate the OASIS data items exactly as written into the agency's comprehensive assessment. For agencies using software that does not accommodate bolding or underlining for emphasis of words in the same manner as the current OASIS data set, capitalizing those words is acceptable. We also recommend including the M item numbers when integrating to alert clinicians that the M items MUST be assessed and completed. Ultimately this will minimize delays in encoding due to uncompleted OASIS data items. Please refer to Chapter 4 of the current OASIS Guidance Manual (available at http://www.cms.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp under "Downloads") for illustrative examples of pages from a comprehensive assessment showing an integration of the OASIS data items with other agency assessment items for several time points. The OASIS data sets are available at http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage

Q7. Is there a separate OASIS admission form that can be used for rehab-only cases where skilled nursing is not involved? [Q&A EDITED 06/14]

A7. CMS does not have sample rehab assessment examples, though such assessments have been developed by commercial vendors. If an agency chooses to develop its own rehab-specific assessment forms, the principles for documenting OASIS items into an agency's clinical documentation are outlined in Appendix A of the current OASIS Guidance Manual available at http://www.cms.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp under "Downloads".

Q8. [Q&A RETIRED 09/09; Outdated]

Q9. Are the OASIS data sets (all time points) to become part of the patient's record? Do we keep them in the charts? Of course, our admission OASIS data set will be part of the chart because we have our admission assessment included in the OASIS questions. But with the ROC, Transfer, DC, do we make this part of the record? [Q&A EDITED 08/07]

A9. The Comprehensive Assessment Final Rules, published January 25, 1999, state that the OASIS data items are to be incorporated into the HHA's own assessments, not only for the start of care, but for all the time points at which an update of the comprehensive assessment is required. Because all such documentation is part of the patient's clinical record, it follows that the OASIS items are also part of the clinical record. Verifying the accuracy of the transmitted OASIS data (part of the Condition of Participation [CoP] on Reporting OASIS information) requires that the OASIS data be retained as part of the clinical documentation. To access the

CoP, go to <http://www.cms.hhs.gov/center/hha.asp>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

Q10. If the OASIS data elements are being filled out for the Start of Care, Follow-up and Discharge, is there an additional nursing note required as a Federal regulation? Or is an additional nursing note (as a summary of data gathered) not required, assuming the OASIS elements include all necessary patient information? [Q&A EDITED 08/07]

A10. As noted in CFR §484.55 (the Condition of Participation [CoP] regarding comprehensive assessment), "each patient must receive a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes." The preamble to this rule also notes that the OASIS data set is not intended to constitute a complete comprehensive assessment. Each agency must determine, according to their policies and patient population needs, the additional assessment items to be included in its comprehensive assessment forms. Clinical notes are to be completed as required by 42 CFR 484.48 and the home care agency's clinical policies and procedures. To access the CoP, go to <http://www.cms.hhs.gov/center/hha.asp>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

Q11. [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat. 2 Q&A #7]

Q12, 13, & 14. [Q&A RETIRED 09/09; Outdated]

Q15. [Q&A RETIRED 08/07; Outdated]

Q16. [Q&A RETIRED 01/08 due to changes in OASIS data set and skip patterns at follow-up (RFA 4, 5)]

Q17. Unless otherwise indicated, scoring of OASIS items is based on the patient's status on the "day of the assessment." Does the "day of the assessment" refer to the calendar day or the most recent 24- hour period? [Q&A EDITED 08/07; ADDED 06/05; Previously CMS OCCB 08/04 Q&A #1]

A17. Since home care visits can occur at any time of the day, and to standardize the time frame for assessment data, the "day of the assessment" refers to the 24-hour period directly preceding the assessment visit, plus the time the clinician is in the home conducting the assessment. This standard definition ensures that fluctuations in patient status that may occur at particular times during the day can be considered in determining the patient's ability and status, regardless of the time of day of the visit.

Q18. [Q&A RETIRED 09/09; Outdated]

Q19. Must the OASIS data items (on the screen and when printed) match the data set language and format exactly? [Q&A EDITED 10/16; Previously CMS Qtrly Q&A 10/16 #4; Q&A EDITED & Updated M numbers 04/15; ADDED 09/09; Previously CMS OCCB 01/08 Q&A #4]

A19. The OASIS hard copy information for the chart printed out by a point of care system must use the exact language of the items from the current data set. If the printout of the assessment (i.e., the "hard copy" to be retained in the patient's clinical record) does not contain the same assessment data entered and submitted to the OASIS system, that may be problematic for the following reasons: 1) State surveyors will likely review records and compare the record on site in the agency with the data submitted to the OASIS system; 2) If a patient record was requested by the Fiscal Intermediary for medical review, it would be imperative that the printed record contain the data collected and submitted to the OASIS system (since the same data were used to document the Plan of Care and calculate the billing codes); and 3) One way for an agency to

monitor quality is to review responses to OASIS items in clinical records and compare those responses with data collected at prior and subsequent visits to the same patient. If any of these processes would be complicated by the printouts received from your system, it could create problems for the agency.

Due to the size and complexity of some of the items (e.g. M1021/1023/1025/1311/1313/2102/2250/2401) the formatting may be modified to fit the computer screen as long as the data set language is not modified, and any format variances in no way impact the accuracy of the item scoring.

Q20. Our agency has been using a typical OASIS form that integrated the comprehensive assessment information with OASIS (as required by the Conditions of Participation) within one single form. We recently decided to use two separate forms. One form is the Comprehensive Assessment as stated above and the second is CMS OASIS data items. Someone told us that this was unacceptable and a single, physically integrated form is required. Is this true? [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 07/08 Q&A #2]

A20. In order to be compliant with the Medicare Condition of Participation, 484.55, Comprehensive Assessment of Patients, the OASIS Assessment Items must be integrated into the agency's comprehensive assessment forms and arranged in a clinically meaningful manner. The data items may not be kept on a separate form and attached as a separate document to the comprehensive assessment.

Q21. Can I reference prior assessments for the purposes of OASIS data collection? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #1]

A21. For assessment items that reflect a patient's current status, like M1830, Bathing or M2020, Management of Oral Medications, clinicians should not reference previous assessments, but should select a response based on the patient's ability on the day of assessment.

For items that are not limited to a patient's current status, the assessing clinician may be required to review the previous assessment, or other clinical documentation since the most recent SOC/ROC assessment in order to determine the correct response, e.g., M1501, Symptoms in Heart Failure Patients, which reports if a patient with heart failure exhibited symptoms of heart failure at the time of or at any time since the most recent SOC/ROC assessment; or M2401, Intervention Synopsis, which reports whether the patient's Plan of Care at the time of or at any time since the most recent SOC/ROC assessment included physician-ordered best practice interventions. This documentation review may be required to determine if specific events occurred, and/or what actions were taken (e.g., orders, interventions implemented).

Q22. How should we complete M2401 Intervention Synopsis at the SOC/ROC if we are not allowed to refer back to previous assessment time points? [Q&A EDITED 10/16; Q&A EDITED & Updated M numbers 06/14; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #2]

A22. When completing items in the OASIS data set at Transfer and Discharge, there are a number of items that will require the clinician to complete a record review in order to answer the item correctly, including:

At Transfer and DC

Immunization Items: M1041-Influenza Vaccine, M1046-Reason Influenza Vaccine not received, M1051- Pneumococcal Vaccine, M1056-Reason Pneumococcal Vaccine not received

Heart Failure Items: M1501-Symptoms in Heart Failure, M1511-Heart Failure Follow-up

Medication Items: M2005-Medication Intervention, M2016-Patient/Caregiver Drug Education Intervention

Emergent Care Items: M2301-Emergent Care, M2310-Reason for Emergent Care
At DC

M1307-Oldest Stage 2 Pressure Ulcer that is present at discharge

M1313-Worsening in Pressure Ulcer Status since SOC/ROC

M2401-Intervention Synopsis

M0906-Date of Last (Most Recent) Home Visit

Q23. Regarding QA#116.5, what is meant by “communication can be directly to/from the physician, or indirectly through physician’s office staff on behalf of the physician, in accordance with the legal scope of practice.”? Can the physician’s secretary be considered office staff if she/he speaks directly to the physician with the clinician’s questions and then gives the information directly back to the clinician? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #3]

A23. The reference to “in accordance with the legal scope of practice” refers to the State requirements defining who can take orders from physicians. Each HHA should have a policy and procedure consistent with State law that describes who can take orders from the physician. In most States it is going to be a clinician. It is important to understand that all orders must come from the physician and eventually be signed by the physician.

Q24. I am concerned that our software vendor has a new version coming out that answers the OASIS questions for you. I believe that it looks at how you answer comprehensive assessment items, and it then answers the OASIS items for the clinician. Does CMS consider this type of software feature compliant? [Q&A EDITED 10/16; Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 01/13 Q&A #3]

A24. In order to be compliant with the Condition of Participation, 484.55, The Comprehensive Assessment of Patients, the assessing clinician responsible for completing the comprehensive assessment must read the question exactly as written in the data set and then choose the appropriate OASIS response from the available response options after carefully considering each one. An agency's software may not "answer" or "generate" the OASIS response for the assessing clinician. Some exceptions to how items might be displayed have been made for a limited number of items, as detailed in CMS OASIS Q&A #19 located in Category 4a, "Due to the size and complexity of some of the items (e.g.

M1021/1023/1025/1311/1313/2102/2250/2401) the formatting may be modified to fit the computer screen as long as the hard copy print out matches the data set and the modification in no way impacts the accuracy of the item scoring."

Q25. When completing a comprehensive assessment, is it acceptable for providers to utilize separate paper-based standardized assessment tools or must all assessment tools be embedded into the agency’s paper or electronic comprehensive assessment? [Q&A ADDED 06/14; Previously CMS Qtrly 04/13 Q&A #1]

A25. There is no Medicare requirement that standardized assessment tools be embedded in the agency's comprehensive assessment with the exception of the PHQ-2 which is included in M1730, the depression screening item. It is acceptable for a clinician to supplement the agency's comprehensive assessment with additional standardized assessment forms to meet the criteria for the OASIS best practice items.

Q26. We have recently added the capability of live video streaming from the patient's residence to another clinician (e.g. physician, WOCN, etc.). Can the use of this technology be used to clarify questions that arise during the comprehensive assessment without violating the one clinician rule? For example, if the admitting clinician is unsure about the stage or healing status of a wound, could the video be live streamed to another clinician who could provide input that the assessing clinician could use to select OASIS responses and complete the comprehensive assessment? [Q&A ADDED 06/14; Previously CMS Qtrly 01/14 Q&A #2 and CMS Qtrly 04/14 Q&A #4]

A26. Current guidance encourages the assessing clinician to confer with the physician when necessary, for example to confirm the diagnosis of a previously undiagnosed pressure ulcer, etc. If the physician requests or participates in video streaming from the patient's residence as part of patient oversight and collaboration with the home health agency, then use of this technology may contribute to the assessing clinician's response selection for one or more OASIS items. Conferring with the physician in this manner does not violate the one clinician rule.

The use of video technology for collaboration, such as that described between the assessing clinician and the physician does NOT extend to the assessing clinician and other agency staff or clinical consultants, which would violate the one clinician rule. The WOCN may view the photograph or video and use the image to educate the "learning" professional regarding pressure ulcer assessment. The violation of the one clinician rule occurs when/if the assessing clinician uses the assessment information from the second clinician to select an OASIS response.

As a general reminder, HIPAA requirements regarding secure transmission/communication of patient information should be considered in conjunction with the practices discussed.

Q27. I would like to better understand the rules on how to collect the OASIS as part of a comprehensive patient assessment. What are the best resources? [Q&A ADDED 10/16; Previously CMS Qtrly 04/16 Q&A #1]

A27. CMS provides several key resources to support OASIS data accuracy. The OASIS Guidance Manual contains an item-by-item review with key instructions within Chapter 3 of the manual. Chapter 3 is organized by M-item number for easy reference. Chapter 1 of the OASIS Guidance Manual contains the general and ADL/IADL specific conventions for completing OASIS items.

There are also 12 categories of OASIS Q&As available at <https://www.qtso.com/hhatrain.html>. Categories 1-4 are most relevant for OASIS data collection activities. At the same site, CMS posts quarterly Q&A updates with new and/or refined guidance related to OASIS items. The user may conduct a key word search in these .pdf documents to expedite the search for information.

CMS also provides web-based training that providers can utilize to support accuracy. The modules are available at <http://surveyortraining.cms.hhs.gov/pubs/ClassInformation.aspx?cid=0CMSOASISCWBT> and are expected to be updated for OASIS-C2 guidance prior to implementation in January 2017.

Questions not otherwise answered in published CMS OASIS resources may be submitted to the CMS OASIS Helpdesk at CMSOASISquestions@oasisanswers.com.

Q28. We utilize an electronic medical record. Do the formatting changes added to OASIS-C2 regarding the single box entry need to be presented to the clinicians in the

EMR? The end result in the extract is the same. Currently the response options are presented to the clinicians in a list with radio buttons to indication response selection. Is this acceptable? [Q&A ADDED 10/16; Previously CMS Qtrly 07/16 Q&A #2]

A28. In the development and maintenance of OASIS-C2 Assessment user tools, Vendors are advised to reference the Data Specifications v2.20.0 (<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/DataSpecifications.html>). While the Data Specifications dictate the Assessment Instrument Items, their applicable time point(s) in the Assessment Instrument, the exact language of the Items, and each Item's allowable response options, the Data Specifications do not dictate the format of the graphical user interface (GUI) software presentation of the Items in the Assessment Instrument. Per your example, presenting the allowable response options in the format of radio buttons in the GUI software is acceptable, and is left to the user's discretion, as long as such modification does not impact the accuracy of the item scoring.

Q29. Traditionally, aside from M0080, M0090, and M0100, the only items that appear on the time point 8 Death at Home assessment are M0903 (Date of Last Home Visit) and M0906 (Discharge/Transfer/Death Date). In OASIS-C2, M2005 (Medication Intervention) has been added to the RFA 8 assessment. This seems like an odd item to add to the Death at Home assessment, especially since no other items are being added to this assessment. Can you explain why M2005 was added, and/or verify that this wasn't a mistake? [Q&A ADDED 10/16; Previously CMS Qtrly 10/16 Q&A #3]

A29. Per the OASIS-C2 Guidance Manual, effective January 1, 2017, M2005 Medication Intervention will be collected at the following time points: Transfer to inpatient facility, Death at home, and Discharge from agency - not to an inpatient facility. M2005 is a data source for a new cross-setting IMPACT Drug Regimen Review process measure, and the quality measure specifications required data collection for all home care episodes, including those ending in a patient death at home.

Category 4B - OASIS Data Items

Q1. PTS. Can the Patient Tracking Sheet be combined with another form such as the agency's referral form?

A1. The agency may choose to use the Patient Tracking Sheet as any other clinical documentation, integrating additional items as desired. If the agency typically collects other items at SOC and updates them only as necessary during the episode of care, these items might be good choices to integrate with the other Tracking Sheet items. The patient's telephone number might be an example of such an item.

Q2. PTS. Can other (agency-specific) items be added to the Patient Tracking Sheet?

A2. The agency can incorporate other items into the Patient Tracking Sheet (PTS) as needed for efficient care provision. Examples of such items that would “fit” nicely with the OASIS PTS items would be the patient's street address, telephone number, or directions to the patient's residence.

Q3. PTS. Must the clinician write down/mark every single piece of information recorded on the Patient Tracking Sheet (e.g., could clerical staff enter the address, ZIP code, etc.)?

A3. Consistent with professional and legal documentation principles, the clinician who signs the assessment documentation is verifying the accuracy of the information recorded. At the time of referral, it is possible for clerical staff to record preliminary responses to several OASIS items such as the address or ZIP code. The assessing clinician then is responsible to verify the accuracy of these data.

Q4. What do the “M0000” numbers stand for?

A4. The “M” signifies a Medicare assessment item. The following four characters are numbers that identify the specific OASIS item.

Q4.1. [Q&A RETIRED 09/09; Outdated]

Q5. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q5.1. M0018. When answering M0018 - National Provider Identifier (NPI) for the Attending Physician Who Has Signed the Plan of Care, what if the ordering physician is not the provider who ultimately signed the 485 (Plan of Care). Which attending physician's number should be entered? This happens when the ordering physician makes the referral and then goes on vacation for a month with another physician from their group signing the 485 on their behalf. [Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 01/13 Q&A #4]

A5.1. At SOC, when completing M0018, National Provider Identifier, the assessing clinician should enter the NPI number of the physician expected to oversee and sign the Plan of Care.

Q6. M0030. Is the start of care date (M0030) the same as the original start of care when the patient was first admitted to the agency, or is it the start of care for the current certification period? [Q&A EDITED 08/07]

A6. The start of care date (M0030) is the date of the first reimbursable service and is maintained as the start of care date until the patient is discharged. It should correspond to the start of care date used for other documentation, including billing or physician orders.

Q7. M0030. What if a new service enters the case during the episode? Does it have a different SOC date?

A7. There is only one Start of Care date for the episode, which is the date of the first billable visit.

Q7.1. M0030. 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 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? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #7]

A7.1. The "start of care" is defined as the first billable visit. 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.

Q7.2. M0040. Can/should an apostrophe be included in a patient’s name in M0040? [Q&A ADDED 10/16; Previously CMS Qtrly 04/16 Q&A #3]

A7.2. The OASIS Guidance Manual, Chapter 3, M0040 Response-Specific Instructions state the patient's name should appear exactly as it does on the Medicare card or other insurance card. Per the data specifications for M0040, the item may contain a (') single quote/apostrophe. For additional information, please refer to the data specifications located at

Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/DataSpecifications.html .

Q7.2.1.M0040. The Guidance Manual states that the patient’s name for M0040 should match the Medicare or insurance card, but what should I do if the patient’s last name has more letters than M0040 allows? [Q&A ADDED 10/16; Previously CMS Qtrly 04/16 Q&A #4]

A7.2.1. For M0040 Patient Name, the OASIS Guidance Manual states the name should appear exactly as it does on the Medicare card or other insurance card. The OASIS item provides a maximum length of 12 characters for the first name, 1 character for the middle initial, and 18 characters for the last name. The length of the text submitted must not exceed the maximum length specified or it will result in a fatal Format Edit when submitted to the CMS ASAP system. In cases where a patient's name has more letters than the OASIS submission allows, enter the first 12 letters (for first name), the first letter (for middle initial), and the first 18 letters (for last name), and disregard any additional letters/characters for the purposes of M0040. This approach should be used for all time points throughout the patient's episode of care. Note that this M0040 limitation should not be applied to other documentation (clinical records, claims, etc.) where the patient's full name should be used.

Q8 & 9. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q10. M0063. If the patient has Medicare, but Medicare is not the primary pay source for a given episode, should the patient’s Medicare number be entered? [Q&A EDITED 08/07]

Q10. The patient's Medicare number should be entered, whether or not Medicare is the pay source for the episode. Keep in mind that Medicare is often a secondary payer, even when another payer will be billed first. In order to bill Medicare as a Secondary Payer, the patient must be identified as a Medicare patient from the start of care. If the agency does not expect to

bill Medicare for services provided by the agency during the episode, then Medicare would not be included as a pay source on M0150, even though the patient's Medicare number is reported in M0063.

Q10.1.M0065. Home Health Agencies in the state of Iowa are transitioning from Traditional Medicaid, to three private companies for Medicaid Managed Care Organizations (MCOs). For M0065 - Medicaid Number, should agencies use the traditional Medicaid number, or the new patient ID number provided by the MCO? [Q&A ADDED 10/16; Previously CMS Qtrly 07/16 Q&A #3]

A10.1.M0065. Medicaid Number specifies the patient's Medicaid number, if the patient has Medicaid. Answer this item whether or not Medicaid is the payer source for the home care episode. (OASIS Guidance Manual, Chapter 3 located at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html>) Do not enter the identification number provided by an HMO or MCO.

Q11. [Q&A RETIRED 08/07; Replaced by updated Q&A.]

Q12 & 12.1. [Q&A RETIRED 08/07; Outdated]

Q13. M0080. Why are Social Workers not included on OASIS item M0080? [Q&A EDITED 08/07]

A13. In item M0080 - Discipline of Person Completing Assessment, you will find the initials of clinicians (RN, PT, SLP/ST, OT) who can initiate a qualifying Medicare home health service and/or are able to complete the assessment. Social workers are not able to initiate a qualifying Medicare home health benefit or complete the comprehensive assessment, but may support other qualifying services. In the Medicare Conditions of Participation (CoP), CFR 484.34, conducting a comprehensive assessment of the patient is not considered a service that a social worker could provide. To access the CoP, go to <http://www.cms.hhs.gov/center/hha.asp>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

Q13.1. M0080. Can a speech therapist do a non-bill admission for a physical therapy only patient? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 04/08 Q&A #3]

A13.1. The Comprehensive Assessment of Patients Condition of Participation (484.55) states in Standard (a) (2) "When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional." Some agencies' policies make this practice more restrictive by limiting some of the allowed disciplines (i.e., PT, OT, and/or SLP) from completing the initial assessment visit and/or comprehensive assessment, and require an RN to complete these tasks, even in therapy only cases where the therapy discipline establishes program eligibility for the payer. While not necessary, it is acceptable for agencies to implement this type of more stringent/restrictive practice. Even though there are no orders for nursing in a therapy only case, the RN may complete the initial assessment visit and the comprehensive assessment, as nursing, as a discipline, establishes program eligibility for most, if not all payers.

In a case where PT is the only ordered service, and assuming physical therapy services establish program eligibility for the payer, the PT could conduct the initial assessment visit and the SOC comprehensive assessment. Likewise, assuming skilled nursing services establish program eligibility for the payer, the RN could complete these tasks as well, even in the absence of a skilled nursing need and related orders. If speech pathology services were also a qualifying service for the payer, it would be acceptable, although not required, for the SLP to conduct the

initial assessment visit and/or complete the comprehensive assessment for the PT only case, even in the absence of a skilled SLP need and related orders. Likewise, a PT could admit, and complete the initial assessment visit and comprehensive assessment for an SLP-only patient, where both PT and SLP were primary qualifying services (like the Medicare home health benefit).

It should be noted that under the Medicare home health benefit (and likely under other payers as well), the visit(s) made by the RN, (or SLP, or PT, etc.) to complete the initial assessment and comprehensive assessment tasks would not be reimbursable visits, therefore would not establish the start of care date for the home care episode.

Q13.2. M0080. Who can complete the OASIS data collection that occurs at the Transfer and Death at Home time points? Can someone in the office who has never seen the patient complete them? Does it have to be an RN, PT, OT or SLP? [Q&A EDITED 06/14; ADDED 01/10; Previously CMS OCCB 01/09 Q&A #4]

A13.2. Since the Transfer and Death at Home OASIS time points require data collection and not actual patient assessment findings, any RN, PT, OT or SLP may collect the data, as directed by agency policy. The current OASIS Guidance Manual, under M0100, explains that a home visit is not required at these time points. As these time points are not assessments and do not require the clinician to be in the physical presence of the patient, it is not required that the clinician completing the data collection must have previously visited the patient. The information can be obtained over the telephone and through record review by any RN, PT, OT or SLP familiar with OASIS data collection practices. This guidance applies only to the Transfer and Death time points, as a visit is required to complete the comprehensive assessments and OASIS data collection at the Start of Care, Resumption of Care, Recertification, Other Follow-up and Discharge.

Q13.3. M0080. Can an OT establish the Plan of Care and perform the SOC assessment when a Medicare Advantage plan is the payer? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #2]

A13.3. OT does not establish eligibility for the Medicare Traditional Home Health benefit. Therefore, an OT may not perform the initial assessment or complete the SOC comprehensive assessment on Medicare traditional fee-for-service (PPS) patients. Other payers, such as Medicaid, Medicare Advantage plans, or private insurers, may have different coverage guidelines that would allow OT to establish eligibility for each respective home health benefit. It will be necessary to contact the payer to find out if the Occupational Therapy discipline establishes program eligibility for that payer, to determine if OT may perform the initial assessment visit and the SOC comprehensive assessment.

Q14. M0090. We have 5 calendar days to complete the admission/start of care assessment. What date do we list on OASIS for M0090 - Date Assessment Completed when information is gathered on day 1, 3 and 5? [Q&A EDITED 04/15]

A14. Generally, you would enter the last day that assessment information was obtained on the patient in his/her home, if all clinical data items were completed. However, if the clinician needs to follow-up, off site, with the patient's family or physician in order to complete an OASIS or non-OASIS portion of the comprehensive assessment, M0090 should reflect the date that last bit of information is collected.

If the original assessing clinician gathers additional information during the SOC 5 day assessment time frame that would change a data item response, the M0090 date would be changed to reflect the date the information was gathered and the change was made. If an error

is identified at any time, it should be corrected following the agency's correction policy and M0090 would not necessarily be changed.

Q15. M0090. We had a patient admitted to the hospital on April 15 and found out about it on April 19. When we enter the transfer (patient discharged) assessment (M0100 reason for assessment 7) into HAVEN, we get a warning message that the record was not completed within correct timing guidelines. (M0090) date should be no earlier than (M0906) date AND no more than 2 days after M0906 date. [Q&A EDITED 08/07]

A15. That message is intended to be a reminder that you should complete a Transfer assessment within 48 hours of learning of it. The regulation states that the assessment must be completed within 48 hours of learning of a transfer to an inpatient facility, so in this case, the assessment has been completed in compliance. The warning does not prevent the assessment from being transmitted. If you find that this warning occurs consistently, you may want to examine whether your staff are appropriately tracking the status of patients under their care.

Q16. M0090. Is the date that an assessment is completed, in M0090, required to coincide with the date of a home visit? When must the date in M0090 coincide with the date of a home visit? [Q&A EDITED 08/07]

A16. M0090, Date Assessment Completed, records the date the assessment is completed. The start of care (SOC), resumption of care (ROC), follow-up, and discharge assessments (reason for assessments [RFA] 1, 3, 4, 5, and 9 for M0100) must be completed through an in-person contact with the patient; therefore these assessments will most often coincide with a home visit. The transfer or death at home assessments (RFAs 6, 7, or 8 for M0100) will report in M0090 the date the agency completes the assessment after learning of the event.

In the situation where the clinician needs to follow up, off site, with the patient's family or physician in order to complete a specific clinical data item that the patient is unable to answer, M0090 should reflect that date.

Q17. M0090. If an HHA's policy requires personnel knowledgeable of ICD-10-CM coding to complete the diagnosis after the clinician has submitted the assessment, should M0090 be the date that the clinician completed gathering the assessment information or the date the ICD-10-CM code is assigned? [Q&A EDITED 04/15; ADDED 06/05; EDITED 08/07]

A17. The HHA has the overall responsibility for providing services, assigning ICD-10-CM codes, and billing. CMS expects that each agency will develop their own policies and procedures and implement them throughout the agency in a manner that allows for correction or clarification of records to meet professional standards. It is appropriate for the clinician to enter the medical diagnosis on the comprehensive assessment. The HHA can assign a qualified coder to determine the correct numeric code based upon the written diagnosis provided by the assessing clinician. The date at M0090 (Date Assessment Completed) should reflect the actual date the assessment is completed by the qualified clinician. If agency policy allows the assessment to be performed over more than one visit, the date of the last visit (when the assessment is finished) is the appropriate date to record. The M0090 date should not necessarily be delayed until coding staff verify the numeric codes.

Q18. M0090. Should the date in M0090, reflect the date that a supervisor completed a review of the assessment? [Q&A EDITED 08/07]

A18. While a thorough review by a clinical supervisor may improve assessment completeness and data accuracy, the process for such review is an internal agency decision and is not

required. The assessment completion date (to be recorded in M0090) should be the last date that data necessary to complete the assessment is collected.

Q19. M0090. A provider has decided to complete discharge assessments for all patients when payers change because they believe that, by doing so, their reports will better indicate their patients' outcomes. Before making this policy shift they need answers to the following questions: [Q&A EDITED 06/14; ADDED 06/05]

- a. Can the agency perform the RFA 09 and RFA 01 on the same visit?
- b. If so, what is the discharge date for the RFA 09 at M0090?
- c. If so, what is the admission date for RFA 01 at M0090?
- d. Will recording of the same date for both of these assessments result in errors when transmitted to the OASIS system?

A19. Under normal business practices, one home health visit should not include two types of assessments and be billed to two payer sources. The discharge date for the (RFA 09) Discharge from Agency should be the last date of service for the payer being terminated. The admission date for the new Start of Care (RFA 01) assessment should be the next scheduled visit, according to the Plan of Care. The agency may send a batch including both assessments to the OASIS system. An edit is in place at the OASIS system to sort for an assessment to close an open patient episode prior to opening a new episode.

Q19.1. M0090. The RN conducted the SOC assessment on Monday. The RN waited to complete the assessment until she could confer with agency therapists after they had completed their therapy evaluations. This communication occurred on Tuesday and included a discussion of the Plan of Care and the therapists' input on the correct response for M2200. If the RN selects a response for M2200 based on the input from the therapists, does this violate the requirement that the assessment is to be completed by only one clinician? And what is the correct response for M0090, Date Assessment Completed? [Q&A EDITED 06/14; ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #2]

A19.1. Tuesday would be the correct date for M0090. Tuesday was the date the assessing clinician gathered all the information needed to complete the assessment including M2200. In this case, the assessing clinician appeared to need to confer with internal agency staff to confirm the Plan of Care and the number of visits planned. M2200 is an item which is intended to be the agency's prediction of the number of therapy visits expected to be delivered in the upcoming episode, therefore, an agency practice may include discussion and collaboration among the interdisciplinary team to determine the M2200 response and this would not violate the requirement that the assessment be completed by one clinician.

Q19.2. M0090. I understand that M0090, Date Assessment Completed, is the day the last information needed to complete the assessment is collected, and at discharge, it is generally the last visit. Due to the Notice of Provider Non-Coverage which must be given to Medicare recipients two days before discharge, there have been occasions when the notice was not signed at the discharge visit. In order to give the patient the 2 day notice, we hold discharging until after they have had the patient sign the notice, and call them back in two days to confirm the discharge plan, however, the OASIS is completed based on the last visit. When this happens, the system gives us an error when we put in the last visit date versus that last discharge date, even though the assessment is based on the last visit. [Q&A EDITED 01/12; ADDED 09/09; Previously CMS OCCB 10/07 Q&A #9]

A19.2. M0090, Date Assessment Completed, is the date the clinician gathered the last piece of information necessary to complete the assessment. In most cases, but not all, M0090 is the day of a visit. Sometimes the clinician may gather information off site, such as Therapy Need, or other items that are dependent on a call back from a caregiver or physician or other non-patient assessment data, like dates. M0906, Discharge Date, is defined by agency policy. For some agencies it is the date of the last visit, but other agencies may define it to be one or two days or more after the last visit. It is not prescribed by regulation, except that the discharge date cannot occur before the date of the last visit. Regulation requires that the discharge assessment must be completed within two calendar days of the actual discharge date or within two calendar days of learning of the need to discharge in the case of an unplanned or unexpected discharge.

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

Q19.3. M0090. Should the M0090 date be changed when a correction is made after a clinician has completed the assessment but before the assessment is locked? For example, the nurse completes the assessment with a M2200 response of 3 visits on February 1st and records that date at M0090. On Feb 2nd the nurse learns that the therapist assessed the patient and received physician orders for 10 therapy visits. Should the M0090 date be changed to February 2nd to reflect the date that M2200 is corrected? [Q&A ADDED & M number updated 09/09; Previously CMS OCCB 04/08 Q&A #4]

A19.3. If the original assessing clinician gathers additional information during the SOC 5 day assessment time frame that would change a data item response, the M0090 date would be changed to reflect the date the information was gathered and the change was made. If an error is identified at any time, it should be corrected following the agency's correction policy and M0090 would not necessarily be changed.

Q19.4. M0090. I was reviewing CMS OASIS Q&A 19.3 and noted that the response states: "if the original assessing clinician gathers additional information during the SOC 5 day assessment time frame", M0090 would need to reflect that more recent date. Our practice is to hold the OASIS SOC until all the therapy disciplines have submitted the add-on orders, complete with their frequencies. Then the OASIS document is submitted with the totaled number. This should be our best estimate of the actual number of visits planned for the patient by therapy.

My question is: In our situation, would "original assessing clinician" extend to the record review department? Would they need to change the M0090 answer once the totaled number of visits is added and put in M2200? [Q&A ADDED & M number updated 09/09; EDITED 04/15; Previously CMS OCCB 01/09 Q&A #4 & #7]

A19.4. Only one clinician can complete the comprehensive assessment including the OASIS. If the clinician responsible for completing the OASIS assessment gathers new information during the 5 day assessment time period, s/he may change the response to that item and change the M0090 date to reflect the date the latest new information was gathered. This would apply to M2200.

If the OASIS is completed by the assessing clinician and then, through an internal review process in the office, it is discovered that the OASIS data contains one or more errors, the identified data item(s) could be corrected by the qualified clinician responsible for performing the review following your agency's correction policy and in such cases of error correction, M0090 would not be changed.

Q19.4.1. M0090. As long as the RFA 4, Recertification OASIS M0090 date is within the 5 day window, can you visit on day one and complete (M0090) any of the other days if you were still gathering data? [Q&A ADDED 01/11; Previously CMS OCCB 04/10 Q&A #3]

A19.4.1. Per the Condition of Participation, 484.55, the agency must perform a comprehensive assessment of the Medicare patient every second calendar month beginning with the start of care. The time period for the RFA 4, Recertification, has been further clarified in a number of references, Category 3 CMS OASIS Q&As, OASIS Assessment Reference Sheet, to mean the last 5 days of every 60 days, i. e. days 56-60 of the current 60-day period.

A clinician may start the comprehensive assessment on day 56 and complete it on any day on or before day 60. Only one clinician may complete a comprehensive assessment though, so if Nurse A begins it on day 56, Nurse A must be the clinician who completes it.

Q19.5. M0090. I am not sure how to complete M0090 when it is a therapy only case and the RN in the office performs the final review and checking off of the medication sheet for interactions or issues? [Q&A ADDED 09/09; Previously CMS OCCB 07/09 Q&A #4]

A19.5. M0090, Date Assessment Completed, is the date that the last piece of information necessary to complete the comprehensive assessment is gathered. The Condition of Participation, 484.55, the Comprehensive Assessment of Patients, requires that a drug regimen review be performed each time a comprehensive assessment is required. If your physical therapists rely on a nurse in the office to perform certain components of the drug regimen review (i.e., identifying drug-drug interactions), the date the RN in the office communicates her drug regimen review findings back to the PT becomes the M0090 date, the date the assessment was completed, assuming all other comprehensive assessment data had been previously collected.

Q20. M0100. Does 'transfer' mean 'transfer to another non-acute setting' or 'transfer to an inpatient facility?' [Q&A EDITED 08/07]

A20. Transfer means transfer to an inpatient facility, i.e., the patient is leaving the home care setting and being transferred to a hospital, rehabilitation facility, nursing home or inpatient hospice for 24 hours or more for reasons other than diagnostic testing. Note that the text of the item indicates that it means transfer to an inpatient facility.

Q20.1. When we complete the RFA 6, Transfer; no discharge and the patient does not return to us, do we have to cancel the RFA 6 and resubmit the RFA 7, Transfer with

Discharge? [Q&A ADDED to Cat. 4b 06/14; ADDED 01/12 to Cat. 2 as Q&A#41.1; Previously CMS OCCB 10/11 Q&A #3]

A20.1. If you complete and transmit the RFA 6, Transfer to Inpatient Facility; patient not discharged from agency, and the patient does not return to the care of the agency during the current 60 day certification period, no further OASIS is required. The quality episode ended with the Transfer (RFA 6) that was completed. You do not need to cancel the RFA 6 and resubmit the RFA 7, just complete your agency's internal discharge paperwork. The patient will remain on your OASIS Patient Management Roster for 6 months; after which time the patient name is dropped from the Data Management System (DMS) report.

Q21. M0100. For a one-visit Medicare PPS patient, is Reason for Assessment (RFA) 1 the appropriate response for M0100? Is it transmitted? Is a discharge OASIS required? [Q&A EDITED 06/14]

A21. Based on CMS policy, OASIS data collection and submission is not required when only one visit is made in a quality episode (SOC/ROC date to TRF/DC). However, to bill Medicare PPS for a single visit payment episode, OASIS data must be collected and submitted to the OASIS system, and used to calculate a HIPPS code for inclusion on the Medicare claim. If you choose NOT TO BILL Medicare for the single visit provided, there is no requirement to collect and transmit OASIS data for single visit episodes.

If OASIS is collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. The discharge OASIS is never mandated in situations of single visits in a quality episode.

If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however.

Q21.1. M0100. New text in the Medicare Claims Processing Manual, CMS Publication 100-4, Chapter 10, reads, "A beneficiary does not have to be discharged from home care because of an inpatient admission. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues. However, if an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same 60-day period, the discharge is not recognized for Medicare payment purposes. All the home health services provided in the complete 60-day episode, both before and after the inpatient stay, should be billed on one claim." Does this mean that providers should never do an RFA7 (Transfer with discharge)? [Q&A EDITED 01/12; ADDED 01/11; Previously CMS OCCB 10/10 Q&A #2]

A21.1. When a Medicare Traditional fee-for-service patient is transferred to the inpatient facility, it should be assessed if the agency anticipates the patient will be returning to service or not. If the HHA plans on the patient returning after their inpatient stay, the RFA 6 should be completed. There will be times when the RFA 7 is necessary to use, but only when the HHA does NOT anticipate the patient will be returning to care. There are several reasons why the RFA7 may be used, including these examples: the patient needs a higher level of care and no longer appropriate for home health care, the patient's family plans on moving the patient out of the service area, or the patient is no longer appropriate for the home health benefit.

The Claims Processing Manual clarified this issue in July 2010, and directs providers to not discharge a patient when goals are not met at the time of a transfer. If a provider does discharge and readmit within the same payment 60-day episode, a Partial Episodic Payment (PEP) adjustment will be automatically made.

These instructions only apply to Medicare Traditional fee-for-service patients. For other payers, follow their payer-specific guidance.

Q22. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q23. M0100. A patient receiving skilled nursing care from an HHA under Medicare is periodically placed in a local hospital under a private pay arrangement for family respite. The hospital describes this bed as a purely private arrangement to house a person with no skilled services. This hospital has acute care, swing bed, and nursing care unit. The unit where the patient stays is not Medicare certified. Should the agency do a transfer and resumption of care OASIS? How should the agency respond to M0100 and M2410?
[Q&A EDITED 12/12; ADDED 06/05; M number updated 09/09]

A23. Yes, if the patient was admitted to an inpatient facility bed for 24 hours or longer for reasons other than diagnostic testing, a Transfer OASIS is required. Respite care is more than diagnostic testing and the response to M0100- Reason for Assessment (RFA) is RFA 6 or 7, Transfer to an Inpatient Facility. If the agency anticipates the patient will return to their care after the inpatient stay, RFA 6 should be completed. RFA 7 will be selected if the agency does NOT anticipate the patient will return to their care. The agency will need to contact the inpatient facility to verify the type of care that the patient is receiving at the inpatient facility and determine the appropriate response to M2410. If the patient is using a hospital bed, response 1 applies; if the patient is using a nursing home bed, Response 3 applies. If the patient is using a swing-bed it is necessary to determine whether the patient was occupying a designated hospital bed, Response 1 applies; or a nursing home bed, Response 3 applies. The hospital utilization department should be able to advise the agency of the type of bed and services the patient utilized.

Q23.01. M0100. If a patient was admitted to the hospital at 3 pm yesterday and then transfers directly to a hospice inpatient unit at 11 am today, are the inpatient hours additive? Should we do a Transfer at 3 pm today, after a full 24 hours of inpatient care, or does the clock start again at 11 am when the patient was admitted to the hospice inpatient? The same could happen with other inpatient settings- such as hospital and NF.
[Q&A ADDED 06/14; Previously CMS Qtrly 07/13 Q&A #3]

A23.01. A Transfer OASIS is required when the patient has been transferred to an inpatient bed for 24 hours or longer for reasons other than diagnostic testing. If the patient was admitted to one inpatient facility bed then transferred to another, the Transfer OASIS would be required once a total of 24 hours have been spent as an inpatient, under an inpatient billing status. In the situation described, a Transfer is required once the patient was inpatient for a total of 24 hours, in one or more inpatient facilities.

Q23.1. M0100. I understand that when calculating the days you have to complete the comprehensive assessment, the SOC is Day “0”. At the other OASIS data collection time points, when you are calculating the number of days you have to complete an assessment, is the time point date, Day “0”, e.g. for RFA 9, Discharge from Agency, the assessment must be completed within 2 calendar days of M0906, Disch/trans/death date. Is M0906 Day “0”? [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #3]

A23.1. Yes, when calculating the days you have to complete the comprehensive assessment, the SOC date is day “0”. For the other time points the date of reference (e.g., transfer date, discharge date, death date) is day “0”.

Note that for the purposes of calculating a 60 day episode, the SOC day is day “1”.

Q23.2. M0100. A patient is admitted to the hospital for knee replacement surgery. During the pre-surgical workup, a test result caused the surgery to be canceled. The patient only received diagnostic testing while in the hospital but the stay was longer than 24 hours. Does this situation meet the criteria for RFA 6 or 7, Transfer to Inpatient Facility? [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #4]

A 23.2. No, under the circumstances described, the patient did not meet the OASIS transfer criteria of admission to an inpatient facility for reasons other than diagnostic testing, if the patient, indeed, did not have any other treatment other than diagnostic testing during their hospitalization. If the patient received treatment for the abnormal test result, then the situation, as described, would meet the criteria for RFA 6 or 7, Transfer to Inpatient Facility.

Q23.3. M0100. What do we do if the agency is not aware that the patient has been hospitalized and then discharged home, and the person completing the ROC visit (i.e., the first visit following the inpatient stay) is an aide, a therapist assistant, or an LPN? [Q&A EDITED 06/14; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #5]

A23.3. When the agency does not have knowledge that a patient has experienced a qualifying inpatient transfer and discharge home, and they become aware of this during a visit by an agency staff member who is not qualified to conduct an assessment, then the agency must send a qualified clinician (RN, PT, OT, or SLP) to conduct a visit and complete both the Transfer (RFA 6) and the ROC (RFA 3). Both assessments should be completed within 2 calendar days of the agency’s knowledge of the inpatient admission. The ROC date (M0032) will be the date of the first visit following an inpatient stay, conducted by any person providing a service under your home health Plan of Care, which, in your example would be the aide, therapist assistant, or LPN.

The home health agency should carefully monitor all patients and their use of emergent care and hospital services. The home health agency may reassess patient teaching protocols to improve in this area, so that the patient advises the agency before seeking additional services.

Q23.3.1 M0100. Our Home Health agency admitted a patient on July 1st. He was admitted to the hospital on July 28th; from there he went to a skilled nursing facility on August 6th where he stayed until he died on September 17th. When our Home Health agency audited the discharged record this week, it was discovered that a Transfer OASIS had never been done. My question is, should a Transfer OASIS be done and submitted this late after discharge from Home Health? [Q&A ADDED 10/16; Previously CMS Qtrly 01/16 Q&A #1]

A23.3.1 In the scenario cited, the Transfer assessment (M0100 -RFA 7 – Transfer with agency discharge) would be completed to end the patient’s quality episode. The M0906 date would be the date the patient transferred to the hospital (July 28th), and the M0090 Data Assessment Completed would be the day the agency completes the transfer data collection. The Transfer

assessment is due within two calendar days of the qualifying transfer to an inpatient facility. Assessments not completed according to the required time frames represent noncompliance with the data collection rules.

Q23.4. M0100. The CoPs require that the comprehensive assessment be updated within 48 hours of the patient's return home from the hospital. The OASIS Assessment Reference Sheet states that the Resumption of Care assessment be completed within 2 calendar days of the ROC date (M0032), which is defined as the first visit following an inpatient stay. Does this mean that the ROC assessment (RFA 3) must be at least started within 48 hours of the patient's return home, but can take an additional 2 days after the ROC visit to complete? [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #6]

A23.4. No. When the agency has knowledge of a hospital discharge, then a visit to conduct the ROC assessment should be scheduled and completed within 48 hours of the patient's return home.

Q23.5. M0100. I accidentally completed the RFA 4 – Recertification assessment early (on day 54) for my Medicare patient. I did not realize this until I was into the next certification period. Should I do a new assessment or can the early assessment be used to establish the new case mix assignment for the upcoming episode? [Q&A EDITED 01/11; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #7; also located in Cat. 3 Q&A #11.2]

A23.5. Whenever you discover that you have missed completing a recertification for a Medicare patient within the required time frame (days 56-60), you should not discharge that patient and readmit, or use an assessment that was completed prior to the required assessment window. As soon as you realize that you missed the recert window, make a visit and complete the recertification assessment. You are out of compliance and will receive a warning from HAVEN or HAVEN-like software. Efforts should be made to avoid such noncompliance by implementing processes to support compliance with required data collection time frames.

Q23.6. M0100. 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 verses diagnostic? [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #9]

A23.6. 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.

Q23.7. M0100 & M2410. 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 & M2410? [Q&A EDITED 12/12; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #10]

A23.7. 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 whether the agency anticipated the patient would return to their care (RFA 6) or not (RFA 7). M2410 would be answered with Response 1-Hospital as you state the patient was admitted to a hospital.

Q23.8. M0100 & M2301. 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? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #11]

A23.8. For purposes of OASIS M2301 Emergent Care, Response 1, Yes, used hospital emergency department WITHOUT hospital admission, is the appropriate response for a patient who was held in an emergency department for outpatient observation services without a subsequent qualifying hospital admission. A qualifying hospital admission is an admission to a hospital inpatient bed for 24 hours or longer for reasons other than diagnostic testing. A Transfer OASIS is not required as the patient did not meet the criteria for the RFA 6 or 7.

If, from observation status, the patient was eventually admitted to the hospital as an inpatient and the transfer criteria were met, the Transfer OASIS would be required. The agency would complete RFA 6 or RFA 7 data collection, depending on whether they anticipated the patient would return to their service (RFA 6) or not (RFA 7).

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.

Q23.9. M0100. 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? [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #12]

A23.9. 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.

Q23.10. M0100. If a patient goes into a hospital as a "planned admission", do we have to do a Transfer? We have a patient who is admitted routinely for chemotherapy treatments as planned admissions. Is this different than an admission for "planned" diagnostic testing? If it is a planned admission for testing and "something goes wrong", does it become a Transfer? [Q&A ADDED 09/09; Previously CMS OCCB 04/09 Q&A #6]

A23.10. An RFA 6 or 7, Transfer to the Inpatient Facility, is required any time the patient is admitted to an inpatient facility for 24 hours or longer for reasons other than diagnostic testing. The fact that it was a planned admission is not a factor in determining if the Transfer OASIS data collection and submission are required. The patient who goes routinely into an inpatient facility for chemotherapy would require an RFA 6 or 7, Transfer, if they are admitted to an inpatient for 24 hours or longer since they are receiving treatment and not just diagnostic testing.

If a patient is admitted for diagnostic testing only and does not receive treatment, they do not require an RFA 6 or 7, Transfer, no matter how long they stay in the inpatient facility. If it was

a planned admission for diagnostic testing and the patient ends up receiving treatment, a Transfer would be required if they stay in the inpatient bed is for 24 hours or longer.

Q23.11. [Q&A RETIRED 09/09]

Q23.11.1. M0102 & M0104. When determining the physician-ordered SOC date (for M0102) or the date of referral (for M0104) should communication from the hospital/SNF DC planner be considered as representing physician referral? [Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #2]

A23.11.1. Yes, a referral received from a hospital or SNF discharge planner on behalf of the physician should be considered when determining the physician-ordered SOC date or the date of referral.

Q23.11.2. M0102 & M0104. How should M0102 - Date of Physician-ordered SOC (ROC) and M0104 - Date of Referral, be answered when you discover that the patient's insurance changed months ago and the new payer requires a new SOC with OASIS data? We have orders for the care but not for a specific date and we do not have a paper referral for that new episode. Do we just use the SOC date as the M0102 date? [Q&A ADDED 01/11; Previously CMS OCCB 07/10 Q&A #1]

A23.11.2. In the situation you present, there is no need to obtain either a physician's ordered start of care date or a referral date as you are not initiating care, just changing payers. In the specific situation where a new SOC comprehensive assessment is completed for the sole purpose of changing payers, M0102 – Date of Physician-ordered SOC would be “NA”. For M0104 -Date of Referral, enter the day prior to the new Start of Care date. If you know the date the insurance is changing, then actual dates can be used.

Q23.11.2.01 M0102/M0104. When following the guidance in Cat 2 Q61 for a late F2F situation, how should M0102 – Date of Physician ordered SOC/ROC and M0104 Date of Referral be answered, as M0030 (Start of Care date) will change based off of the first billable visit? This “workaround” for the late F2F has the potential to have a negative impact on the timely initiation of care process measure.

Category 2 Q61: If the face-to-face does not occur within 30 days after the start of care (SOC), but it does occur, for example, on the 35th day, how should OASIS data be collected and submitted?

Answer (excerpt): Where a face-to-face encounter did not occur within the 90 days prior to the SOC or within 30 days after the SOC, a provider may use an existing OASIS assessment to generate another OASIS with a reported SOC date equal to the first visit date after all Medicare HH eligibility criteria are met. If multiple OASIS assessments exist, the data from the assessment conducted closest to the date of Medicare eligibility should be used.

[Q&A ADDED 10/16; Previously CMS Qtrly 01/16 Q&A #2]

A23.11.2.01 In the scenario cited, where a new Start of Care date is established based on the completion of a late face-to-face encounter for Medicare eligibility, report M0102 – Date of Physician-ordered SOC as “NA” and report M0104 -Date of Referral, as the day prior to the new Start of Care date.

Q23.11.2.1. M0102 & M0104. Since there is no regulatory language allowing the ROC to be delayed by physician order beyond 2 calendar days of the facility discharge, what date if any is placed in M0102 on the Resumption of Care Assessment? [Q&A ADDED 12/12; Previously CMS Qtrly 10/12 Q&A #2]

A23.11.2.1. There is no regulatory allowance for a physician-ordered Resumption of Care date to extend beyond 2 calendar days of the facility discharge. If the physician orders the agency to resume care on a specific date that falls within 2 calendar days of the inpatient facility discharge, the specific ROC date ordered by the physician should be reported in M0102 Date of Physician-ordered SOC/ROC. If the physician orders the agency to resume care on a specific date that extends beyond 2 calendar days of the inpatient facility discharge, "NA" would be selected for M0102, Date of Physician-ordered SOC/ROC, and the date of the referral for resumption of home care services would be entered into M0104, Date of Referral. Clinical documentation would explain the timing of the patient's ROC visit.

Q23.11.2.2. M0102 & M0104. We received a referral for home care but were unable to reach the patient for several days. We notified the physician of the problem. When we finally reached the patient, he requested we start care a week after the original order date. We sent a fax to the MD 5 days after the original order was received requesting a delay in the SOC with a specific date 3 days from then. If we received the order back from the MD prior to that new date, how do we answer M0102, Physician-ordered SOC date and M0104, Date of Referral? [Q&A EDITED 04/15; ADDED 06/14; Previously CMS Qtrly 04/14 Q&A #5]

A23.11.2.2. The OASIS Guidance Manual, Chapter 3, Response-Specific Instructions state "If the originally ordered start of care is delayed due to the patient's condition or physician request (e.g., extended hospitalization), then the date specified on the updated/revised order to start home care services would be considered the date of physician\ordered start of care (resumption of care)."

In order to report this new updated/revised physician's ordered start of care date in M0102, it must have been received before the end of the 48 hour initial assessment time frame (or before the date of the previous physician's ordered start of care date, if one was provided). If the order to extend the physician's ordered start of care date is received after the 48 hour initial assessment time frame (or after the date of the previous physician's ordered start of care date, if one was provided), report NA for M0102 and report the original referral date in M0104.

Q23.11.3. M0104. The home health agency received a referral on June 1st, and then on June 2nd received a faxed update with additional patient information that indicates a possible delay in the patient's hospital discharge date. What is the referral date for M0104? [Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #3]

A23.11.3. If start of care is delayed due to the patient's condition or physician request and no date was specified as the start of care date, then the date the agency received updated/revised referral information for home care services to begin would be considered the date of referral. In your scenario, June 2 is the correct response for M0104.

Q23.11.4. M0104. If a referral is faxed to the agency after business hours but does not get processed until the next day, what date would we use for the referral date? [Q&A ADDED 01/12; Previously CMS OCCB 10/11 Q&A #4]

A23.11.4. M0104, Date of Referral, is the date stamped by your fax machine indicating when the referral was received.

Q23.11.5.M0102. We have a very large referral base send referrals via fax. The physician ordered SOC date indicated on the referral is often 2-3 days before the date we even receive the fax (time stamp on fax is January 6th for a physician ordered SOC date of January 4th). We have been completing M0102 Date of Physician Ordered SOC date with the date specified by the physician (January 4th), which has penalized our agency on the Timeliness of Care measure. We have attempted to obtain a verbal order to update the SOC date, however the physician group have become irritated with our calls. Please advise. [Q&A ADDED 04/15; Previously CMS Qtrly 01/15 Q&A #4]

A23.11.5. The agency should contact the physician to state that a patient referral was received after the physician ordered SOC date and to confirm that patient is still in need of home care services. If the need still exists, a valid SOC order, with updated referral or physician's ordered SOC date can be obtained.

Q23.11.6.M0104. 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? [Q&A ADDED 04/15; Previously CMS Qtrly 10/14 Q&A #2]

A23.11.6. 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.

Q23.12. M0110. When we collect OASIS for a private insurance or Medicare HMO patient because the payer source pays using a "Medicare PPS-like" model, how do we answer M0110, Episode Timing? To select a response, do we define an episode as just Medicare PPS paid episodes? Or for these non-Medicare PPS patients, should we define an episode as any paid by a payer using the PPS model? [Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #6]

A23.12. M0110 was developed for use in refining the PPS model and payment for the Medicare home health benefit. In that analysis, the definition of episode is specific to those episodes where Medicare fee-for-service (PPS) is the payer. When M0110 is collected on an OASIS-

required patient and/or to facilitate Medicare PPS payment, this definition must be applied. If a non-Medicare PPS payer requests/requires information on episode timing to be collected using different definitions or parameters, the “payer-specific” information should be collected separately from the established OASIS items (i.e., the M0110 item should not be used, with parameters different than those required by CMS, to gather other payer-specific data).

Q23.13. M0110. A patient is admitted to Agency A on July 5th, 2007 (with an end of payment episode date of Sept 2nd) , then recertified on Sept 3rd (with an end of episode date November 1st, 2007). Agency B admits on Jan 1, 2008. Is agency B’s episode Early or Later? [Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #9]

A23.13. When determining if 2 eligible episodes are adjacent, the HHA should count the number of days from the last day of one episode until the first day of the next episode.

Adjacent episodes are defined as those where the number of days from the last day of one episode until the first day of the next episode is not greater than 60. The first day after the last day of an episode is counted as day 1, and continue counting to, and including, the first day of the next episode. In the scenario presented,. In this example, November 1st was the last day of the episode (day 120) and January 1 is the first day of the next episode. When counting the number of days from the last day of one episode (Nov 1st), November 2nd would be day 1, and Jan 1 would be day 61. Since the number of days from the end of one episode to the start of the next is more than 60 days, these two episodes are not adjacent. The episode starting January 1st would be reported by Agency B as “Early”.

December 31 represents day 60 in this example. If the next episode started December 31 instead of January 1, that episode would be considered adjacent since the number of days counted is not greater than 60. The episode starting December 31 would be reported by Agency B as “Later.” All other episodes beginning between November 2 and December 31 in this example would also be reported as “Later”.

Q23.14. M0110. Agency 1 provides 90 days of care (1 and 1/2 episodes) under Medicare PPS and the patient is discharged. Agency 2 admits under Medicare PPS and begins care at what would have been a day in the 2nd episode (lets say day 45 in the second episode) had agency 1 still been caring for the patient. Is agency 2 still in an early episode? Or is this now a later episode for M0110? [Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #10]

A23.14. It would be reported as a later episode. Agency 1 provided care for one full payment episode, then recerted to establish a second payment episode, though the patient was discharged before the end of this 2nd episode. A partial episode payment will apply to the 2nd episode when Agency 2 admits the patient to their service under Medicare PPS, and the episode started by Agency 2 will be the third adjacent episode because there was not more than 60 days between the last billable visit provided by Agency 1 and the first billable visit provided by Agency 2. Since it was the third in a series of adjacent episodes, it should be reported as “Later” for M0110.

Q23.15. M0110. If a Medicare PPS patient is admitted and discharged with goals met several times within one 60 day period, is each admission counted when determining early vs. later episodes? For example, a patient is admitted 10/1 and discharged 10/15 (episode #1- early?), then readmitted 10/30 and discharged 11/15 (episode #2-early?), then readmitted 11/20 (episode #3- later?). Would this represent 3 distinct episodes, for the purpose of determining M0110 Episode Timing? [Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #11]

A23.15. For M0110, episodes are considered adjacent if there was no greater than 60 days between the last day of one Medicare Fee-for-Service (MC FFS) or PPS payment episode and the first day of the subsequent PPS payment episode. If a home care agency admits a Medicare patient and they had not been in a Medicare FFS Payment episode in the 60 days prior to the admission, the correct M0110 response would be "Early". If this patient was under the Medicare FFS benefit on 10/1 and was then discharged 10/15 and readmitted 10/30, a new payment episode would begin. The agency would receive a partial episode payment for the 10/1 - 10/15 episode. When an episode is ended by an intervening event that causes it to be paid as a partial episode payment [PEP] adjustment, then the last billable visit date is the end of the episode. When completing M0110 at the 10/30 episode, the patient would still be in an "Early" episode, as it would be the second in a series of adjacent episodes (assuming there was not an additional adjacent episode previous to the 10/1 episode). If that patient was then discharged on 11/15 (receiving a PEP payment) and readmitted on 11/20, the correct response to M0110 would now be "Later" as the patient would be in the third adjacent episode in the series.

Q23.16. M0110. We had a Medicare patient who received 2 contiguous episodes of service which did not meet the home health benefit. In order to receive payment from a secondary insurer, we submitted demand bills to our intermediary, fully expecting, and receiving denials. One month after being discharged from care, the patient now needs services which do meet Medicare eligibility and we are completing a new SOC to initiate a new episode under Medicare PPS. When answering M0110, should the previous 2 episodes, which were billed to, but denied by the intermediary, be considered when counting adjacent episodes or should they be ignored, since payment under Medicare PPS was denied? For the purposes of defining Medicare PPS episodes for M0110, does it mean the episode was BILLED AND PAID by Medicare PPS, or just that it was BILLED to the Medicare via the Medicare Administrative Contractor (MAC)? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/08 Q&A #3]

A23.16. Denied episodes should not be counted when determining the correct response to M0110 Episode Timing.

Q23.17. M0110. When the clinician is unsure if there have been any adjacent episodes, is it better to report M0110 Episode Timing as "early" or "unknown" (which defaults to "early")? If Medicare makes the adjustment automatically to correct this if it was wrong, will it make a difference if we marked "early" vs. "unknown" initially? [Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #7]

A23.17. The use of the Unknown response for M0110 may be impacted by agency preference/practice. Some agencies may choose not to invest the resources necessary to determine whether episodes are early or later episodes and it is perfectly acceptable for an agency to select "UK" consistently for M0110. Other providers who want to ensure an accurate RAP payment in the case of later episodes may choose to invest the resources to determine which episode the patient is in, and this is also compliant practice. Marking "Early" and "Unknown" have the same effect on payment calculations. If a M0110 response is determined to

be inaccurate at the time of the final claim, payment will be auto-adjusted to the correct episode amount.

Q23.18. M0110 & M2200. If we determine that we answered M2200, Therapy Need or M0110, Episode Timing, incorrectly at SOC, ROC or Recert, what actions do we have to take? [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 10/07 Q&A #10]

A23.18. In the Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Final Rule available at: <http://www.gpo.gov/fdsys/pkg/FR-2007-08-29/pdf/07-4184.pdf> it states:

“The CWF will automatically adjust claims up or down to correct for episode timing (early or later, from M0110) and for therapy need (M2200) when submitted information is found to be incorrect. No canceling and resubmission on the part of HHAs will be required in these instances. Additionally, as the proposed rule noted, providers have the option of using a default answer reflecting an early episode in M0110 in cases where information about episode sequence is not readily available.”

Since medical record documentation standards require a clinician to correct inaccurate information contained in the patient’s medical record, if it comes to the clinician’s attention that the OASIS response for M0110 - Episode Timing is incorrect, the original assessment may be corrected following the agency’s correction policy. Agencies can make this non-key field change to their records and retransmit the corrected assessment to the OASIS system. For example, if the clinician chose “Early” and during the episode, s/he learned that the patient was in a “Later” episode, M0110 may be corrected. Alternatively, in order to maintain compliance with standard medical record accuracy expectations, the clinician or agency could otherwise document the correction in a narrative correction note, or other format, since CMS is not specifically requiring the correction to be made to the OASIS assessment.

It is quite possible that providers may underestimate or overestimate the number of therapy visits M2200 that will be required in the upcoming episode. Because M2200 is an estimation of an exact number of therapy visits the agency expects to provide and the CWF will automatically adjust claims if the estimation is found to be incorrect, there will be no need to go back to the original OASIS assessment and change the M2200 response and resubmit the data.

The clinician cannot be expected to correct what is unknown to them and since in these specific cases the Common Working File (CWF) will automatically adjust claims found to be incorrect, no extraordinary efforts need to be taken after the original data collection to determine the accuracy of the data specific to M0110 and M2200.

Q23.19. M0110 & M2200. I have entered an assessment into HAVEN, it is ready to be locked and exported, but when I try to calculate the HIPPS Code I receive a message that grouper returned blank values. Why is this? [Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 01/08 Q&A #12]

A23.19. If M0110 or M2200 are marked as ‘Not Applicable’ then the Grouper will not return a value for the HIPPS Score. To determine how these fields should be completed please contact your state’s OASIS Education Coordinator.

Q24. M0150. For M0150, Current Payment Sources for Home Care, what should be the response if the clinician knows that a patient has health insurance but that the insurance typically won't pay until attempts have been made to collect from the liability insurance (e.g., for injuries due to an auto accident or a fall in a public place)? [Q&A EDITED 08/07]

A24. The purpose of this data item is to identify the current payer(s) that your agency will bill for services provided by your agency during this home care episode. Note that the text of M0150

asks for the "current payment sources" (emphasis added) and contains the instruction, "Mark all that Apply." For Medicare patients, the clinician should indicate at admission that the patient has Medicare coverage and any other coverage available that the agency will bill for services and mark all of the appropriate responses. The item is NOT restricted to the primary payer source. When a Medicare patient has a private insurance pay source as the primary payer, Medicare should always be treated as a likely/possible secondary payer. For example, when a Medicare patient is involved in a car accident and someone's car insurance is paying for his/her home care, Medicare is the secondary payer and the response to M0150 should include either Response 1 or 2 as appropriate for that patient. The only way an agency can bill Medicare as a secondary payer is to consider that patient a Medicare patient from day 1, so that all Medicare-required documentation, data entry and data submission exist. Although the agency may "intend" that the private pay source will pay the entire cost of the patient's home care that usually cannot be verified at start of care and may not be determined until the care is completed.

Q25. M0150. Please clarify what Title V and Title XX programs are?

A25. Title V is a State-determined program that provides maternal, child health, and crippled children's services, which can include home health care. Title XX of the Social Security Act is a social service block grant available to States that provide homemaking, chore services, home management, or home health aide services. (Title III, also mentioned in Response 6 to M0150 is part of the Older Americans Act of 1965 that gives grants to State Agencies on Aging to provide certain services including homemaker, home-delivered meals, congregate nutrition, and personal care aide services at the State's discretion.)

Q26. [Q&A RECALLED 08/07]

Q27. M0150. A patient with traditional Medicare is referred for skilled services, and upon evaluation, is determined to *not* be homebound, and therefore *not* eligible for the home health benefit. The patient agrees to pay privately for the skilled services. Should M0150 include reporting of response 1 – Medicare (traditional fee-for-service)? [Q&A ADDED 06/05; Previously CMS OCCB 10/04 Q&A #2]

A27. The purpose of M0150 is to identify any and all payers to which any services provided during this home care episode are being billed. Although the patient described is a Medicare beneficiary, Response 1 of M0150, Medicare (traditional fee-for-service), would not be marked, since the current situation described does not meet the home health benefit coverage criteria. In fact, since Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 temporarily suspended OASIS data collection for non-Medicare and non-Medicaid patients, if the services will not be billed to Medicare or Medicaid, then no OASIS collection would be required for this patient; although, if desired, the agency may voluntarily collect it as part of the still-required comprehensive assessment. If at some point during the care, a change in patient condition results in the patient becoming homebound, and otherwise meeting the home health benefit coverage criteria, then a new SOC assessment would be required, on which Response 1 – Medicare (traditional fee-for-service) would be indicated as a payer for the care.

Q28. M0150. The patient's payer source changes from Medicare to Medicaid or private pay. The initial SOC/OASIS data collection was completed. Does a new SOC need to be completed at the time of the change in payer source? [Q&A EDITED 06/14]

A28. Different States, different payers, and different agencies have varying responses to these payer change situations, so we usually find it most effective to ask, "Does the new payer require a new SOC?" HHAs usually are able to work their way through what they need to do if they

answer that question. If the new payer source requires a new SOC (Medicare is one that DOES require a new SOC), then it is recommended that the patient be discharged from the previous pay source and re-assessed under the new pay source, i.e., a new SOC comprehensive assessment. The agency does not have to re-admit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails a new admission). If the payer source DOES NOT require a new SOC, then the schedule for updating the comprehensive assessment continues based on the original SOC date. The HHA simply indicates that the pay source has changed at M0150. OASIS data collection and submission would continue for a Medicare/Medicaid patient changed to another pay source without a discharge. Because the episode began with Medicare or Medicaid as a payer, the episode continues to be for a Medicare/Medicaid patient. Transmittal 61, posted January 16, 2004, includes a section on special billing situations and can be found in the Medicare Claims Processing Manual. Go to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c10.pdf> ; scroll to "Section 80 - special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your Medicare Administrative Contractor (MAC).

Q29. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q29.1. M0150. Do I mark response 1, Medicare (traditional fee-for-service) if the patient's payer is VA? [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #8]

A29.1. If the patient has both VA and Medicare and both are expected payers, then you need to mark Response 1, Medicare (traditional fee-for-service) and Response 7, Other government (e.g. CHAMPUS, VA, etc.). But if the patient does not have Medicare, or Medicare is not an expected payer for provided services, then Response 7, Other government (e.g. CHAMPUS, VA, etc.) would be the correct response.

Q29.2. M0150. If a patient is receiving Meals-on-Wheels services, do you capture the payment for the service as a Response 10; Self Pay on M0150 Current Payment Sources for Home Care? [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #9]

A29.2. No, food is not considered within the scope of M0150. Most patients pay for their food, whether they purchase it directly, a caregiver purchases and delivers it, or a service such as Meals-on-Wheels is utilized.

Q29.3. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q29.4. M0150. It has come to our attention that we have been answering M0150 incorrectly. How far do we need to go back when correcting our errors? [Q&A EDITED 01/12; ADDED 09/09; Previously CMS OCCB 10/07 Q&A #11]

A29.4. Identified errors must be corrected. Corrections should be made to the last 12 months of OASIS data to ensure accurate quality reporting. For errors that impact payment, contact your Medicare Administrative Contractor for instructions regarding the time frame allowed for repayment or adjustments. For additional guidance related to making corrections, see CMS OASIS Q&As, Category 2, Q&A #37.4.

Q29.5. M0150. CMS Q&A Cat 4b Q24 says that "when a Medicare patient has a private insurance pay source, Medicare is always a likely secondary payer", therefore whenever we have a private insurance patient who also has Medicare, for M0150 we routinely mark both "1 - Medicare" and "8 - Private Insurance" (for health) and/or "11 - Other" (for auto, etc.), just in case Medicare ends up getting billed for a portion of the home care services. Are we interpreting this guidance accurately? And, for those cases where Medicare never ends up getting billed for services, can we retroactively correct M0150, eliminating response "1" or inactive the assessments altogether, since OASIS data

collection/submission is not required for Private Pay patients only? [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 01/08 Q&A #14]

A29.5. M0150, Current Payer Sources, is asking for identification and reporting of any payers the agency plans to bill for services during this episode of care. When a Medicare patient is admitted for home care services under a private insurer and the Medicare eligibility criteria are met, Medicare is always a likely payer and may be included in M0150. This action will ensure that OASIS data is collected in the event, Medicare is a payer. If at the end of the episode, the agency did not bill Medicare for services, (and assuming there were no other Medicare or Medicaid payers for home health services), then the agency should take action to delete any and all assessments (e.g., SOC, transfer, ROC, discharge), clarifying in the clinical chart why the assessment is being deleted. Simply correcting M0150 and resubmitting to the OASIS system, or inactivating affected assessments will not adequately remove the patient from the data base. If the assessment is not deleted, the patient identifiable data will remain in the data base, and may inappropriately impact the agency's OBQI and OBQM reports.

Q29.6. M0150. CMS Q&A Category 4b Q24 states that if a patient is involved in an auto accident the M0150 response should be 1 or 2 as appropriate for that patient. Would we also pick response 11 - Other and enter auto insurance or UK - Unknown? [Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #15]

A29.6. Response 8 - refers to private health insurance. Response 11 – Other (specify) would be selected for home care services expected to be covered by auto insurance.

Q30. M1000. If the patient has outpatient surgery within the 14-day time frame described in M1000, should 1 or NA be marked? [M number updated 09/09]

A30. The correct response would be 'NA' for M1000 because the patient's status would have been an outpatient for this situation.

Q31. M1000. For M1000, what is the difference between response 1 (long-term nursing facility) and 2 (skilled nursing facility)? [Q&A EDITED 01/10]

A31. Response 1, Long-term nursing facility, would be appropriate if the patient was discharged from a long term nursing facility or a Medicare-certified skilled nursing facility, but did not receive care under the Medicare Part A benefit in the 14 days prior to home health care. Response 2, Skilled nursing facility, would be appropriate if the patient was discharged from a Medicare certified nursing facility where they received a skilled level of care under the Medicare Part A benefit or a transitional care unit within a Medicare-certified nursing facility during the last 14 days.

Q32. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q32.1. M1000. When a patient is discharged from an inpatient facility in the last 5 days of the certification period, should M1000 on the Resumption of Care (ROC) assessment report inpatient facilities that the patient was discharged from during the 14 days immediately preceding the ROC date or the 14 days immediately preceding the first day of the new certification period? [Q&A EDITED 01/12; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #11]

A32.1. When completing a Resumption of Care assessment which will also serve as a Recertification assessment, M1000 should reflect inpatient facility discharges that have occurred during the two-week period immediately preceding the first day of the new certification period.

Q32.2. M1000. We had a client who was admitted to an inpatient facility for less than 24 hours. We did not do a Transfer OASIS because the criteria for it were not met. Two days

later the patient was discharged from our agency and we completed a discharge comprehensive assessment. Approximately 1 week later, the client developed a wound and was readmitted to our agency. When completing the new SOC comprehensive assessment, how do we mark M1000 regarding Inpatient Facility Discharge in the Past 14 Days? [Q&A ADDED & M number updated 09/09; Previously CMS OCCB 10/07 Q&A #12]

A32.2. M1000 asks if the patient was discharged from an inpatient facility during the past 14 days. In your scenario, you describe a patient who was admitted and discharged from an inpatient facility during the 14 days prior to the completion of the new RFA 1 SOC comprehensive assessment. The inpatient stay would be reported in M1000.

M1000 does not ask you to only report inpatient facility stays that meet the criteria for the OASIS Transfer, i.e. it does not require that the stay in the inpatient facility is for 24 hours or greater for reasons other than diagnostic test. It simply asks whether the patient was discharged from an inpatient facility during the past 14 days

Q32.3. M1000. We are seeing more patients referred to our agency that have been in observation bed status while in the hospital (not admitted). What would be the correct response to M1000 in this case? [Q&A ADDED & M number updated 09/09; Previously CMS OCCB 04/09 Q&A #7]

A32.3. M1000, Inpatient Facility Discharge, is asking from which of the following inpatient facilities was the patient discharged during the past 14 days. If the patient had been admitted to the hospital as an inpatient and was placed under observation, it is considered a hospital discharge. If the patient was placed under observation utilizing one of the two G-codes for hospital outpatient department observation services, then it would not be an inpatient facility discharge and therefore not reportable in M1000.

Q32.8. M1000, M1005 & M1011. Is treatment in the hospital emergency department and discharge home considered an inpatient admission when scoring the OASIS items M1000, M1005 & M1011? [Q&A EDITED/Number updated 04/15; ADDED 12/12; Previously CMS Qtrly 01/12 Q&A #7]

A32.8. Treatment in the hospital's emergency department without admission to an inpatient bed is not considered an inpatient admission and would not be reported as such when answering the OASIS items.

Q33. M1005. In OASIS field M1005, if there is no date, do you just fill in zeros? [Q&A EDITED/Number updated 04/15; M number updated 09/09]

A33. As noted in the skip instructions for item M1000, if the patient was not discharged from an inpatient facility within the past 14 days, (i.e., M1000 has a response of NA), M1005, M1011 and M1012 should be skipped. If the patient was discharged from an inpatient facility during the past 14 days, but the date is unknown, you should mark UK at M1005 and leave the date blank.

Q33.1. M1005. Our patient was confirmed as inpatient status on 11/27/2012. However, on 11/28/2012 his status was changed to outpatient observation. (We have documentation to confirm these dates and change in status.) The patient remained in the facility as "observation" until 12/1/2012. We performed a ROC assessment on 12/2/2012.

What date do we enter in M1005-Inpatient discharge date? Is it 11/28/2012, the day his status went from inpatient to observation or do we use the date he actually left the hospital (i.e., 12/1/2012)?

If we are supposed to use the 11/28/2012 date, will that impact our compliance with

performing a ROC within 48 hours of hospital discharge? [Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 01/13 Q&A #5]

A33.1. The M1005, Inpatient Discharge Date, identifies the date of the most recent discharge from an inpatient facility within the past 14 days. Assuming the patient, in the above scenario, was discharged from the inpatient status and admitted to an outpatient observation status, 11/28/2012 would be the appropriate date to enter into M1005. Clinical documentation will explain the unusual events that led to the non-compliant Resumption of Care date.

(Note that a Transfer would only be required if the patient's inpatient stay was ≥ 24 hours.)

Q34. M1011. How would additional inpatient facility diagnoses and ICD-10-CM codes be entered into M1011 since the field only allows for six sets of codes? When we include this item in our clinical forms, can we add more lines? [Q&A EDITED/Number updated 04/15; EDITED 01/12]

A34. M1011 requests only those diagnoses that were actively treated during the inpatient stay, not all diagnoses that the patient may have. Agencies should carefully consider whether additional information is needed and, if so, include only the most relevant diagnoses in M1011. OASIS items must be reproduced in the agency clinical forms exactly as they are written. If the agency desires additional information, the most appropriate course of action may be to insert an additional clinical record item immediately following M1011.

Q35. M1011. It takes days (sometimes even a week) to get the discharge form from the hospital. How can we complete this item in a timely manner? [Q&A EDITED/Number updated 04/15]

A35. Information regarding the condition(s) treated during the inpatient facility stay has great relevance for the SOC/ROC assessment and for the plan of care. The agency may instruct intake personnel to gather the information at the time of referral. Alternatively, the assessing clinician may contact the hospital discharge planner or the referring physician to obtain the information.

Q36. M1011. Can anyone other than the assessing clinician enter the ICD codes? [Q&A EDITED/Number updated 04/15; EDITED 09/09]

A36. Coding may be done in accordance with agency policies and procedures, as long as the assessing clinician determines the primary and secondary diagnoses and records the symptom control ratings. The clinician should write-in the medical diagnoses requested in M1011, M1017, and M1021/1023/1025, if applicable. A coding specialist in the agency may enter the actual numeric ICD-10 codes once the assessment is completed. The HHA has the overall responsibility for providing services, assigning ICD-10-CM codes, and billing. It is expected that each agency will develop their own policies and procedures and implement them throughout the agency that allows for correction or clarification of records to meet professional standards. It is prudent to allow for a policy and procedure that would include completion or correction of a clinical record in the absence of the original clinician due to vacation, sick time, or termination from the agency.

Q37. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q38 & 39. [Q&A RETIRED 09/09; Outdated]

Q39.1 & 39.2. [Q&A RETIRED 01/12; Outdated]

Q39.3 [Q&A RETIRED 12/12; Added to Ch.3]

Q39.4. M1011 & M1017. Is it appropriate to code only a manifestation diagnosis in M1011, Inpatient Diagnoses and/or M1017, Diagnoses Requiring Medical or Treatment Regimen

Change Within Past 14 Days, if it required active treatment and/or change in medication or treatment in the 14-day timeframe, but its etiology diagnosis did not?

Example - The patient has a diabetic ulcer. ICD-10-CM coding guidelines instruct that this diagnosis be coded as an etiology and manifestation pairing with the diabetes diagnosis immediately preceding the ulcer diagnosis in a diagnosis list. The patient is treated for the ulcer within the 14-day timeframe, but the diabetes remains chronic and stable with no changes. [Q&A EDITED/Number updated 04/15; ADDED 06/14; Previously CMS Qtrly 04/14 Q&A #6]

A39.4. When reporting diagnoses in M1011 Inpatient Diagnoses and/or M1017 Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days, the ICD-10-CM Official Guidelines for Coding & Reporting must be followed. The coding rules state that the etiology (diabetes) code must immediately precede the manifestation (ulcer) code. Both codes are required to convey that care is being provided for a diabetic ulcer.

Q40. M1017. If the patient had a physician appointment in the past 14 days, or has a referral for home care services, does that qualify as a medical/treatment regimen change? [EDITED/Number updated 04/15; M number updated 09/09]

A40. A physician appointment by itself or a referral for home health services does not qualify as a medical or treatment regimen change.

Q41. M1017. If the treatment regimen change occurred on the same day as the visit, does this qualify as within the past 14 days? [EDITED & Number updated 04/15; M number updated 09/09]

A41. A treatment regimen change occurring on the same day as the assessment visit does qualify as occurring within the past 14 days as long as the change occurs prior to the assessment visit/HHA admission.

Q41.1. M1017. Explain when the M1017 Response-Specific Instruction "Mark NA if changes in the medical or treatment regimen were made because a diagnosis improved" applies and give an example. [Q&A EDITED/Number updated 04/15; EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 01/12 Q&A #3; 06/14 edits based on CMS Qtrly 07/13 Q&A #4]

A41.1. M1017 is utilized in the risk adjustment of outcomes. The Ch. 3 Item Intent explains, "The purpose of this question is to help identify the patient's recent history by identifying new diagnoses or diagnoses that have exacerbated over the past 2 weeks. This information helps the clinician develop an appropriate Plan of Care, since patients who have recent changes in treatment plans have a higher risk of becoming unstable."

The intent of the item is not to identify diagnoses where all medical or treatment regimen changes in the last 14 days were related to improvements in a condition. If at any time in the last 14 days the patient requires a medical or treatment regimen change due to development of a new condition or lack of improvement or worsening of an existing condition, the diagnosis should be reported in M1017, even if the condition also showed improvement or stabilization during that time, or is improved at the time of the SOC/ROC.

Q42. [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat. 4b, Q&A #40.]

Q42.1. [Q&A RETIRED 09/09; Outdated]

Q42.2. M1017. If physical therapy (or any other discipline included under the home health Plan of Care) was ordered at Start of Care (SOC) and discontinued during the episode, does this qualify as a service change for M1017 at the Resumption of Care (ROC) data

collection time point? I understand that the referral and admission to home care does not qualify as a med/tx/service change for M1017. [Q&A EDITED/Number updated 04/15; EDITED 06/14; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #13]

A42.2. Physical therapy (or any other discipline) ordered at SOC and then discontinued during the episode, may qualify as a service change for M1017 at the ROC data collection time point as long as the reason for discontinuation was not solely due to improvement in the diagnosis.

You are correct that referral and admission to home care does not “count” as a medical or treatment regimen change. This means that all home care services or treatments ordered at SOC/ROC would not “count” for M1017, but would thereafter, if there was a change that was not due to an improvement in the diagnosis.

Q43. M1017. For the medical diagnosis in the changed medication section at OASIS item M1017, does this need to be the current diagnosis we are seeing the patient for, or a diagnosis that is specific for the medication? [Q&A EDITED/Number updated 04/15; EDITED 06/14]

A43. Item M1017 identifies the diagnosis(es) causing a change to the patient's treatment regimen, health care services, or medication within the past 14 days that was not due to solely improvement in their diagnosis. The ICD-10-CM code can be a new diagnosis or an exacerbation of an existing condition that is specific to the changed medical or treatment regimen. Also note that this item is not restricted to medications, but refers to changes in medical or treatment regimen.

Q43.1. [Q&A RETIRED 09/09; Outdated]

Q43.2. M1018. How is intractable pain defined for this item? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #5]

A43.2. Intractable pain occurs at least daily, it is not easily relieved, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity. Intractable pain, as reported in Response 3 of M1018, should refer to pain that is not relieved by ordinary medical, surgical, and nursing measures. The pain is often chronic and persistent and can be psychogenic in nature.

Q43.3. M1018. When answering M1018, if client has a nephrostomy tube do you mark indwelling/suprapubic catheter? [Q&A ADDED 12/12; Previously CMS Qtrly 10/12 Q&A #3]

A43.3. If the nephrostomy tube is utilized for urinary drainage, it is an indwelling catheter, therefore Response 2 – Indwelling/suprapubic catheter would be selected.

Q44. [Q&A RETIRED 06/14; Outdated]

Q44.1. M1021, M1023 & M1025. During a supervisor's audit of a SOC assessment, the auditor finds a manifestation code listed as primary without the required etiology code reported. Can this be considered a “technical coding error”, and can the agency follow their correction policy allowing the agency's coding expert to correct the non-adherence to multiple coding requirements mandated by the ICD-10-CM coding guidelines, without conferring with the assessing clinician? [Q&A EDITED/Number updated 04/15; EDITED 06/14; ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #14]

A44.1. The determination of the primary and secondary diagnoses must be completed by the assessing clinician in conjunction with the physician. If the assessing clinician identifies the diagnosis that is the focus of the care and reports it in M1021, and ICD-10-CM coding guidelines required that the selected diagnosis is subject to mandatory multiple coding, the addition of the etiology code and related sequencing is not a technical correction because a

diagnosis is being added. If any diagnosis is being added, in this case for etiology/manifestation coding requirements, the assessing clinician must be contacted and agree.

If, based on the review of the comprehensive assessment and plan of care, the auditor questions the accuracy of the primary diagnosis selected by the assessing clinician, this is not considered a “technical error” and the coding specialist may not automatically make the correction without consulting with the assessing clinician.

If after discussion of the etiology/manifestation coding requirement between the assessing clinician and the coding specialist, the assessing clinician agrees with the coding specialist or auditor that the sequence of the diagnosis codes should be modified to more accurately reflect the diagnosis that is most related to the current POC per ICD-10-CM coding guidelines, agency policy will determine how (e.g., by whom) this change is made.

Q44.1.5. M1021, M1023, M1025 & M1011. Can anyone other than the assessing clinician enter the ICD codes? [Q&A EDITED/Number updated 04/15; EDITED 06/14]

A44.1.5. Coding may be done in accordance with agency policies and procedures, as long as the assessing clinician determines the primary and secondary diagnoses and records the symptom control ratings. The clinician should write-in the medical diagnoses requested in M1011, M1017, and M1021/1023/1025, if applicable. A coding specialist in the agency may enter the actual numeric ICD-10-CM codes once the assessment is completed. The HHA has the overall responsibility for providing services, assigning ICD-10-CM codes, and billing. It is expected that each agency will develop their own policies and procedures and implement them throughout the agency that allows for correction or clarification of records to meet professional standards. It is prudent to allow for a policy and procedure that would include completion or correction of a clinical record in the absence of the original clinician due to vacation, sick time, or termination from the agency.

Q44.2. M1021 & M1023. Is it true that you can never change M1021 or M1023 from the original POC (cert) until the next certification? [Q&A EDITED/Number updated 04/15; EDITED 06/14; Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #13]

A44.2. Guidance in Chapter 3 of the current OASIS Guidance Manual, M1021/1023/1025, 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, M1023 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.”

M1021, Primary Diagnosis and M1023, 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.

Q44.2.1 M1023. Regarding OASIS-C2 data set and M1023 Secondary Diagnoses: Please clarify if we should list diagnoses that affect the patient's responsiveness to treatment and rehabilitative prognosis even if the condition is not the focus of any home health treatment itself. [Q&A ADDED 10/16; Previously CMS Qtrly 07/15 Q&A #1]

A44.2.1 Yes, when determining secondary diagnoses, the assessing clinician should consider diagnoses that are actively addressed in the Plan of Care as well as diagnoses that affect the patient's responsiveness to treatment and rehabilitative prognosis even if the condition is not the focus of any home health treatment itself.

Q44.3. [Q&A RECALLED 09/09]

Q44.4. M1025. Can ICD-10-CM codes that are case mix codes be placed in M1025 on any OASIS which is a Non-PPS Payer? (Example: Medicaid HMO) [Q&A EDITED/Number updated 04/15; ADDED & EDITED 01/10; Previously CMS OCCB 04/08 Q&A #6]

A44.4. M1025 is an optional item and an agency is not required to complete it. When an agency chooses to complete M1025, the general OASIS data collection instruction states "agencies may choose to report an underlying condition in M1025 when a Z code is reported in Column 2 and the underlying condition for the Z code in Column 2 is a resolved condition". M1025 is optional, and may be completed for any assessment, including for payers other than Medicare PPS.

Q44.5. M1025. Is there any regulation that would prohibit the use of applying diagnostic codes to M1025 on our Non-MC or non-PPS OASIS patients when any Z code replaces a diagnostic code? [Q&A EDITED/Number updated 04/15; ADDED & M numbers updated 09/09; Previously CMS OCCB 07/09 Q&A #5]

A44.5. M1025, Optional Diagnoses, is just that – an optional item. It is intended to provide the agency with the opportunity to document a resolved underlying condition, if a Z code is reported as a primary or secondary diagnosis in M1021/M1023, when the underlying condition is no longer active. There is no regulation that prohibits completing M1025 for private pay patients when a Z code replaces a diagnostic code that describes a resolved condition.

Q44.6. [Q&A RETIRED 04/15; Obsolete with ICD-10-CM]

Q45 & 46. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q46.1.M1028. For M1028 (Active Diagnosis) and other IMPACT ACT added items, what do I record on the paper instrument if I could not assess or did not have the information at the time of the assessment? I realize I would submit a dash (-) in the electronic submission. I understand the circumstances in which a dash is appropriate per the Guidance Manual. So I don't need any guidance of when to use the dash. However, there is NO dash on the paper instrument. I would feel uncomfortable submitting something electronically that does not appear on the paper instrument. So, which takes precedence? The paper instrument, which does NOT allow a dash, OR the electronic data specs which allow a dash? [Q&A ADDED 10/16; Previously CMS Qtrly 10/16 Q&A #5]

A46.1.For OASIS items that allow the dash (–) as a valid option, the clinician should enter a dash in the applicable box on the agency's paper or electronic assessment. CMS expects dash use to be a rare occurrence.

Q46.2.M1028. Regarding M1028, the way M1028 is displayed on the instrument, you either check box 1 (patient has PVD/PAD) or check box 2 (patient has diabetes) or check both boxes (patient has both PVD/PAD and diabetes) or check neither box (patient has neither

PVD/PAD nor diabetes). If my clinician leaves both boxes unchecked, how am I to know whether she truly assessed the patient (and the patient has neither diagnosis) or she just forgot to answer this question? All the other "Mark all that apply" items in the instrument have an "out", like a "None of the Above", but this item does not. [Q&A ADDED 10/16; Previously CMS Qtrly 10/16 Q&A #6]

A46.2. The current guidance for completion of M1028 directs the clinician to select a response if the condition is an active diagnosis or to use a dash if the information is not available or could not be assessed.

If the assessment is completed and it is determined that the patient does not have a diagnosis of diabetes, PVD, or PAD, both boxes should be left unchecked. Implementation of documentation or auditing strategies to ensure accurate completion of the comprehensive assessment are at the discretion of your organization.

Q46.3.M1028. Regarding M1028, according to the OASIS-C2 Guidance Manual, if information regarding active diagnoses is learned after the M0090 Assessment Completed Date, the OASIS Data Set should not be revised to reflect this new information. The OASIS Data Set should reflect what was known and documented at the time of the assessment.

Does the assessment timeframe (e.g., 5 days at SOC) apply in this situation? The patient referral states that the patient is pre-diabetic. On the third day (still within the 5 days for the assessment) new information is received that the patient is being considered diabetic and orders are received. Can M1028 be changed based on this new information? Or should it not be changed because information was obtained after the admission? [Q&A ADDED 10/16; Previously CMS Qtrly 10/16 Q&A #7]

A46.3. Each assessment type has a defined timeframe for completion as specified in Appendix A of the OASIS Guidance Manual. Information collected by the assessing clinician during the timeframe for the specified assessment type should be documented and M0090 Date Assessment Completed would reflect the date when the final assessment data are collected.

In the scenario cited, if the clinician confirmed the diagnosis of diabetes during the assessment timeframe and before the assessment was completed, reporting M1028 Active Diagnoses as Response 2 – Diabetes Mellitus (DM) would be appropriate.

Q46.4.M1028. In M1028, I need clarification on the term "active diagnoses." Specifically, when would a diagnosis of DM, PAD or PVD that is reported in M1021 or M1023 not be reported in M1028 as well? Are active interventions (treatments) on the POC required, or is it enough that the diagnosed condition justifies general monitoring/assessment? For example, a patient is admitted to home health for physical therapy s/p total hip arthroplasty. The patient is also a type 2 diabetic. Her diabetes is controlled by her diet & she is independent with monitoring her blood sugars. She is knowledgeable about diabetic foot care & checks her own feet daily using a mirror. Because her change in activity could affect her blood sugar levels and because the diabetes could affect her ability to heal from her surgery, DM meets the selection criteria for a secondary diagnosis and would be reported in M1023. While the PT will be monitoring the patient holistically to identify problems and modify the plan of care as appropriate with physician collaboration, the PT orders do not list any active interventions related to her DM. Should DM be reported in M1028 as an Active Diagnosis? [Q&A ADDED 10/16; Previously CMS Qtrly 10/16 Q&A 8]

A46.4. "Active diagnoses" are diagnoses that have a direct relationship to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment. Diseases or conditions that have been resolved are not included for M1028.

In the scenario cited, it is stated that the patient has a diagnosis of diabetes which could be affected by the patient's currently limited mobility, and/or could impact the healing of the patient's surgical incision(s). The home health provider's monitoring of the patient/wound healing with specific knowledge that the patient is a diabetic, would make diabetes an active diagnosis for this patient.

Q46.5.M1028, M1021, M1023. Is it possible that DM, PAD or PVD would be identified as an Active Diagnosis in M1028 but not be included as a primary or secondary diagnosis in M1021 or M1023? For example, a patient is referred to home health for speech language pathology interventions related to her dysphagia. The patient also has PAD which is documented in the patient's medical history. However, the PAD, while identified in the physician's summary/notes, does not meet the selection criteria for inclusion as a primary or secondary diagnosis as the SLP has no interventions related to the patient's PAD nor is it felt to have an impact on the patient's prognosis related to her dysphagia. Should the PAD be reported in M1028? [Q&A ADDED 10/16; Previously CMS Qtrly 10/16 Q&A #9]

A46.5. In the scenario cited, you ask if it is possible for DM, PAD or PVD to be considered an Active Diagnosis in M1028, but not be reported as a primary (M1021) or other (M1023) diagnosis. In the scenario cited, while the patient has the diagnosis of PAD, the clinician is determining that the PAD is not the chief reason for home health services (not the primary diagnosis), and is not a comorbid condition that is addressed in the plan of care, and isn't felt to have the potential to affect the patient's responsiveness to treatment (not a secondary diagnosis). Therefore, for this patient, PAD does not appear to have a direct relationship to the patient's current functional, cognitive, mood or behavior status, medical treatment, nurse monitoring or risk of death at the time of assessment, and therefore would not be reported as an Active Diagnosis in M1028.

Note that OASIS item M1023 provides space for the listing of up to 5 Other (secondary) diagnoses. If DM, PAD or PVD were considered to be a comorbid condition that is addressed in the plan of care, with the potential to affect the patient's responsiveness to treatment, then it would be considered an active diagnosis in M1028, even if it ends up not being listed in M1023, due to the limited number of coding spaces available in the OASIS.

Q47. M1030. Does an IM or SQ injection given over a 10-minute period "count" as an infusion?

A47. No, this injection does not "count" as infusion therapy.

Q48. M1030. If the patient refuses tube feedings, does this "count" as enteral nutrition? [Q&A EDITED 08/07]

A48. If the patient's refusal has resulted in the patient not receiving enteral nutrition on the day of the assessment, Response 3 would not be appropriate at the time of the assessment. The refusal of the tube feedings would be noted in the clinical record. Flushing the feeding tube does not provide nutrition.

Q49. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q50. M1030. Do therapies provided in the home have to be documented in the clinical record? [Q&A EDITED 06/14]

A50. It seems clear that any of the therapies identified in M1030 (IV/infusion therapy, parenteral nutrition, enteral nutrition) would be acknowledged in the comprehensive assessment and be noted in the Plan of Care. Even if the family or caregiver manages the therapies completely independently, the clinician is likely to evaluate the patient's nutritional or hydration status, signs of infection, etc. It is difficult to conceive of a situation where the answer to this question would be "no."

Q51. M1030. Does M1030 relate to other OASIS items? [Q&A EDITED & M number updated 06/14]

A51. Note the subsequent item of M2102e. (Types and Sources of Assistance), which addresses IV/infusion therapy and enteral/parenteral equipment or supplies.

Q52. [Q&A RETIRED 01/11]

Q53. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q53.1. M1030. When a patient has a G-tube (NG-tube, J-tube, and PEG-tube) and it is only utilized for medication administration, do you mark Response 3, Enteral nutrition for M1030, Therapies? [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #15]

A53.1. No, M1030 Response 3 captures the administration of enteral nutrition. Medication administration alone is not considered nutrition.

Q53.2. M1030. When a patient has a feeding tube and it is only utilized for the administration of water for hydration (continuous or intermittent), do you mark Response 3, Enteral nutrition for M1030, Therapies? [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #16]

A53.2. No, M1030 Response 3 captures the administration of enteral nutrition. Hydration alone is not considered nutrition.

Q53.3. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q53.4. M1030. A patient has a Hickman catheter and is receiving TPN over 12 hours. At the beginning of the infusion, the line is flushed with saline and at the end of the infusion, it is flushed with saline and Heparin. For M1030, do you mark both 1 and 2? [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #18]

A53.4. When the patient is receiving intermittent parenteral therapy at home and requires a pre- and post-infusion flush, it is not appropriate to mark Response 1, Intravenous or infusion therapy (excludes TPN), in addition to Response 2, Parenteral nutrition (TPN or lipids). The flushing of the line for intermittent parenteral therapy is considered a component of the parenteral therapy.

Q53.4.1. M1030. How do I score M1030, Therapies at home, if the patient has a multi-lumen central line and is receiving continuous TPN through one lumen and the other two lumens are flushed daily to maintain patency of the line? [Q&A ADDED 01/12; Previously CMS OCCB 04/11 Q&A #3]

A53.4.1. If there had only been one lumen, you would have followed the guidance in the CMS OASIS Category 4b Q&A 53.4 and reported "Response 2 – Parenteral nutrition" only. Since

there are two additional lumens that are ordered to be flushed to maintain patency, you would mark both “Response 1 - IV or infusion therapy” and “Response 2 - Parenteral nutrition.”

Q53.5. M1030. 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?” [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 05/07 Q&A #14]

A53.5. 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.

Q53.6. M1030. 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 M1030? [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/07 Q&A #5]

A53.6. When a patient is receiving an infusion at home, M1030 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, M1030 would be marked "1" at SOC.

Q53.6.1. M1030 & M1340. Our patient has a “Mammosite”, a device implanted in her lumpectomy site. She receives radiation bead insertion through this catheter. It requires a sterile dressing change daily. Is this device a surgical wound for M1340 and M1342? Is this an infusion device for M1030? [Q&A ADDED 12/12; Previously CMS Qtrly 07/12 Q&A #3]

A53.6.1. Based on the details provided in the question, the incision created to insert the balloon catheter is considered a surgical wound in OASIS. Utilize existing CMS guidance to determine the healing status.

MammoSite® breast brachytherapy (balloon catheter radiation) is a type of accelerated breast radiation treatment. Since the saline and radiation seed remains in the balloon catheter, it is not an infusion and would not be reported in M1030, Therapies at home.

Q53.7. M1030. For M1030, is Pedialyte, an electrolyte based drink, considered enteral nutrition? [Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 10/07 Q&A #14]

A53.7. M1030, Response 3 is selected when the patient receives enteral nutrition while in the home. Oral electrolyte maintenance solutions, such as Pedialyte, are administered to prevent dehydration and are not designed to act as nutrition. Response 3 would not be selected unless other forms of enteral nutrition are being administered in the home.

Q53.8. M1030. Is medication administered via the transdermal route considered an infusion (Response 1) for M1030, Therapies at Home? [Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 01/08 Q&A #18]

A53.8. A transdermal medication is absorbed through the skin and should not be considered an infusion for M1030, Therapies the patient receives at home. M1030 Response 1 IV or infusions

involve a therapeutic drug or solution that is administered via an infusion device, including a needle flush, implanted or external pump, or other infusion device, such as an eclipse bulb.

Q53.8.1. M1030. Are insulin and morphine pumps captured in M1030, Therapies at Home? [Q&A Edited 04/15; ADDED 01/12; Previously CMS OCCB 07/11 Q&A #9]

A53.8.1. A pump infusing medication while the patient is at home is reported as Response 1 in M1030, Therapies at home. This is true whether it is an infusion via an implanted device or an infusion via an external pump.

Q53.8.2. M1030. Our patient is not presently undergoing peritoneal dialysis and there is an order to flush the peritoneal dialysis catheter daily to maintain patency. Is the flush considered an infusion for purposes of M1030? [Q&A ADDED 12/12; Previously CMS Qtrly 01/12 Q&A #4]

A53.8.2. Yes. If the patient has a peritoneal dialysis catheter and there is an order to flush it while in the home to maintain patency, M1030 Response 1 is appropriate.

Q53.8.3. M1030. Our patient has a Tenckhoff peritoneal dialysis catheter that instead of being used for peritoneal dialysis, is being used to drain ascites and then being flushed after drainage is complete. Since flushing a PD catheter while PD is on hold counts for Response 1- IV or infusion therapy, can we report the flush of this catheter in M1030, Therapies at Home? [Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 01/14 Q&A #3]

A53.8.3 No, flushing tubes utilized for drainage of urine, ascites and other wound drainage does not count as an infusion when scoring M1030.

Q53.8.4 M1030. Should flushing of a biliary tube with normal saline be reported on M1030 – Therapies received at home? [Q&A ADDED 10/16; Previously CMS Qtrly 01/16 Q&A #3]

A53.8.4 The flushing of catheters/tubes utilized for infusion therapy are considered for M1030. Flushing a biliary tube used for bile drainage would not be considered a catheter/tube used for infusion, therefore flushing the biliary tube would not be reported on M1030.

Q53.9. M1030, M2020, M2102e. I have a patient who has just started chemotherapy with IV access present. She is unable to take oral medications or food and has a gastrostomy tube that is being flushed with water to maintain patency. The patient is scheduled to return to the physician in two weeks for further assessment and to obtain enteral nutrition orders. How do I score M1030, M2020, M2102 at SOC? [Q&A EDITED 04/; M number updated 06/14; ADDED 09/09; Previously CMS OCCB 07/09 Q&A #6]

A.53.9. M1030, Therapies at Home - If the patient's IV access for the chemotherapy was ordered to be flushed in the home, Response 1 would be appropriate, otherwise it would be 4- None of the above, as the patient is not receiving one of the listed therapies at home.

M2020, Management of Oral Medications, would be NA-No oral medications prescribed.

M2102, Types and Sources of Assistance, e. Management of Equipment - Even though the patient's g-tube is only being flushed with water to maintain patency until the feeding is ordered, the patient/cg must maintain the enteral nutrition equipment, so it would be appropriate to assess and report the level of caregiver ability and willingness to provide assistance with managing the equipment.

Q53.10. M1030. Since the flush of a peritoneal dialysis catheter to maintain patency counts for M1030, Therapies at Home, would the flush of a nephrostomy tube to maintain

patency also be considered infusion therapy? [Q&A ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #12]

A53.10. No, flushing catheters utilized for urinary drainage is not included when scoring M1030, Therapies at Home.

Q53.11. M1030. If a patient removes the q-pump on the day of our admission assessment, how is M1030 answered if we assume the q-pump was infusing medication just prior to the point of removal? [Q&A ADDED 04/15; Previously CMS Qtrly 07/14 Q&A #1]

A53.11. M1030, Therapies at home, identifies if the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy at home, whether or not the home health agency is administering the therapy.

If, on the day of assessment (24 hours preceding the visit and time spent in home for the visit), there was an ongoing order for the infusion and the patient was receiving or will begin receiving the medication infusion in the home, Response 1 would be appropriate. You cannot make assumptions though, that the patient was receiving the infusion. The patient/caregiver would need to confirm that it was infusing while in the home during the 24 hours prior to the assessment.

Q54 & 55. [Q&A RETIRED 09/09; Outdated]

Q55.0.1. M1033. When a clinician is responding to M1033, how should exhaustion be defined? Does this refer to mental or physical exhaustion, or both? [Q&A ADDED 04/15; Previously CMS Qtrly 04/15 Q&A #1]

A55.0.1. M1033. The assessing clinician may consider both physical and/or mental exhaustion when responding to M1033. Note that the information can be gathered by report, and refers to the patient's "current" (day of assessment) status.

Q55.1. M1036. In answering M1036 Risk Factors, what does CMS consider "drug dependency" (response 4)? A consultant instructed our agency to interpret it to mean any drugs that the patient is dependent on. The consultant then commented that response 4 should be marked for most patients. The specific example in the reviewed chart was a patient who was very dependent on all of their respiratory drugs. We previously interpreted this to mean dependency on illegal drugs. Please clarify. [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 01/09 Q&A #8]

A55.1. Chapter 3 of the current OASIS Guidance Manual defines the intent of M1036, "Identifies specific factors that may exert a substantial impact on the patient's health status response to medical treatment, and ability to recover from current illnesses, in the care provider's professional judgment." The intent of the item is not to address those medications/drugs that the individual takes/consumes/administers to achieve a therapeutic effect, such as insulin, blood pressure medication, cardiac arrhythmia medication, respiratory medication, etc. It is also necessary to acknowledge that situations can occur where the once-therapeutic use of medication becomes a true dependency situation, e.g. pain medications.

Q56, 57, 57.1, 57.2, 58, 59, 60, & 61. [Q&A RETIRED 09/09; Outdated]

Q62. [Q&A RETIRED 08/07]

Q62.1, 62.2, 62.2.1. [Q&A RETIRED 06/14; No longer relevant]

Q62.2.2. M1041. When completing M1041, Influenza Vaccine, what response option is correct if we gave the flu vaccine on Sept. 15th and there was a Transfer date (M0906) of Sept. 30th, but the date the Transfer OASIS was completed (M0090) was Oct. 2nd? [Q&A EDITED; ADDED & Number Updated 06/14; Previously CMS Qtrly 04/14 Q&A #7]

A62.2.2. Patients that did not receive care, (or have any days of their care episode occur) between October 1 and March 31 are excluded from the computation of the Influenza process measures. The care episode begins with M0030/M0032 SOC/ROC date and ends with the Discharge/Transfer Date, M0906. In your scenario, the appropriate response for M1041, Influenza Vaccine Data Collection Period, would be "0 – No [Go to M1051]" because the patient transferred to the inpatient facility (M0906) on September 30th.

Q62.3. M1046. What is the appropriate response for M1046, Reason Influenza Vaccine not received, in a case where the patient states his physician told him not to get the vaccine during the 6 week period post joint replacement surgery? Joint replacement surgery is not listed at the CDC website as a medical contraindication for administration of the influenza vaccine. [Q&A EDITED & M number updated 06/14; ADDED 01/12; Previously CMS OCCB 01/11 Q&A #5]

A62.3. If the assessing clinician confirmed the fact that the physician medically restricted the patient from receiving the vaccine for any reason, the appropriate response for M1046 would be "5 - Assessed and determined to have medical contraindication(s)".

Q62.4. M1046. How would we score M1046 in the following situation? Patient has a SOC date of September 1 and receives the influenza vaccine from the home health agency on September 20. The patient remains on service for several subsequent episodes and is discharged from the agency the following June 15.

How would we score M1046 if the patient remained on service into the next "current flu season"? For example, the patient was admitted September 1, 2014, the vaccine was given September 15, 2014 and the patient was discharged on October 1, 2015, the following year, without having a flu vaccine for the 2015/2016 flu season.

Does the March 31 date serve as an official "end date" when determining current flu season? When answering M1046 at Transfer/Discharge, is there a point in time that we move from "this year's" flu season to the next year's flu season as we consider the period of time following SOC/ROC? [Q&A ADDED, EDITED & M number updated 06/14; Previously CMS Qtrly 01/13 Q&A #6]

A62.4. M1046, Influenza Vaccine Received, is not answered unless the patient received services from the home health agency during the time period for which influenza vaccine data are collected (October 1 and March 31).

The current flu season is established by the Centers for Disease Control (CDC). Each year, flu vaccine manufacturers only release the vaccine per CDC recommendations. Therefore, when the flu vaccine is available for administration in late summer or early fall, it signals the beginning of the current flu season. The end of the flu season is generally considered March 31st.

If the patient was on service during the October 1 through March 31 data collection time frame and the flu vaccine was given by the agency after the typical end of flu season, March 31st,

M1046 would be answered "1-Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)". For example, patient admitted January 1, 2015, the flu vaccine was administered by the agency April 2, 2015, and patient was discharged June 10, 2015.

If a patient's quality episode began during the flu season, as determined each year by the CDC, and ended well beyond the typical end of flu season, March 31st, the agency would answer M1046 "1-Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)" if the patient received the flu vaccine from the agency during the quality episode. For example, SOC date September 1, flu vaccine administered September 20th, discharged June 15th.

If a patient's quality episode overlaps more than one influenza season, M1046 should be answered based on whether or not the agency gave the influenza vaccine for the current flu season, e.g. Patient admitted January 1, 2014 and discharged October 10, 2014. M1046 would be answered "1-Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)" if the agency gave the flu vaccine for the flu season that was current at the time of discharge, in this case, the one that began in the fall.

If a patient's quality episode overlaps more than one influenza season and the agency gave the vaccine for the past flu season, but not the current flu season, one of "No" responses would be appropriate. For instance, patient admitted January 1, 2014, and the influenza vaccine was given by the agency January 5th, 2014 (2013/2014 flu season), and discharged October 10, 2014. No influenza vaccine was given between the beginning of the 2014/2015 flu season and discharge. M1046 would be answered with one of the five "No" responses.

Q62.4.1. M1046. Chapter 3 guidance states “You may select Response 2 if a current patient was given a flu vaccine by your agency during a previous roster billing situation during this year’s flu season”. Is this still true, now that the Response 2 language in the OASIS-C1 item M1046 has been changed to specifically state that your agency gave the vaccine during a prior episode of care (SOC/ROC to Transfer/Discharge)? [Q&A ADDED 04/15; Previously CMS Qtrly 07/14 Q&A #3]

A62.4.1. The M1046 Response 2 – “Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)” should be used if prior to the individual becoming a patient of the agency, the agency gave the individual the vaccine for the current flu season, as in a roster billing situation during a community flu clinic event, etc.

Q62.5. M1046, M1051 & M1056. Due to state law and/or agency policies, some home health staff may not be allowed to transport meds (including vaccines)? Patient and/or the family members might need to pick the vaccine up for the agency to administer. How would the agency get credit for these outcome measures? [Q&A EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #5]

A62.5. The process measures describing the best practice gives credit not only when the agency provides the immunization(s) (regardless of who transports the vaccine to the patient's home), but the agency also may get credit by facilitating the patient's receipt of the immunization through other health care providers. This facilitation will be represented in M1046 and M1056, and computation of these related process measures will rely on both M1041 and M1046 (for influenza) and M1051 and M1056 (for pneumonia).

Q62.5.1.M1046, M1051, M1056. When the patient and caregiver cannot remember if flu or pneumococcal vaccinations had been received, what response should be selected for M1046 – Influenza Vaccine Received, M1051 – Pneumococcal Vaccine, and M1056 –

Reason Pneumococcal Vaccine not Received? [Q&A ADDED 04/15; Previously CMS Qtrly 01/15 Q&A #5]

A62.5.1. OASIS data are collected using a variety of strategies, including observation, interview, review of pertinent documentation (for example, hospital discharge summaries), discussions with other care team members where relevant (for example, phone calls to the physician to verify diagnoses), and measurement (for example, intensity of pain). In the scenarios provided, the patient and caregiver do not remember if the patient received the vaccination, the assessing clinician should employ other assessment strategies to obtain the needed information, such as, review of the medical record for history and physical information and communication with the physician.

If the assessing clinician is unable to determine whether the patient received the influenza and/or pneumococcal vaccination, the OASIS items would reflect the following negative responses:

M1046 Influenza Vaccine Received: Response 8 – No, patient did not receive the vaccine due to reasons other than those listed in Responses 4-7

M1051 Pneumococcal Vaccine: Response 0 – No

M1056 Reason Pneumococcal Vaccine not received: Response 4 – None of the above

Q62.6. M1056. Has the CDC updated the recommended age/condition guidelines for pneumovax administration that should be considered for M1056 - Reason Pneumococcal Vaccination not received? [Q&A EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB 10/10 Q&A #5]

A62.6. In September 2010, the CDC and the Advisory Committee on Immunization Practices provided the most substantial update since 1997 for pneumococcal vaccine administration. The important changes are that persons ages 18-64 with asthma or those who smoke are included in the groups for whom routine administration of the pneumococcal vaccine is recommended. Those removed from routine pneumococcal vaccination include American Indians and Alaska Natives age < 65 unless they have a condition that qualifies them for the pneumococcal vaccine. The recommendations regarding those age 65 and older and re-vaccination were not changed.

Each agency should have a process in place that ensures their clinicians are knowledgeable regarding current recommendations. More detailed information on the risk groups for whom vaccination is recommended is available from the CDC: <http://www.cdc.gov/vaccines/vpd-vac/pneumo/default.htm>

Q62.7. M1056. How do we answer M1056, Reason Pneumococcal Vaccination not received, when the physician ordered us not to administer it for reasons not included in the CDC's list of medical contraindications? [Q&A ADDED, EDITED & M number updated 06/14; Previously CMS Qtrly 04/13 Q&A #2]

A62.7. If the assessing clinician confirmed the fact that the physician medically restricted the patient from receiving the vaccine for any reason, the appropriate response for M1056 would be "2 - Assessed and determined to have medical contraindication(s)".

Q62.8. M1056. If your agency does not immunize patients, would the answer to M1056, Reason Pneumococcal Vaccination not received, always be "4-None of the above"? What if another provider offered and the patient refused, could we select Response "1- Offered and declined"? [Q&A ADDED, EDITED & M number updated 06/14; Previously CMS Qtrly 07/13 Q&A #5]

A62.8. It is not required that the agency offer to administer the pneumococcal vaccine in order to select "1-Offered and declined", only that the patient was offered the vaccine by any healthcare provider and he/she refused. All response options are available for selection regardless of whether or not the agency immunizes their patients.

Q62.9.M1060. For the new OASIS item M1060, can the agency gather the patient's height and weight by patient/caregiver report? M1060a requests most recent height measure since SOC/ROC, but M1060b allows most recent weight measurement in last 30 days. So does that mean that height must be actually measured after the home health admission, but weight can be entered based on hospital discharge paperwork documented within the last 30 days? Can we ask the patient or caregiver the patient's height and/or weight? [Q&A ADDED 10/16; Previously CMS Qtrly 10/16 Q&A 10]

A62.9. The assessing clinician should measure the patient's height and weight in accordance with the agency's policies and procedures, which should reflect current standards of practice (shoes off, etc.). The assessing clinician is expected to weigh and measure the patient as part of the comprehensive assessment. Data collection for M1060 by self-report or from paperwork from another provider setting is not acceptable. If a patient cannot be weighed/measured, enter the dash value ("–") and document the rationale on the patient's medical record. A dash (–) value indicates that no information is available and /or an item could not be assessed. CMS expects dash use to be a rare occurrence.

Q62.9.1.M1060. For the new OASIS item M1060, can the agency gather the patient's height and weight by patient/caregiver report? M1060a requests most recent height measure since SOC/ROC, but M1060b allows most recent weight measurement in last 30 days. So does that mean that height must be actually measured after the home health admission, but weight can be entered based on hospital discharge paperwork documented within the last 30 days? Can we ask the patient or caregiver the patient's height and/or weight? [Q&A ADDED 10/16; Previously CMS Qtrly 10/16 Q&A 11]

A62.9.1. The assessing clinician should measure the patient's height and weight in accordance with the agency's policies and procedures, which should reflect current standards of practice (shoes off, etc.). The assessing clinician is expected to weigh and measure the patient as part of the comprehensive assessment. Data collection for M1060 by self-report or from paperwork from another provider setting is not acceptable. If a patient cannot be weighed/measured, enter the dash value ("–") and document the rationale on the patient's medical record. A dash (–) value indicates that no information is available and /or an item could not be assessed. CMS expects dash use to be a rare occurrence.

Q63. [Q&A RETIRED 09/09; Duplicative of Q&A #64.2]

Q63.1. M1100. My patient lives in an Assisted Living Facility with her spouse and it is the spouse who requires the facility's assistance, not my patient. The facility is not contracted to provide any level of assistance to my patient, only the husband. How do I report her living arrangement in M1100? [Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #10]

A63.1. Report the patient's living arrangement as "c. Patient lives in congregate situation (e.g., assisted living)" because she is living in the ALF. The availability of assistance selected should be determined using instructions from the OASIS Item guidance.

Q63.2. M1100. To select a response for M1100, should an agency request to see the ALF contract to determine availability of assistance? [Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #11]

A63.2. For M1100, a response from row C should be selected for a patient living in an assisted living setting. This would be true regardless of the services provided to the patient. To determine the frequency of availability of assistance, the clinician may refer to the ALF service contract or may gather information from the patient or family.

Q63.3. M1100. Does the rule that the availability of a call bell equates to "around the clock care" apply only to the ALF setting, or if one is available in congregate housing would the availability of assistance in that situation also be reported as around the clock availability of assistance as well? [Q&A ADDED 01/11; Previously CMS OCCB 01/10 Q&A #6]

A63.3. If, in a congregate housing situation, the patient has available in-person assistance in response to a call bell 24 hours a day, the correct answer would be "around the clock."

Q63.4. M1100. How do you answer M1100, Patient Living Situation, when the patient lives with their family member and the family member is being paid to care for the patient, either by the patient or by a state funded program? [Q&A ADDED 01/11; Previously CMS OCCB 01/10 Q&A #8]

A63.4. When answering M1100, Patient Living Situation, if a patient lives with their family, Row b., Patient lives with other person(s) in the home, would appropriately depict their living arrangement, even if the patient pays their family member to provide care or the family member is being paid through another source, e.g. another family member or state funded program.

Q63.5. M1100. How do we answer M1100, Patient Living Situation, when the patient lives with the daughter, but the patient stays in an adult day care center during the day while the daughter works? [Q&A ADDED 06/14; Previously CMS Qtrly 01/13 Q&A #7]

A63.5. In M1100, "availability of assistance" refers to in-person assistance provided in the home of the patient. If the daughter leaves the home to work during the day, but plans to be there for all the nighttime hours for the entire upcoming episode of care (with infrequent exceptions), "8-Patient lives with another person with Regular nighttime assistance" would be appropriate. If the daughter is gone some nights or not present all the hours of the nighttime, "9-Occasional/short-term assistance" would be appropriate.

Assistance provided outside the home is not reported in M1100.

Q63.6. M1100. My patient lives in the independent apartments section of a large continuum of care complex. No personal care or nursing care is included in the rent, but the patient does receive housekeeping weekly, meals and someone onsite will go to their

room if they pull the call cord. They cannot assist them off the floor if they have fallen, only call 911. What is my patient's living situation when scoring M1100? [Q&A ADDED 04/15; Previously CMS Qtrly 07/14 Q&A #4]

A63.6. M1100, Response-specific instructions state "Select a response from Row c if the patient lives in an "assisted living" setting (assistance, supervision and/or oversight are provided as part of the living arrangement). For example, the patient lives alone or with a spouse or partner in an apartment or room that is part of an assisted living facility, residential care home, or personal care home."

In the large care continuum complexes, the patient is living in an congregate setting when "assistance, supervision and/or oversight are provided as part of the living arrangement." This is true even if, as described above, they are in an independent cottage or an independent apartment and they are getting services, like meals, housekeeping, or laundry services, as part of the living arrangement. Since they have a call bell in their apartment, the assistance is considered Around the Clock if onsite care continuum staff is available to respond to the bell 24/7 for the entire upcoming episode of care.

Q63.7.M1100. My patient lives in a large continuum of care community. In this community, he lives in a single family home with his wife and at this point, does not receive any support, assistance or oversight because he lives there. He phones 911 for an emergency and has access to shared recreational areas within the community. For the purposes of M1100, does he live with other persons in the home, or in a congregate living situation? [Q&A ADDED 10/16; Previously CMS Qtrly 04/16 Q&A #5]

A63.7. Assuming that the option for the patient to receive assistance, supervision or oversight is not a part of the living arrangement with the continuum of care community, a response from Row b - Patient lives with other person(s) in the home would be appropriate. If assistance, supervision, or oversight is provided to the patient as part of the living arrangement, (for example weekend brunches in the main dining hall, or a morning check-in call), but the patient doesn't need and/or chooses not to utilize the available services, a response from Row c - Patient lives in congregate situation would be appropriate.

Q64. M1200. Does information on vision documented in OASIS have to be backed up with documentation elsewhere in the patient's record?

A64. A patient who has partially or severely impaired vision (Responses 1 or 2) is likely to require adaptations to the care plan as a result of these limitations. Therefore, it is likely that the vision impairments would be included in additional assessment data or as rationale for care plan interventions.

Q64.1. M1200. 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 M1200, Vision to be answered? Is the physical impairment to be considered? Visual acuity has not been affected. [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/07 Q&A #6]

A64.1. When selecting the correct response for M1200, 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 M1200 if with the patient’s existing vision, they are able to see adequately in most situations and can see medication labels or newsprint.

Q64.1.1 M1200. Is a person with severe kyphosis and or with limited neck mobility who cannot adequately see objects in their path creating a safety issue on ambulation but can read med labels and newsprint considered to have partially (“1”) or severely (“2”) impaired vision? [Q&A ADDED 10/16; Previously CMS Qtrly 07/15 Q&A #2]

A64.1.1 When selecting the correct response for M1200 Vision, the clinician is assessing the patient’s functional vision, not conducting a formal vision acuity 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 physical deficit/impairments (like limited neck range of motion) prevent a patient from seeing objects in his path, affecting safe function in his environment, M1200 should be 2 - severely impaired vision.

Q64.2. M1200. Our patient has dementia and is unable to answer questions related to his vision appropriately or read a medication bottle out loud. He has no obvious visual problems as outlined in M1200 response 1 or 2. How does a clinician correctly answer this question given this level of verbal impairment? [Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 07/08 Q&A #5]

A64.2. When a patient is cognitively impaired, the clinician will need to observe the patient functioning within their environment and assess their ability to see functionally. Does it appear the patient can see adequately in most situations? Can they see eating and grooming utensils? Do they appear to see the buttons on their shirt/blouse? If so, the patient would be reported as a “0-Normal vision” even though the constraints of the dementia may not allow the patient to communicate whether they can see newsprint or medication labels.

Q64.3. M1200. Our patient has macular degeneration and wears corrective lenses and uses an adaptive reader. With the corrective lenses and the adaptive reader, the patient can read prescription labels. Do we assess what the patient can see while using the adaptive reader? [Q&A ADDED 06/14; Previously CMS Qtrly 01/14 Q&A #4]

A64.3. An adaptive reader, like a magnifying glass, would not be considered corrective lens when scoring M1200, Vision. In the scenario above, report what the patient is able to see with the corrective lens on only.

Q64.4. M1200. Vision guidance states that this item "Identifies the patient’s ability to see and visually manage (function) safely within his/her environment, wearing corrective lenses if these are usually worn." Please define the meaning of the term "usually". [Q&A ADDED 06/14; Previously CMS Qtrly 04/14 Q&A #8]

A64.4. For the purposes of selecting a response for M1200, the clinician should use clinical judgment to determine if the patient usually wears corrective lenses to see and visually manage safely within his/her environment. For a patient with presbyopia who only requires reading glasses, there would be no expectation that they would wear their glasses greater than 50% of the time (hours) of the day of assessment. After gathering information by observation and interview, the assessing clinician should use clinical judgment to determine if the patient usually does or usually doesn’t use corrective lenses, as needed based on their specific visual impairment, then selects a response for M1200 accordingly.

Q64.5.M1200. M1200 Vision references “newsprint” in Responses 0 – Normal Vision and Response 1 – Partially Impaired. Is this intended to specifically refer to the patient’s ability to see the general 12 point font-size in a newspaper? If the patient can see larger

font (>12 point), but not smaller font (< 12 point) would the response be 0 or 1? Also, the guidance states to “consider ability to differentiate between medications”. Is this referring solely to reading the medication label, or just identifying the medication by any visual method? [Q&A ADDED 10/16; Previously CMS Qtrly 04/16 Q&A #6]

A64.5. The intent of M1200 is to identify the patient’s “functional vision”, meaning the patient’s ability to see and visually manage (or function) safely within his/her environment, wearing corrective lenses if usually worn. M1200 is not intended to be a formal screen for visual acuity, nor is it a reporting of the patient’s ability to read. And differentiating medications is offered only as an example of a daily activity that the clinician could use to assess the patient’s functional vision. The item’s responses provide descriptions of varying levels of functional vision. The clinician would also consider any physical deficits or impairments (like limited neck range of motion, or facial swelling) that may be present, affecting the patient’s ability to use their existing vision in a functional way. Newsprint is intended to serve as an example of the size and type of print found in a newspaper, magazine or book, on medication or food labels, and on other products or documents that might be routinely encountered for day-to-day functioning. Rather than focusing on specific font sizes, the clinician should use clinical judgment to select the response to M1200 that best represents the patient’s vision status, as it relates to managing in their home environment safely. Rather than determining if the patient can read the medication labels, the clinician could use a determination of

the patient’s ability to differentiate between medications, especially if medications are self-administered, as a possible assessment strategy. Functional vision may involve assessing the patient’s ability to read the label, identify colored medication bottle caps, differentiate medications based on pill size, color or shape and/or the use of other visual cues to carry out the daily activity of medication identification.

Q65. M1220. Our agency would like clarification concerning M1220 - Understanding of Verbal Content in patient's own language. If a patient speaks Spanish and there is an interpreter, it is difficult to ascertain the level of complexity of interpreted instructions. How are we to answer this? [Q&A EDITED 09/09]

A65. You will need to ask the interpreter to help you determine at what level the patient is responding. Responses to 0-Understands: clear comprehension without cues or repetitions and UK-Unable to assess understanding should be relatively simple to determine. To determine the difference between levels 1, 2 or 3, you can interact with the interpreter to determine with what difficulty the patient is responding. Inasmuch as the assessment includes assistance from an interpreter, your clinical documentation of the visit should indicate the presence of an interpreter who assists with communication between clinician and patient.

Q66. [Q&A RETIRED 09/09; Outdated]

Q66.1. M1220. My patient's primary language is German, but he does speak English well enough for us to generally communicate without the use of an interpreter. Often I need to repeat my request, or reword my statements, but he eventually adequately understands what I'm asking or saying. When scoring concerning M1220 - Understanding of Verbal Content, I marked response "2" based on my assessment, but I wonder if the patient's hearing/comprehension would be better (i.e., a Response "0" or "1") if he were being spoken to in German, his primary language. Do I have to assess the patient with an interpreter in order to score M1220 in the patient's primary language, even if I feel communication is generally adequate to allow evaluation of the patient's healthcare needs and provision of care outlined in the Plan of Care? [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #19]

A66.1. M1220 is an evaluation of the patient's ability to comprehend spoken words and instructions in the patient's primary language. If a patient is able to communicate in more than one language, then this item can be evaluated in any language in which the patient is fluent. If however, as you suggest, your patient's ability to hear and understand is likely not as functional in a secondary language, you should make efforts necessary to access an interpreter to determine the patient's ability to hear and comprehend in the patient's primary language.

Q66.2. M1230. For M1230, Speech and Oral (Verbal) Expression of Language, augmented speech (i.e. use of electrolarynx) is considered verbal expression of language. Does CMS consider use of augmented speech devices (like the Dynavox) verbal expression? I understand how an electrolarynx would be considered verbal because the words are generated by the patient; but with devices like the Dynavox, verbal speech is generated via the device by direction of the patient. [Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #6]

A66.2. M1230 identifies the patient's ability to communicate with words through vocalization of ideas, feelings, and needs. The item does not address communicating in sign language, in writing, or by any nonverbal means including message boards, electronic devices that convert text to speech or a speech generating device utilizing symbols and a keyboard. If the patient cannot vocalize sounds and depends entirely on the speech generating device, the appropriate score would be a 5-Patient nonresponsive or unable to speak.

Q67, 68, 69, & 70. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q70.1. M1240. If I mark a process measure assessment item "Yes" (that the assessment was done), is that sufficient documentation or do I have to explain which tool I used and how I came to the decision regarding my patient's level of risk? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #15]

A70.1. Whether the clinician uses a standardized, validated assessment or a combination of clinical factors for assessment of fall risk, pain severity, depression, or pressure ulcer risk, it is expected that the clinical record would detail the clinical factors or tool that was used and the related findings and analysis to support the OASIS response selected.

Q70.2. M1240. Do all the OASIS pain items refer to severe pain? If not, how are they different? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #8]

A70.2. The home care clinician assesses for and is concerned about any and all pain the patient experiences. All pain is documented in the clinical record and addressed in the Plan of Care. Remembering that the OASIS items are just a part of the comprehensive assessment for

patients who require data collection helps to put all the OASIS items and their focused data collection into perspective.

M1240, Pain Assessment, is assessing if the patient had a formal pain assessment during the allowed assessment time period utilizing a standardized, validated pain assessment tool, as defined in Chapter 3 of the current OASIS Guidance Manual. The response options then report either “No” that the standardized, validated assessment was not conducted or “Yes” that the assessment was conducted and whether it indicated severe pain or not.

When answering M2250, Plan of Care Synopsis, Row e, the assessing clinician is reporting whether the physician ordered Plan of Care included interventions to monitor and mitigate pain, any pain, not just severe pain. ‘NA’ is an option if the comprehensive assessment, not necessarily the formal assessment, revealed the patient had no pain. “Yes” or “No” can be selected for M2250 based solely on the presence or absence of interventions on the physician ordered Plan of Care to monitor and mitigate pain, regardless of whether or not the patient was assessed for pain. “NA”, however, may not be selected unless the patient was assessed to have no pain. Therefore, if orders are included on the POC that address both the assessment and plans for mitigation of pain, M2250 may be answered as “Yes”, even though the comprehensive assessment did not reveal any pain.

When answering M2401, Intervention Synopsis, Row d, the same principles apply except for two major differences. First, you may not select “NA” unless the formal pain assessment utilizing a standardized, validated tool as defined in M1240 was conducted at the time of or since the most recent SOC/ROC assessment and it revealed no pain. Second, in order to answer “Yes” or “No”, the orders to monitor and mitigate the pain not only have to be present, but there must be evidence in the clinical record that they were implemented.

Q70.3. M1240. Is the intention of M1240 – Pain Assessment to identify whether a clinically significant pain is present at the time the pain assessment is conducted regardless of the activity level at the time (i.e., using a numeric pain scale ask the patient to rate his pain this moment) or the presence of clinically significant pain on the day of assessment (i.e., using a numeric intensity pain scale, ask the patient to rate his pain on the average for the day of assessment)? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #9]

A70.3. M1240 - Pain Assessment, reports if the patient had a formal pain assessment during the allowed assessment time period utilizing a standardized, validated pain assessment tool, as defined in Chapter 3 of the current OASIS Guidance Manual. The response options then report either “No” that the standardized, validated assessment was not conducted or “Yes” that the assessment was conducted and whether it indicated severe pain or not, at the time of the standardized, validated assessment, per the assessment's scale and the Ch. 3 Response-Specific Instructions. The response selected is not necessarily a reflection of an average or summary of the pain experienced on the day of assessment.

The home care clinician assesses for and is concerned about any and all pain the patient experiences. All pain is documented in the clinical record and addressed in the Plan of Care. Remembering that the OASIS items are just a part of the comprehensive assessment for patients who require OASIS data collection helps to put all the M items and their focused data collection into perspective

Q70.4. M1240. If the ROC comprehensive assessment with OASIS was completed after the CMS-allowed 48 hour time frame, do all the best practice questions need to be answered “NA”? [Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #13; 06/14 edit based on CMS Qtrly 10/13 Q&A#2]

A70.4. The ROC comprehensive assessment must be completed within 48 hours of discharge following a qualifying inpatient stay or within 48 hours of knowledge of a qualifying stay in an inpatient facility. If the ROC assessment is late, "Yes" may still be selected for the best practices in M2250, Plan of Care Synopsis, if the relevant orders were present within the 48 hour ROC time frame. Likewise, M1240, Pain Assessment, M1300, Pressure Ulcer Risk Assessment, M1730, Depression Screening, and/or M1910, Falls Risk Assessment may also be reported with "Yes" responses, if the relevant standardized, validated assessments were conducted by the assessing clinician within the 48 hour time frame, even if the ROC comprehensive assessment was completed after the 48 hour time frame. When the assessing clinician takes credit on M1240, M1300, M1730 and/or M1910 for standardized, validated assessments completed within the 48 hour time frame and the M0090 date indicates that the ROC comprehensive assessment was completed late (beyond the 48 hour time frame), clarifying documentation to support the reported OASIS responses is expected.

If the relevant standardized, validated assessment was completed greater than 48 hours after inpatient facility discharge or greater than 48 hours after gaining knowledge of a qualifying stay in an inpatient facility, M1240, M1300, M1730 and M1910 must be answered "No".

The agency should make every effort to complete the ROC assessment within the 48 hours from the discharge home. If the patient refuses or isn't available, the ROC assessment should be completed as soon as possible, with any physician communication and circumstance details documented in the clinical record.

Q70.5. M1240. We are requesting clarification regarding the time frame used to assess pain for the response to M1240. [Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 07/13 Q&A #6]

A70.5. When completing M1240, Pain Assessment, the period of time that the clinician should consider when determining if the pain assessment reveals severe pain ("Response 2") or not ("Response 1"), is determined by the administration protocols associated with the exact standardized, validated tool that the clinician uses to assess pain. Examples of time frames stated in protocols include "at the present time", and "at its worst during the past 24 hours". If the tool selected has multiple sets of validated administration protocols, in order to standardize data collection agency policy may state which protocol the agency prefers the clinicians use. If no standardized pain assessment is conducted within the SOC or ROC assessment time frames, Response "0 - No standardized assessment conducted" must be reported."

Q70.6. M1240. The clinician assesses the patient and determines there is no pain medication and no pain present and documents that pain is assessed as “0” on the pain scale of 0-10. Is this a valid use of a standardized pain assessment tool? Or, because there is no pain issue and no pain medication, would the clinician mark M1240 Response “0 - No standardized assessment conducted”, because there is no pain to assess? [Q&A ADDED 06/14; Previously CMS Qtrly 10/13 Q&A #4]

A70.6. If the assessing clinician utilized a validated and standardized pain assessment tool, such as the numeric scale, M1240, Pain Assessment is answered either 1 or 2 based on whether or not the patient had severe pain. This is true even if the patient is not taking pain medication. In the scenario provided, the patient stated he was free of pain. The assessing

clinician then administered the numeric scale confirming it was rated as a "0" by the patient. M1240 is then appropriately answered "1-Yes, and it does not indicate severe pain."

Q70.7. M1240. The clinician utilized a standardized 0-10 numeric pain scale. No other parameters regarding pain are assessed (e.g., location, onset, exacerbating/relieving factors). Is it legitimate to say that a standardized pain assessment has been conducted and select Response 1 or 2 for M1240? Or, should Response "0 - No standardized assessment conducted" be selected? [Q&A ADDED 06/14; Previously CMS Qtrly 10/13 Q&A #5]

A70.7. If the assessing clinician administered a standardized and validated tool, such as the numeric scale, according to the tool's administration protocols, M1240, Pain Assessment may be answered "Yes", even if a more comprehensive pain assessment was not completed.

Q71. M1242. If a patient uses a cane for ambulation in order to relieve low back pain, does the use of the cane equate to the presence of pain interfering with activity? [Q&A ADDED 06/05; M number updated 09/09; Previously CMS OCCB 08/04 Q&A #6]

A71. If use of the cane provides adequate pain relief that the patient can ambulate in a manner that does not significantly affect distance or performance of other tasks, then the cane should be considered a "non-pharmacological" approach to pain management and should not, in and of itself, be considered as an "interference" to the patient's activity. However, if the use of the cane does not fully alleviate the pain (or pain effects), and even with the use of the cane, the patient limits ambulation or requires additional assistance with gait activities, then activity would be considered as "affected" or "interfered with" by pain, and the frequency of such interference should be assessed when responding to M1242.

Q72. M1242. Would a patient who restricts his/her activity (i.e., doesn't climb stairs, limits walking distances) in order to be pain-free thus be considered to have pain interfering with activity? And if so, would the clinician respond to M1242 based on the frequency that the patient limits or restricts their activity in order to remain pain-free? [Q&A ADDED 06/05; M number updated 09/09; Previously CMS OCCB 08/04 Q&A #7]

A72. Yes, a patient who restricts his/her activity to be pain-free does indeed have pain interfering with activity. Since M1242 reports the frequency that pain interferes with activity (not the presence of pain itself), then M1242 should be scored to reflect the frequency that the patient's activities are affected or limited by pain, even if the patient is pain free at present due to the activity restriction.

Q73. M1242. A patient takes narcotic pain medications continuously and is currently pain free. Medication side effects, including constipation, nausea, and drowsiness affect the patient's interest and ability to eat, walk, and socialize. Is pain interfering with the patient's activity? [Q&A ADDED 06/05; Previously CMS OCCB 10/04 Q&A #3]

A73. M1242 identifies the frequency with which pain interferes with a patient's activities, taking into account any treatment prescribed. If a patient is pain-free as a result of the treatment, M1242 should be answered to reflect the frequency that the patient's activities are affected or limited by pain. In this scenario, the patient is described as being pain-free, but also is described as having medication side effects that interfere with activity. Medication side effects are not addressed in responding to M1242 and, given the information in the scenario; pain apparently is not interfering with the patient's activity.

Q73.1. M1242. Could you clarify the time period under consideration when answering M1242 Frequency of Pain Interfering with Activity or Movement? If a patient reports they have no pain currently because they have modified their activity

level several weeks or months ago to exclude an activity they know will cause pain, do we answer M1242 based on the fact that they have modified their activity level (e.g., aren't even attempting to perform that activity due to the possibility of the pain returning), or do we not even consider that activity when answering the question because the patient has excluded it from their activities a "long" time ago. And if that is true, what would be the time frame for a "long" time ago? [Q&A ADDED 1/12; Previously CMS OCCB 07/11 Q&A #5]

A73.1. The timeframe under consideration when answering M1242, Frequency that Pain interferes with Activity or Movement is the day of assessment and recent pertinent past. If the patient has stopped performing an activity in order to be free of pain, the patient HAS pain that is interfering with activity.

If a patient at some point stopped performing activity because of pain and there is no reasonable expectation that they could or would ever perform the activity again, an assessing clinician's judgment may determine that the activity is not considered to be in the pertinent past. Examples: stopped skiing after a knee injury 20 years ago.

Q73.2. M1242. How does a physician order to immobilize a surgical extremity impact the scoring of M1242, Frequency of Pain Interfering with patient's activity or movement? [Q&A ADDED 06/14; Previously CMS Qtrly 04/13 Q&A #3]

A73.2. If a patient has stopped performing an activity due to a medical restriction, not due to pain, the pain is not considered to be interfering with activity or movement. If, however, the patient is experiencing other pain that interferes with activity or movement or restricting other activity due to pain, it would be reported in M1242.

Q73.3. M1242. For M1242, could you define the term "All of the time"? Does pain have to keep a patient awake all night long in order to select it? [Q&A ADDED 06/14; Previously CMS Qtrly 07/13 Q&A #7]

A73.3. M1242 Response "4-All the time" is selected, when the patient reports and/or the clinician observes that pain is interfering with the patient's ability to move and/or perform desired activities at all times. "At all times" means constantly throughout the day and night with little or no relief. Pain is also considered to be interfering if a patient stops performing an activity in order to avoid the pain. For the pain to be interfering "all the time" the frequency of the activity that was stopped in order to avoid pain must collectively represent all the hours of the day/night. Pain must wake them frequently at night. The clinician must use judgment based on observation and patient interview to determine if pain is interfering all the time.

Q74 & 75. [Q&A RETIRED 09/09; Outdated]

Q76, 77, 77.1 & 77.2. [Q&A RETIRED 08/07; Outdated]

Q78. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q79, 80, 81, 82 & 86. [Renumbered and moved to Q&A #112.6-112.10]

Q83, 84, 85 & 87. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q87.1. M1300's. Do CMS OASIS instructions supersede a clinical wound nurse training program? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #22]

A87.1. 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 bowel ostomy 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 ostomy.

Q87.1.1. M1300s. Is the WOCN's Guidance Document on OASIS copyrighted? And can we use it for education? [Q&A EDITED 10/16; Q&A ADDED 04/15; Previously CMS Qtrly 10/14 Q&A #4]

A87.1.1. The WOCN has copyrighted the Wound, Ostomy and Continence Nurses Society's Guidance on OASIS 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.

Q87.2. M1300. If I mark a process measure assessment item "Yes" (that the assessment was done), is that sufficient documentation or do I have to explain which tool I used and how I came to the decision regarding my patient's level of risk? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #15]

A87.2. Whether the clinician uses a standardized, validated assessment or a combination of clinical factors for assessment of fall risk, pain severity, depression, or pressure ulcer risk, it is expected that the clinical record would detail the clinical factors or tool that was used and the related findings and analysis to support the OASIS response selected.

Q87.3. M1300 & M1302. If a patient scores no risk on the Braden Scale but the RN performs an evaluation of clinical factors and determines the patient is at risk for pressure ulcers, how do we answer M1300? [Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 01/11 Q&A #7]

A87.3. The response to M1300 should be "2-Yes, using a standardized tool, e.g., Braden, Norton, other" if a standardized, validated tool assessment tool, e.g., Braden, Norton, was utilized, regardless of whether another non-standardized tool or clinical evaluation was also conducted. If both a standardized, validated pressure ulcer assessment AND an evaluation of clinical factors were conducted, the response to M1302 should be "1-Yes" if either the clinical evaluation or the standardized, validated tool is positive for risk.

Q87.4. M1300. If the ROC comprehensive assessment with OASIS was completed after the CMS-allowed 48 hour time frame, do all the best practice questions need to be answered "NA"? [Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #13; 06/14 edit based on CMS Qtrly 10/13 Q&A#2]

A87.4. The ROC comprehensive assessment must be completed within 48 hours of discharge following a qualifying inpatient stay or within 48 hours of knowledge of a qualifying stay in an inpatient facility. If the ROC assessment is late, "Yes" may still be selected for the best practices in M2250, Plan of Care Synopsis, if the relevant orders were present within the 48 hour ROC time frame. Likewise, M1240, Pain Assessment, M1300, Pressure Ulcer Risk Assessment, M1730, Depression Screening, and/or M1910, Falls Risk Assessment may also be reported with "Yes" responses, if the relevant standardized assessments were conducted by the assessing clinician within the 48 hour time frame, even if the ROC comprehensive assessment was

completed after the 48 hour time frame. When the assessing clinician takes credit on M1240, M1300, M1730 and/or M1910 for standardized assessments completed within the 48 hour time frame and the M0090 date indicates that the ROC comprehensive assessment was completed late (beyond the 48 hour time frame), clarifying documentation to support the reported OASIS responses is expected.

If the relevant standardized assessment was completed greater than 48 hours after inpatient facility discharge or greater than 48 hours after gaining knowledge of a qualifying stay in an inpatient facility, M1240, M1300, M1730 and M1910 must be answered "No".

The agency should make every effort to complete the ROC assessment within the 48 hours from the discharge home. If the patient refuses or isn't available, the ROC assessment should be completed as soon as possible, with any physician communication and circumstance details documented in the clinical record.

Q88. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q88.1. [Moved to Q&A #102.1]

Q88.5. M1306. If you have two Stage 4 pressure ulcers with intact skin in-between them and a tunnel that connects them underneath the wound surface, do you have one pressure ulcer or two? [Q&A EDITED 10/16; Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #8]

A88.5. If a patient develops two pressure ulcers that are separated by intact skin but have a tunnel which connects the two, they remain two pressure ulcers.

Q88.6. M1306. We are seeking direction regarding serum filled blisters that are caused by shoes rubbing against the foot. Some of our clinicians consider these "trauma wounds" and others consider them "stage 2 pressure ulcers". Please advise. [Q&A ADDED 10/16; Previously CMS Qtrly 01/16 Q&A #4]

A88.6. If the cause of a wound is solely a friction force which leads to visible skin impairment, such as the serum filled blister cited in the scenario, it would NOT be categorized as a pressure ulcer. The 2009 International NPUAP-EPUAP Pressure Ulcer Prevention and Treatment Clinical Practice Guideline eliminated reference to friction as a factor in pressure ulcer development.

Q89. M1306-M1350. Are diabetic foot ulcers classified as pressure ulcers, stasis ulcers, or simply as wound/lesions at M1350? [Q&A EDITED 09/09]

A89. The clinician will have to speak with the physician who must make the determination as to whether a specific lesion is a diabetic ulcer, a pressure ulcer, stasis ulcer, or other lesion. There are some very unique coding issues to consider for ulcers in diabetic patients (vs. ulcers in non-diabetic patients), and the physician should be aware of these in his/her contact with the patient. In responding to the OASIS items, an ulcer diagnosed by the physician as a diabetic ulcer would be considered a lesion (respond "Yes" to M1350, if it will receive clinical intervention and was not reported in one of the prior OASIS wound items), but it would not be considered a pressure ulcer or a stasis ulcer.

Q89.1. M1306-M1340. If a pressure ulcer or a burn is covered with a skin graft, does it become a surgical wound? [Q&A EDITED 10/16; Previously CMS Qtrly Q&A 10/16 #12; Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #23]

A89.1. Yes, covering a pressure ulcer with a skin graft changes it from a pressure ulcer to a surgical wound. Applying a skin graft to a burn results in a surgical wound. In either case, a donor site, until healed, would also be considered a surgical wound.

Q89.1.1. M1306, M1307, M1311, M1313, M1322, M1324. The National Pressure Ulcer Advisory Panel (NPUAP) announced a change in terminology from pressure “ulcer” to pressure “injury” and updated the stages of pressure injury. In addition to the change in terminology, Arabic numbers are now used in the names of the stages instead of Roman numerals. Will OASIS-C2 update the terminology to match (pressure ulcer to pressure injury)? [Q&A ADDED 10/16; Previously CMS Qtrly 07/16 Q&A #9]

A89.1.1 The language for the pressure ulcer items in the posted OASIS-C2 data set are specifically designed to align with the language in the assessment instruments utilized in other Post-Acute Care settings, to meet the standardization requirements imposed by the IMPACT Act of 2014. This standardization effort included transitioning from Roman numerals to Arabic, to represent pressure ulcer stages. CMS is aware of the press release dated April 13, 2016, in which NPUAP announced the change in terminology within the NPUAP staging system. CMS is reviewing this update, but at this time no decision has been made to revise the OASIS-C2 item wording. Once the OASIS-C2 data set is approved by the Office of Management and Budget, the OMB approval number will be affixed to the document, and the data set file will be reposted as final at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-Data-Sets.html>.

Q89.2. [Q&A RETIRED 06/14; Redundant to 89.2]

Q89.3. M1306-M1324. In the NPUAP’s 2/2007 Pressure Ulcer Stages document, for the description of a Stage 4 pressure ulcer it states “Exposed bone/tendon is visible or directly palpable.” What does “directly palpable” mean? I can palpate bone through healthy, intact tissue. [Q&A EDITED 10/16; Q&A ADDED & M number updated 09/09; Previously CMS OCCB 10/07 Q&A #16]

A89.3. Within the context of answering OASIS Pressure Ulcer items, "directly palpable" means visible.

Q89.4. M1306-M1324. If at the SOC visit, the assessing clinician observes an open ulcer over a bony prominence, with history of pressure and visible bone, can the clinician report this as a Stage 4 pressure ulcer, even if not able to get confirmation of the diagnosis from the physician prior to completing the assessment? [Q&A EDITED 10/16; Q&A EDITED 4/15; ADDED 06/14; Previously CMS Qtrly 01/14 Q&A #5]

A89.4. At SOC, the assessing clinician responsible for completing the SOC comprehensive assessment must have visualized the wound in order to include it as a Stage 4 pressure ulcer in the SOC OASIS pressure ulcer items. These items are a report of the clinician's integumentary status assessment findings. A pressure ulcer may be reported on OASIS based on visualization of the wound, patient assessment and interview and review of relevant related historical documentation. Although the assessing clinician can report the observed ulcer on the OASIS without physician confirmation, collaboration with the physician would be required in order to diagnose and code the ulcer, and to receive related orders and/or provide physician ordered care related to the pressure ulcer.

Q89.5. M1306-M1322. On SOC, the RN assesses a scar from a closed pressure ulcer. Upon further interview and assessment, the patient's family states that the patient had a pressure ulcer but they are not able to give the RN any staging information. How would this pressure ulcer be documented in M1311, Current Number of Unhealed Pressure Ulcers at Each Stage? [Q&A EDITED 10/16; Previously CMS Qtrly Q&A 10/16 #13; Q&A ADDED 06/14; Previously CMS Qtrly 04/14 Q&A #9]

A89.5. If the assessing clinician becomes aware that the patient had a full-thickness (Stage 3 or 4) pressure ulcer in the past that is now closed, the ulcer is considered healed and no longer reportable as a pressure ulcer on the OASIS.

Q89.6.M1311. 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 M1311? [Q&A EDITED 10/16; Previously CMS Qtrly Q&A 10/16 #14; Q&A ADDED 04/15; Previously CMS Qtrly 10/14 Q&A #6]

A89.6. Once the full thickness pressure ulcer is completely covered with new epithelial tissue, the wound is considered healed and no longer reportable as a pressure ulcer on the OASIS.

Q90, 90.1 & 93. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q91 & 92. [Q&A RETIRED 09/09; Outdated]

Q94. M1306-M1324. If a Stage 3 pressure ulcer is closed with a muscle flap, what is recorded? What if the muscle flap begins to break down due to pressure? [Q&A EDITED 10/16; Q&A EDITED 06/14]

A94. If a pressure ulcer is closed with a muscle flap (defined as full thickness skin and subcutaneous tissue partially attached to the body by a narrow strip of tissue so that it retains its blood supply), the new tissue completely replaces the pressure ulcer. In this scenario, the pressure ulcer "goes away" and is replaced by a surgical wound. If the muscle flap healed completely, but then began to break down due to pressure, it would be considered a new pressure ulcer. If the flap had never healed completely, it would be considered a non-healing surgical wound.

Q94.1. M1306. If the patient had a pressure ulcer and the post-op surgical report states it was surgically excised and closed without placement of a muscle flap, do we still have a Stage 4 pressure ulcer-the original etiology or did this become a surgical incision? [Q&A EDITED 10/16; Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 07/13 Q&A #8]

A94.1. If all the tissue damaged by pressure is removed surgically, e.g. amputation or surgical excision, there is no longer a pressure ulcer. It becomes a surgical wound until healed.

Q95. M1306-M1324. If a pressure ulcer is debrided, does it become a surgical wound as well as a pressure ulcer?

A95. No, as debridement is a treatment procedure applied to the pressure ulcer. The ulcer remains a pressure ulcer, and its healing status is recorded appropriately based on assessment.

Q96. M1306-M1324. If a single pressure ulcer has partially granulated to the surface, leaving the ulcer open in more than one area, how many pressure ulcers are present? [Q&A EDITED 09/09]

A96. Only one pressure ulcer is present.

Q97. [Q&A RETIRED 09/09; Outdated]

Q98. M1306-M1324. Can a previously observable Stage 4 pressure ulcer that is now covered with slough or eschar be categorized as Stage 4? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 06/05]

A98. No. In order to stage the pressure ulcer as a Stage 4, bone, muscle, tendon, or joint capsule (Stage 4 structures) must be visible. A pressure ulcer that has some degree of necrotic tissue (eschar or slough) or scabbing present that the clinician believes may be obscuring the visualization of Stage 4 structures cannot be staged, even if it previously stageable.

The status of the pressure ulcer needs to correspond to the visual assessment by the skilled clinician on the date of the assessment. This is documented on the Wound, Ostomy, and Continence Nurses (WOCN) Association website at www.wocn.org in the WOCN Guidance Document and at the NPUAP site at www.npuap.org.

Q98.1. M1306-M1324. If a patient has a Stage 3 pressure ulcer on the first episode, and in the second episode it is covered with slough, can it still be reported a Stage 3? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 10/08 Q&A #3]

A98.1. A Stage 3 pressure ulcer that has some degree of necrotic tissue (eschar or slough) or scabbing present that the clinician believes may be obscuring the visualization of Stage 4 structures cannot be staged, even if it previously stageable as a Stage 3.

Q98.1.1. M1306-M1324. We are recertifying a patient who had a Stage 2 pressure ulcer at SOC that is now closed and only red. We understand not to “back-stage” but when a Stage 2 pressure ulcer closes and is only red, is it now considered a Stage 1 pressure ulcer? Or is it considered healed and gone in which we would no longer score it on OASIS? [Q&A EDITED 10/16; Q&A ADDED 12/12; Previously CMS Qtrly 07/12 Q&A #2]

A98.1.1. It is accurate to say that back-staging of pressure ulcers is never appropriate. When a Stage 2 ulcer re-epithelializes, it is considered "healed" and no longer reported in the OASIS data set. If you are describing a patient who now has non-blanchable redness at the same site where the Stage 2 ulcer healed, then this would now be considered a new Stage 1, as it has been caused by new pressure at the same site, and is not reversing the staging of a healed Stage 2 ulcer.

Q98.2. M1306, M1311, M1313, M1320 & M1324. How do I categorize a pressure ulcer that has been sutured closed? [Q&A EDITED 10/16; Previously CMS Qtrly Q&A 10/16 #15; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 07/10 Q&A #3]

A98.2. Since it is relatively uncommon to encounter direct suture closure of a pressure ulcer, it is important to make sure that the pressure ulcer was not closed by a surgical procedure (such as a skin advancement flap, rotation flap, or muscle flap). A pressure ulcer that is sutured closed (without a flap procedure) would still be reported as a pressure ulcer. While this approach (direct suture closure) may rarely be attempted due to a low success rate, home care providers are reporting occurrence.

For M1306, Any Unhealed Stage 2 or Higher or “Unstageable” pressure ulcers? select Response “1 – Yes”, since the wound bed of a pressure ulcer sutured shut is obscured, it would be reported as an Unstageable pressure ulcer.

For M1311 – Current Number of Unhealed Pressure Ulcers at Each Stage, it would be reported in row D1 as Unstageable due to non-removable dressing or device.

For M1313 – Worsening in Pressure Ulcer Status since SOC/ROC, report the unstageable pressure ulcer as new or worsened if a pressure ulcer was not present in that location at the

most recent SOC/ROC assessment, otherwise, do not report the unstageable pressure ulcer as new or worsened.

For M1320 – Status of Most Problematic Pressure Ulcer that is Observable, select “NA-No observable pressure ulcer”, since in this unusual situation for the purposes of OASIS data collection, we are treating the pressure ulcer closed with sutures as a pressure ulcer that is covered with a dressing that cannot be removed.

For M1324, Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable, select Response “NA-Patient has no pressure ulcers or no stageable pressure ulcers” because the ulcer cannot be staged as it is closed and because for the purposes of OASIS data collection, we are considering this to be a pressure ulcer that is Unstageable due to a non-removable dressing or device.

Q98.2.1. M1307. If the patient had a Stage 1 pressure ulcer at SOC that progressed to a Stage 2, how do we answer M1307 at discharge? [Q&A EDITED 10/16; Previously CMS Qtrly Q&A 10/16 #16; Q&A ADDED 12/12; Previously CMS Qtrly 01/12 Q&A #5]

A98.2.1. If a patient had a Stage 1 pressure ulcer at SOC/ROC and it advanced to a Stage 2 by discharge, Response “2-Developed since the most recent SOC/ROC assessment” would be appropriate due to the fact that the ulcer, caused by pressure, was not present as a Stage 2 at the most recent SOC/ROC assessment.

Q98.2.2. M1306, M1311, M1313, M1320, M1322 & M1324. How are mucosal membrane pressure ulcers reported in the OASIS data set? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #14]

A98.2.2. The OASIS data set integumentary items only include wounds and lesions to the integumentary system and do not include mucosal membrane wounds or lesions. Pressure ulcers occurring to mucosal membranes would be reported in the comprehensive assessment and clinical documentation but not in any of the following OASIS M items - M1306, M1311, M1313, M1320, M1322, or M1324.

Q98.4. [Q&A RETIRED 06/14; No longer applicable]

Q98.4.1. [DELETED 04/15; Replaced by 4b Q.98.4.3.1]

Q98.4.2. M1311. My patient had a closed Stage 4 pressure ulcer at SOC. Two weeks later, it appeared to be a shallow open ulcer. Can I report it as a Stage 2 or do I have to say it is an Unstageable Stage 4 because I can't visualize bone, muscle or tendon? [Q&A EDITED 10/16; Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 04/13 Q&A #4]

A98.4.2. A previously closed Stage 3 or Stage 4 pressure ulcer that opens again should be reported at its worst stage. As long as the wound bed is free of slough and eschar, it may be reported as a Stage 4. If slough or eschar is present that the clinician believes may be obscuring the visualization of Stage 4 structures (bone, muscle, tendon or joint capsule) in the wound bed, it may not be staged and is reported in M1311 as E1: Known but not stageable due to coverage of wound bed by slough and/or eschar.

Q98.4.2.1. M1311. Is a pressure ulcer automatically a Stage 4 if osteomyelitis is present, despite what type of breakdown there might be (for example only superficial skin loss)? [Q&A ADDED 10/16; Previously CMS Qtrly 01/16 Q&A #5]

A98.4.2.1. The presence of osteomyelitis is not a characteristic used to stage a pressure ulcer, and does not automatically result in a Stage 4 ulcer. The pressure ulcer stage should correspond to the clinician's visual assessment on the day of assessment. The definitions for staging the pressure ulcer are documented on the Wound, Ostomy, and Continence Nurses

(WOCN) Association website at www.wocn.org in the WOCN Guidance on OASIS Integumentary Items and at the NPUAP site at www.npuap.org.

Q98.4.2.2 . M1311. In OASIS-C2, M1311 appears to be taking the place of M1308. M1308 has been collected at SOC, ROC, FU & Discharge, but it appears that portions of M1311 will not be completed at all time points? Please clarify? [Q&A ADDED 10/16; Previously CMS Qtrly 07/16 Q&A #4]

A98.4.2.2. M1311. M1311 will be collected at SOC/ROC, Follow-up and Discharge, although the portions of the item referenced as A2, B2, C2, D2, E2, and F2 should be omitted at the SOC/ROC time points.

Q98.4.3. M1311 & M1313. Our patient has a Stage 3 pressure ulcer that we have been treating during the episode. At the reassessment, it is covered with a scab. I know it's Unstageable if it has a non-removable dressing or is covered with eschar or slough but I do not know how a scab would affect the staging. [Q&A EDITED 10/16; Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 07/13 Q&A #9]

A98.4.3. Refer to WOCN guidance on pressure ulcers. If, in a pressure ulcer with full thickness tissue loss, the clinician can visualize bone, muscle or tendon, the pressure ulcer has advanced to a Stage 4, and should be reported as such, regardless of the presence of eschar, slough or a scab.

If, however, no bone, muscle, tendon or joint capsule (Stage 4 structures) are visible, and some degree of necrotic tissue (eschar or slough) or scabbing is present that the clinician believes may be obscuring the visualization of Stage 4 structures, then the pressure ulcer is Unstageable. If in a full thickness pressure ulcer, no bone, muscle, tendon or joint capsule is visible, and in the clinician's judgment the amount and/or placement of any necrotic tissue or scabbing present could NOT be obscuring visualization of Stage 4 structures, the clinician should report the pressure ulcer as Stage 3.

In the unusual situation of an Unstageable scabbed pressure ulcer, when completing M1311, Current Number of Unhealed Pressure Ulcers at Each Stage, report the pressure ulcer in row E1, Unstageable: Known but not stageable due to coverage of wound bed by slough and/or eschar. When completing M1313, Worsening in Pressure Ulcer Status since SOC/ROC, report the pressure ulcer in row e, Unstageable – known or likely but Unstageable due to coverage of wound bed by slough and/or eschar. Note that a scab is not slough or eschar, but due to the constraints of the data set, the Unstageable scabbed pressure ulcer must be reported in this manner. Documentation in the patient's medical record will describe the clinical findings.

Q98.4.3.1. M1311 & M1313. Upon admission, our patient had two distinct pressure ulcers in close proximity. Over the course of the episode the ulcers deteriorated and no longer had any separating tissue. Do we now call this one pressure ulcer at the worst stage? [Q&A EDITED 10/16; Q&A ADDED 04/15; Previously CMS Qtrly 04/15 Q&A #2]

A.98.4.3.1. M1311 & M1313. If at the SOC/ROC the patient had two distinct pressure ulcers (for example, one Stage 3 and one Stage 4), and the surface areas of the pressure ulcers progressed to the point that they "became one ulcer" in that the assessing clinician could no longer differentiate one pressure ulcer from the other; at discharge, if the pressure ulcer was stageable, the patient would have one Stage 4 pressure ulcer reported in M1311 row C1. Since at discharge, the patient has a Stage 4 pressure ulcer in the area that had been a Stage 4 at SOC/ROC, the Stage 4 would not be reported as "new or worsened" in M1313, row c.

Q98.4.4. M1311 & M1320. If a patient had a Stage 2 pressure ulcer at SOC, but at ROC, the same wound developed a "scab" (not eschar/slough), how would M1311 and M1320 be answered at ROC? [Q&A EDITED 10/16; Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 10/13 Q&A #6]

A98.4.4. If, at the ROC assessment, the wound bed is obscured and cannot be visualized, the assessing clinician cannot know the exact depth of damage, therefore the pressure ulcer cannot be staged. In the situation of an Unstageable scabbed pressure ulcer, when completing M1311, Current Number of Unhealed Pressure Ulcers at Each Stage, report the pressure ulcer in row E1, Unstageable: Known but not stageable due to coverage of wound bed by slough and/or eschar. **Note that a scab is not slough or eschar, but due to the constraints of the data set, the Unstageable scabbed pressure ulcer must be reported in this manner.**

Documentation in the patient's medical record will describe the clinical findings.

When completing M1320, Status of Most Problematic Pressure Ulcer that is Observable, the healing status options available are determined by whether the pressure ulcer had partial or full thickness tissue loss. If the assessing clinician identifies a scab is present and appears to have developed over part of a partial thickness wound, without granulation, the M1320 healing status is "3-Not healing", since partial thickness ulcers do not heal by granulation and a wound with a scab adhering to the wound base could not be considered newly epithelialized.

When a scab has formed over part of a pressure ulcer with full thickness tissue loss, refer to the current WOCN Guidance on OASIS Integumentary Items for the definitions of the healing status of pressure ulcers. If a scab is obscuring the wound bed, you would not be able to assign the status of "0-Newly epithelialized" because the wound bed is not completely covered by new epithelium. *If you identify that the scab is raised and appears to be covering a wound that has filled with granulation to the same level as the surrounding skin surface, you would report "1-Fully granulating".* You might not be able to assign the status of "Fully granulating" if the scab prevents you from visualizing if the wound bed is filled with granulation tissue to the level of the surrounding skin. If the scab is present in a wound bed which is sunken below the level of the surrounding skin, then you could not select "0-Newly epithelialized" or "1-Fully granulating". If there are no s/s of infection and you can visualize that at least 25% of the wound bed is covered with granulation tissue, then select "2-Early/partial granulation". Note that a scab is NOT avascular tissue (eschar or slough), so the "<25% of the wound bed is covered with avascular tissue" criteria for the "Early/partial granulation" healing status does not apply to a scab. If the scab covered wound could be observed to meet ANY of the criteria for "3-Not Healing", Response 3 should be reported. (See CMS OASIS Q&A, Cat. 4b #99.2.1).

When a scab has formed over a pressure ulcer and COMPLETELY covers the pressure ulcer preventing the clinician from determining the presence or amount of granulation tissue, or even if the underlying wound was partial or full thickness, then the clinician may have no choice but to consider the scab similar to avascular tissue, and use their best judgment in applying the WOCN Guidance to determine whether the pressure ulcer is 1- Fully Granulating, 2- Early/Partial Granulation, or 3- Not Healing.

Q98.5. [Q&A RETIRED 10/16; Redundant to revised Q 89.1]

Q98.6.M1313. For M1313, if the patient had Stage 4 pressure ulcer that became infected during the episode, at DC would the new infection be considered a "worsening" of the pressure ulcer? [Q&A EDITED 10/16; Q&A ADDED 04/15; Previously CMS Qtrly 07/14 Q&A #5]

A98.6. No, the specific and only definition of "worsening" that should be applied to M1313 is that the pressure ulcer has increased in numerical stage, for instance worsened or progressed from

a Stage 3 pressure ulcer to a Stage 4 pressure ulcer. "Worsening", as defined by M1313, does not take into consideration other aspects of the pressure ulcer, like changes in healing status due to a new infection, or increased pain intensity at DC, compared with SOC.

Q99. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q99.1. [Q&A RETIRED 09/09; Outdated]

Q99.1.1. [Q&A RETIRED 06/14; Item deleted]

Q99.2. M1320. What is the healing status (M1320) of a pressure ulcer that presents as an intact serum filled blister? [Q&A EDITED 10/16; Previously CMS Qtrly Q&A 10/16 #17; Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #19]

A99.2. An intact serum-filled blister resulting from pressure would be reported as a Stage 2 pressure ulcer, as long as examination of the area adjacent to or surrounding the blister did not demonstrate signs of tissue damage indicative of a deep tissue injury. Since Stage 2 pressure ulcers do not granulate, and since the presence of the serum-filled blister demonstrates a defect in epidermis, the status of "Not Healing" is the most appropriate response.

Q99.2.1. M1320. How do you define the healing status of a Stage 4 pressure ulcer that has closed to the point it has a scab on the surface? It is not eschar or slough. [Q&A EDITED 10/16; Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 07/13 Q&A #10]

A99.2.1. Refer to the current WOCN Guidance on OASIS Integumentary Items for the definitions of the healing status of pressure ulcers. If a scab is obscuring the wound bed, you would not be able to assign the status of "0-Newly epithelialized" because the wound bed is not completely covered by new epithelium. If you identify that the scab is raised and appears to be covering a wound that has filled with granulation to the same level as the surrounding skin surface, you would report "1-Fully granulating". You might not be able to assign the status of "Fully granulating" if the scab prevents you from visualizing if the wound bed is filled with granulation tissue to the level of the surrounding skin. If the scab is present in a wound bed which is sunken below the level of the surrounding skin, then you could not select "0-Newly epithelialized" or "1-Fully granulating". If there are no s/s of infection and you can visualize that at least 25% of the wound bed is covered with granulation tissue, then select "2-Early/partial granulation". Note that a scab is NOT avascular tissue (eschar or slough), so the "<25% of the wound bed is covered with avascular tissue" criteria for the "Early/partial granulation" healing status does not apply to a scab. If the scab covered wound could be observed to meet ANY of the criteria for "3-Not Healing", Response 3 should be reported.

Q99.2.2.M1320. 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? [Q&A ADDED 04/15; Previously CMS Qtrly 10/14 Q&A #7]

A99.2.2. 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.

Q99.3. M1320 & M1324. My patient has a Stage 3 pressure ulcer that is closing. How do I report the stage and status when the opening has shrunk to a pinpoint size and does not present a viewable base due to the small opening? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 10/11 Q&A #7]

A99.3. If you have a Stage 3 that is in the process of closing, it remains an observable Stage 3 unless the wound bed was covered with a dressing that could not be removed or the wound bed was obscured with avascular tissue. If the wound margins are open and have now closed to the

point where the opening is a pinpoint, the pressure ulcer would remain a Stage 3. The status could be either Early/partial granulation or Fully granulating, based on the descriptors in the current WOCN Guidance on OASIS Integumentary Items, until the wound margins closed, at which time it would no longer be considered a pressure ulcer.

Q99.15. M1324. Is reverse staging now acceptable for Stage 1 and 2 pressure ulcers?

[Q&A EDITED 10/16; Q&A ADDED 12/12; Previously CMS Qtrly 01/12 Q&A #6]

A99.15. CMS guidance regarding reverse staging is unchanged. Do not reverse stage pressure ulcers.

Q100. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q100.01. M1330. Our patient's lower extremity wound originated as a trauma wound due to a fall. The patient also has diagnoses of venous insufficiency and stasis dermatitis. The physician stated the wound is not healing due to the venous insufficiency. Is there a point in time when the wound is no longer classified as a traumatic wound and considered a stasis ulcer for M1330? [Q&A ADDED 06/14; Previously CMS Qtrly 01/13 Q&A #9]

A100.01. M1330, Does this patient have a Stasis Ulcer, identifies patients with ulcers caused by inadequate circulation in the area affected. The healing process of other types of wounds, e.g. traumatic wounds, surgical wounds, burns, etc., may be impacted by the venous insufficiency, but it would not change the traumatic or surgical wound into a venous stasis ulcer.

Q100.1. M1330, M1332, M1334 & M1350. How do we answer the OASIS stasis ulcer questions when the patient diagnoses include Peripheral Arterial Disease and Venous Stasis Insufficiency? The nurse spoke with the physician who stated the patient had "mixed arterial and venous disease." [Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 07/11 Q&A #6]

A100.1. In a situation where the clinician visually assessed ulcers on the lower legs that the physician diagnosed as a mixture of venous stasis and arterial ulcers, the OASIS stasis ulcer items would be answered as follows: (Utilization of the WOCN's "Quick Assessment of Leg Ulcers" located at www.wocn.org may be helpful when distinguishing the ulcers that have a venous disease etiology versus the arterial disease.)

M1330, Does this patient have a Stasis Ulcer = Yes.

M1332, Current Number of Stasis Ulcer(s) that are Observable would be answered reflecting only those ulcers that were a result of venous insufficiency, not arterial. Utilize WOCN Quick Assessment of Leg Ulcers to help distinguish venous from arterial.

M1334, Status of Most Problematic Stasis Ulcer that is Observable would be based on the one observable ulcer resulting from venous insufficiency that is the most problematic.

M1350, Skin Lesion/Open Wound would report the ulcers that were purely a result of arterial disease, if they are receiving intervention from the agency.

Q100.1.1.M1330. Cat 4b Q100.1 states that a patient with Peripheral Arterial Disease and Venous Stasis Insufficiency could have mixed arterial and venous stasis ulcers, which would be reported on M1330 – Stasis Ulcers. For a patient with an ulcer who has mixed arterial and venous disease, should M1330 always be “yes”, that the patient has a Stasis Ulcer? [Q&A ADDED 10/16; Previously CMS Qtrly 01/16 Q&A #6]

A100.1.1. No. In a situation where the patient has a mixture of venous stasis and arterial disease, the wound appearance and characteristics will often help the physician determine if the ulcer is venous, arterial, or mixed. If the wound is determined to be a venous stasis ulcer, or a

mixed arterial and venous ulcer, the assessing clinician would document the wound in M1330. If the wound is determined to be arterial and it is receiving clinical assessment or intervention from the home health agency, the assessing clinician would document the wound in M1350 Skin Lesion or Open Wound.

Q100.2. M1332. My patient has a venous stasis wound of the lower extremity that covers the entire lower leg, but in the midst of the wound there are two dark areas. Do we count this as one ulcer or two? [Q&A ADDED 01/12; Previously CMS OCCB 07/11 Q&A #7]

A100.2. If areas of venous stasis ulceration are contiguous and developed at the same time, the entire area would be counted as one stasis ulcer. If the patient had a venous stasis ulcer and then later developed another venous stasis ulcer, and eventually the wound margins met, it would be counted as two ulcers, as long as it remains possible to differentiate one ulcer from another based on wound margins. Depending on the timing and progression, it may be difficult for the clinician to know that a current ulcer was once two ulcers, and/or where one ulcer ends and another begins for assessment/reporting purposes. It would be up to the assessing clinician to determine the number of stasis ulcers in situations where multiple ulcers may have merged together.

Q101. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q102. M1340-M1342. Is a gastrostomy that is being allowed to close on its own considered a surgical wound? [Q&A EDITED 09/09]

A102. A gastrostomy that is being allowed to close would be excluded from consideration as a surgical wound, because it is an ostomy. It may be reported in M1350 if it was receiving intervention from the home health agency.

Q102.1. M1340 & M1350. Is a peritoneal dialysis catheter considered a surgical wound? Isn't the opening in the abdominal wall a type of ostomy? [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #22]

A102.1. The site of a peritoneal dialysis catheter is considered a surgical wound. The opening in the abdominal wall is referred to as the exit site and is not an ostomy.

Q103. M1340. If the patient had a port-a-cath, but the agency was not providing any services related to the cath and not accessing it, would this be scored as a surgical wound? [Q&A EDITED 09/09]

A103. Yes.

Q104. M1340. Are implanted infusion devices or venous access devices considered surgical wounds? Does it matter whether or not the device is accessed routinely? [Q&A EDITED 09/09]

A104. Yes, the surgical sites where such devices were implanted would be considered surgical wounds. It does not matter whether the device is accessed at a particular frequency or not.

Q104.1. M1340. Is the Vantas implanted device considered a surgical wound? [Q&A ADDED 06/14; Previously CMS Qtrly 07/13 Q&A #12]

A104.1. The VANTAS® Implant is inserted just under the skin in the upper arm and provides a continuous 12-month administration of histrelin acetate for the palliative treatment of advanced prostate cancer. Once the surgical incision that was created to implant the device is made and until the implant device is removed, it is considered a surgical wound for M1340.

Q105. M1340. If debridement is required to remove debris or foreign matter from a traumatic wound, is the wound considered a surgical wound? [Q&A ADDED 06/05; Previously CMS OCCB 08/04 Q&A #9]

A105. No. Debridement is a treatment to a wound, and the traumatic wound does not become a surgical wound.

Q105.1. M1340. If a patient has a venous access device that no longer provides venous access, (e.g. no bruit, no thrill, unable to be utilized for dialysis), is it considered a venous access device that would be “counted” as a surgical wound for M1340, Surgical Wound and the subsequent surgical wound question? [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #26]

A105.1. Yes, as long as the venous access device is in place, it is considered to be a surgical wound whether or not it is functional or currently being accessed.

Q105.1.1. M1340. Is an arteriovenous (AV) fistula considered as a current surgical wound? Does it matter if it is still utilized for dialysis? [Q&A ADDED 06/14; Previously CMS Qtrly 07/13 Q&A #11]

A105.1.1. While the surgical connection of a vein to an artery is not a synthetic access/device, an AV fistula is considered a current surgical wound once it is surgically created and as long as it is present in the patient's body. This is true even if the fistula never matures, and/or is not currently used for vascular access.

In addition to AV fistulas, the sites of implanted venous access devices or other implanted infusion devices such as medication pumps, catheters for peritoneal dialysis, AV shunts or AV grafts should all be considered surgical wounds for as long as they are present, whether functional or not.

Q105.2. M1340. Does the presence of sutures equate to a surgical wound? For example, IV access that is sutured in place, a pressure ulcer that is sutured closed or the sutured incision around a fresh bowel ostomy. [Q&A EDITED 01/10; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #27]

A105.2. No, the presence of sutures does not automatically equate to a surgical wound. In the examples given, a peripheral IV, even if sutured in place, is not a surgical wound. A pressure ulcer does not become a surgical wound by being sutured closed, and the bowel ostomy would be excluded from M1340, Does this patient have a Surgical Wound and M1350, Skin Lesion or Open Wound.

Q105.3. M1340. Since an implanted venous access device is considered a surgical wound for M1340, when it is initially implanted, is the surgical incision through which it was implanted a second surgical wound (separate from the venous access device)? [EDITED 06/14; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #28 and CMS OCCB 04/10 Q&A #12]

A105.3. An implanted venous access device is considered a current surgical wound as long as it is implanted in the patient's body.

When first implanted, the incision is the surgical wound. The assessing clinician will follow the 12/09 WOCN guidance and related guidance in Ch. 3 of the current OASIS Guidance Manual and the CMS OASIS Q&As to determine the healing status of the incision. Once it is fully epithelialized, the site due to the implanted device will remain a current surgical wound with a status of "Newly epithelialized" for as long as it is present in the patient's body, unless it later develops complications.

Q105.4. M1340. If an abscess is incised and drained, does it become a surgical wound? [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #29]

A105.4. No, an abscess that has been incised and drained is an abscess, not a surgical wound.

Q105.4.1. M1340. If, when reading op reports I find that tissue and/or other structures (mesh, necrotic tissue etc.) were excised when the operation procedure only states I&D, is the resulting wound a surgical wound even though the surgery is labeled I&D? [Q&A ADDED & EDITED 09/09; M number updated 09/09; Previously CMS OCCB 10/07 Q&A #18]

A105.4.1. A simple I&D of an abscess is not a surgical wound for OASIS reporting. A surgical procedure that involves excision of necrotic tissue beyond general debridement (such as excision of a necrotic mass), excision of mesh or other appliances or structures goes beyond a simple I&D and the resulting lesion would be reported as a surgical wound for M1340 until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

Q105.4.1.1 M1340. My patient has a diagnosed diabetic foot ulcer. Recently she had an I&D of the foot with a bone biopsy (needle or other technique) to rule out osteomyelitis. Would the ulcer be classified as a surgical wound after the biopsy? [Q&A ADDED 10/16; Previously CMS Qtrly 07/15 Q&A #3]

A105.4.1.1 The wound in the example you cite would continue to be considered a diabetic foot ulcer, and not reported as a surgical wound.

Q105.4.2. M1340. If a patient had an intra-abdominal abscess that was drained percutaneously and then a JP drain was inserted via interventional radiology is this considered a surgical wound? [Q&A ADDED 06/14; Previously CMS Qtrly 01/14 Q&A #8]

A105.4.2. Yes. Even though the opening was created percutaneously, it is considered a surgical wound because a drain was inserted.

Q105.5. M1340. 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? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #17]

A105.5. 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. It is considered a surgical wound until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

Q105.5.1. M1340. An I&D is not considered a surgery - but a drain inserted during this procedure makes the wound a surgical wound. Dilemma: This makes the OASIS answer for surgical wound a yes but we cannot code aftercare because we don't code the I&D as a surgery - but we do have surgical wound care. This is quite confusing. [Q&A ADDED 09/09; M numbers updated 09/09; Previously CMS OCCB 07/08 Q&A #8]

A105.5.1. The OASIS M0 item response will not always mirror diagnoses and ICD-10 codes found in M1021 and M1023. Continue to score the OASIS following current CMS guidance, and follow ICD-10 CM coding guidance for code selection for M1021 and M1023.

Q105.6. M1340. A patient, who has a paracentesis, has a stab wound to access the abdominal fluid. Is this a surgical wound? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #18]

A105.6. 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 re-epithelialization has been present for approximately 30 days at which time it becomes a scar) 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.

Q105.7. [Q&A RETIRED; Duplicative of Q&A #105.11]

Q105.8. M1340. Does a patient have a surgical wound if they have a traumatic laceration and it requires plastic surgery to repair the laceration? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #20]

A105.8. 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 M1340 for this type of wound would be 1 or 2 depending on whether or not it was observable.

Q105.9. M1340. 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. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #21]

A105.9. 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.

Q105.9.1. M1340. A patient had a “PICC” catheter inserted centrally into the internal jugular. Is this considered a central line when scoring M1340, Surgical Wounds? [Q&A ADDED 06/14; Previously CMS Qtrly 01/14 Q&A #7]

A105.9.1. Central venous catheters or central lines are those with the catheter tip located in the superior vena cava. Central lines can be peripherally inserted (i.e., basilic or cephalic vein in upper arm, or femoral vein in the groin) or centrally inserted (i.e., internal jugular vein in the neck, or subclavian or axillary vein in the chest). Central lines that are centrally inserted (as in the internal jugular example) ARE considered surgical wounds for M1340 because of the central insertion, even if the type of catheter inserted into the central vein was intended to be inserted peripherally. Central lines that are peripherally inserted are not considered surgical wounds.

Q105.10. DELETED 04/15; Replaced by 4b Q109.1

Q105.11. M1340. Is a heart cath site (femoral) considered a surgical wound? If not, what if a stent is placed? [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/07 Q&A #9]

A105.11. 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 M1340. The fact that a stent was placed does not have an impact.

Q105.11.1. M1340. I know existing guidance states that a femoral stick site created to perform cardiac catheterization is not a surgical wound. Does the same apply for the femoral sheath site created with a cut down procedure to perform endovascular AAA repair? What if a cut down procedure is needed to create a larger “wound” than a typical

femoral sheath stick....would this change its status? [Q&A ADDED 01/11; Previously CMS OCCB 10/10 Q&A #7]

A105.11.1. If an incision or "cut down" was completed in order to perform a procedure per femoral sheath, this incision would be considered a surgical wound. A femoral puncture site created without "cut down" is not a surgical wound on M1340.

Q105.12. M1340. If a drain was placed post-op and removed prior to admission to home health is the drain site considered a surgical wound upon admission to home care? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 10/07 Q&A #17]

A105.12. A wound with a drain is reported as a surgical wound at M1340. It remains a surgical wound after the drain is pulled until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

Q105.13. M1340. A patient had a skin cancer lesion removed in a doctor's office with a few sutures to close the wound. Is this considered a surgical wound? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 10/07 Q&A #19]

A105.13. A shave, punch or excisional biopsy, utilized to remove and/or diagnose skin lesions, does result in a surgical wound. It is considered a surgical wound until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

Q105.13.01. M1340. Our patient had skin cancer treated with electrodesiccation and curettage, creating a lesion. Is this considered a surgical wound when completing M1340, Surgical Wounds? [Q&A ADDED 06/14; Previously CMS Qtrly 01/14 Q&A #6]

A105.13.01. Yes.

Q105.13.02 M1340. The Q&As address wounds caused by electrodesiccation and curettage as being surgical wounds. Would lesions resulting from freezing with liquid nitrogen be considered surgical wounds for M1340? [Q&A ADDED 10/16; Previously CMS Qtrly 07/15 Q&A #6]

A105.13.02 A lesion resultant from cryosurgery is not considered a surgical wound when scoring the OASIS item M1340. The lesion may be reported in M1350 Wounds/Lesion if the lesion requires clinical assessment or intervention from the home health agency.

Q105.13.1. M1340. Is the removal of a callus considered to be a surgical wound? [Q&A ADDED 01/11; Previously CMS OCCB 10/10 Q&A #8]

A105.13.1. A callus that was removed is NOT considered a surgical wound when scoring the OASIS item M1340, although it may be reported in M1350 Wounds/Lesions if it is receiving intervention from the agency.

Q105.14. M1340. Are arthrocentesis sites considered surgical wounds? [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 04/08 Q&A #10]

A105.14. 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 re-epithelialization has been present for approximately 30 days at which time it becomes a scar) should be reported as a surgical wound. If a needle was inserted to aspirate fluid and then removed, (no drain left in place), it should not be reported as a surgical wound.

If a physician performs a surgical procedure via arthroscopy, the arthrocentesis site would be considered a surgical wound until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

Q105.14.1 M1340. Is a wound from an abdominal laparoscopy surgery considered a surgical wound? No drain was placed after the procedure. [Q&A ADDED 10/16; Previously CMS Qtrly 07/15 Q&A #5]

A105.14.1 Per existing guidance, for M1340, an incision created for the purpose of laparoscopic surgery, arthroscopy, and other minimally invasive surgery/procedure would be considered a surgical wound. It remains a current surgical wound until the site is completely epithelialized and is without signs/symptoms of infection for approximately 30 days, at which time it becomes a scar.

Q105.15. M1340. Is an implanted mechanical left ventricle device (LVAD) that has an air vent exiting through lower right abdomen a surgical wound? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/08 Q&A #7]

A105.15. The Left Ventricular Assist Device's (LVAD/HeartMate) cannula exit site would be considered a surgical wound until the LVAD is discontinued and the wound is re-epithelialized for approximately 30 days at which time it becomes a scar.

Q105.16. M1340. Is a chest tube site a surgical wound? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/08 Q&A #10]

A105.16. A chest tube site is a thoracostomy. Ostomies are excluded as surgical wounds in the OASIS. A chest tube site is not a surgical wound even if a chest tube or drain is present. It may be reported in M1350 if they are receiving intervention from the home health agency.

Q105.16.1. M1340. A surgical incision was created to perform exploratory surgery. When closing the wound, the surgeon inserted a chest tube utilizing the opening created for the surgery. Can this closed incision with a chest tube be counted as a surgical wound when completing M1340? [Q&A ADDED 01/11; Previously CMS OCCB 10/10 Q&A #9]

A105.16.1. The wound described should be considered a thoracostomy and is not considered a surgical wound when completing the OASIS data set item M1340.

Q105.17. M1340. Would an enterocutaneous fistula that developed as a result of a surgery be documented as a surgical wound? [Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 10/08 Q&A #5]

A105.17. A fistula is a complication of surgery but it is not a surgical wound. Though fistulas are sometimes located within surgical wounds, answering M1340 & M1342 would be based on the condition of the surgical wound, not the fistula, using the WOCN OASIS Guidance document. For example, if the only opening in a 3 month-old closed surgical wound healed by primary intention was an enterocutaneous fistula then the answer to M1340 (Does this patient have a surgical wound?) would be "0-No".

Q105.18. M1340. Our patient has a complicated wound involving a mid-line abdominal incision and 6 buttons holding retention sutures running under the skin. Would each button be considered a surgical wound for OASIS data collection? [Q&A ADDED 09/09; Previously CMS OCCB 07/09 Q&A #8]

A105.18. No, a retention suture that utilizes a button to prevent damage to the skin is not considered a surgical wound.

Q105.19. M1340. Is a Q ball used for pain management following a joint replacement considered a surgical wound if the Q ball remains in place? Is it considered a surgical wound after removal if the site is still observable? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/09 Q&A #9]

A105.19. The ON-Q pump was developed to continuously infuse local anesthetic through 2 small catheters inserted at the wound site. If the catheters are inserted into the surgical incision, they are not considered separate surgical wounds. If the surgeon implanted the catheters at locations other than the surgical incision, the insertion sites would be considered separate surgical wounds, as the ON-Q pump catheters are implanted infusion devices. After discontinuation of the infusion, the insertion sites would be considered current surgical wounds until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

Q105.20. M1340. Is a VP shunt for hydrocephalus a current surgical wound, no matter how old it is? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/09 Q&A #10]

A105.20. The incision created to implant the VP shunt is a surgical wound until re-epithelialization has been present for approximately 30 days at which time it becomes a scar. At this point it is no longer considered a current surgical wound, as the VP shunt is neither venous access device nor an infusion device.

Q105.21. M1340. Are toenail removals by a MD considered a surgical wound with or without sutures? [Q&A ADDED 01/12; Previously CMS OCCB 07/11 Q&A #8]

A105.21. Removal or excision of a toenail is not considered a surgical wound. If a surgical procedure was performed that goes beyond simple excision, it would be considered a surgical wound.

Q105.22. M1340. Are insulin and morphine pumps captured in M1340, Surgical Wounds? [Q&A EDITED 04/15; ADDED 01/12; Previously CMS OCCB 07/11 Q&A #9]

A105.22. If the infusion device is implanted, it would also qualify as a surgical wound under M1340. An external device infusing medication via a SQ needle is not counted as a surgical wound.

Q105.23 M1340. Are burr holes on the head following an evacuation of a subdural hematoma which still have tightly adhered scabs considered a surgical wound for M1340? [Q&A ADDED 10/16; Previously CMS Qtrly 07/15 Q&A #4]

A105.23 For the purposes of the OASIS Integumentary Status items, a burr hole is a hole that is surgically placed in the skull, or cranium and is considered a surgical wound. It remains a current surgical wound until the site is completely epithelialized and is without signs/symptoms of infection for approximately 30 days, at which time it becomes a scar.

Q106. M1340. Is a peritoneal dialysis catheter considered a surgical wound? [Q&A EDITED 01/11]

A106. A peritoneal dialysis catheter (or an AV shunt) is considered a surgical wound in the OASIS data set, as long as they are present in the patient's body. This also true for central lines and implanted vascular access devices.

Q106.1. M1340 & M1030. Our patient has a “Mammosite”, a device implanted in her lumpectomy site. She receives radiation bead insertion through this catheter. It requires a sterile dressing change daily. Is this device a surgical wound for M1340 and M1342? Is this an infusion device for M1030? [Q&A ADDED 12/12; Previously CMS Qtrly 07/12 Q&A #3]

A106.1. Based on the details provided in the question, the incision created to insert the balloon catheter is considered a surgical wound in OASIS. Utilize existing CMS guidance to determine the healing status.

MammoSite® breast brachytherapy (balloon catheter radiation) is a type of accelerated breast radiation treatment. Since the saline and radiation seed remains in the balloon catheter, it is not an infusion and would not be reported in M1030, Therapies at home.

Q106.2. M1340. Is the site resulting from a kyphoplasty procedure counted as a surgical wound when answering M1340? [Q&A ADDED 12/12; Previously CMS Qtrly 07/12 Q&A #4]

A106.2. If the kyphoplasty procedure was performed percutaneously and resulted in a pinpoint needle puncture site where the bone cement was injected, it would not be considered a surgical wound. If the kyphoplasty procedure involved an open approach, requiring a surgical incision, the resulting wound would be considered a surgical wound for M1340.

Q107 & 108. [RETIRED 09/09; Outdated]

Q108.01. M1340. When does a surgical wound become “healed” or no longer reportable as a surgical wound on M1340? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/08 Q&A #11]

A108.01. For the purposes of determining the healing status for this OASIS item, a surgical wound can be considered fully healed and not reportable as a current surgical wound once re-epithelialization has been present for approximately 30 days at which time it becomes a scar. The incision must be clean, dry and completely closed with no signs or symptoms of infection.

Q108.02. M1340. If the patient had a pressure ulcer and the post-op surgical report states it was surgically excised and closed without placement of a muscle flap, do we still have a Stage 4 pressure ulcer-the original etiology or did this become a surgical incision? [Q&A EDITED 10/16; EDITED 04/15; Q&A ADDED 06/14; Previously CMS Qtrly 07/13 Q&A #8]

A108.02. If all the tissue damaged by pressure is removed surgically, e.g. amputation or surgical excision, there is no longer a pressure ulcer. It becomes a surgical wound until healed.

Q108.03. M1306-M1324, M1340. 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? [Q&A ADDED 04/15; Previously CMS Qtrly 10/14 Q&A #5]

A108.03. 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.

Q108.1. M1340 & M1342. Recently released guidance states that a surgical wound becomes "healed" or no longer reportable as a surgical wound on M1340 once re-epithelialization has been present for approximately 30 days. Determining a specific

timeframe in regards to complete epithelialization presents some issues. For instance, if we get a post surgery patient who has been in the nursing home and then to home health, we may not know when complete epithelialization occurs. Please provide further clarification. [Q&A EDITED 01/12; ADDED 09/09; Previously CMS OCCB 10/08 Q&A #6]

A108.1. If, at the SOC or other assessment time points, the clinician assesses the wound to be completely epithelialized (including no sign of infection or separation), and the date of complete epithelialization is unknown, the clinician will have to make a determination regarding the wound status based on the history of the date of surgery, any reported wound healing progress/complications and clinical assessment findings.

Since for the purposes of the OASIS, a surgical wound is considered healed and no longer counted as a current surgical wound once re-epithelialization has been present for approximately 30 days (assuming no sign of infection or separation), then if based on the surgery date, it is clear that the completely epithelialized wound could not possibly have been fully epithelialized for at least 30 days, Response 0-Newly epithelialized should be reported.

If the wound appears completely epithelialized (no sign of infection or separation) and the date of epithelialization is unknown, but based on the known wound history and date of surgery it is possible that the wound could have been fully epithelialized for at least 30 days, then the wound status is deemed “healed” and no longer reportable as a surgical wound. CMS will remind HHAs of their responsibility to comply with the HH Conditions of Participation, (see 42 CFR 484.18), when a surgery date is not provided on the referral. CMS expects the documentation within the patient’s medical record to reflect consultation with the patient’s physician therefore it is difficult to envision the HHA being unable to ascertain the patient’s date of surgery.

Q109. M1340 & M1342. Is a mediport "nonobservable" because it is under the skin? [Q&A EDITED 06/14]

A109. Please refer to the definition of “not observable” used in the OASIS surgical wound items in the current OASIS Guidance Manual – “not observable” is an appropriate response ONLY when a non-removable dressing is present. This is not the case with a mediport. As long as the mediport is present, whether it is being accessed or not, the patient is considered as having a current surgical wound.

Q109.1. M1340 & M1342. How would M1340 – Surgical Wound and M1342 – Status of Most Problematic Surgical Wound be answered, if the clinician determines that the steri-strips completely obscure the incision preventing visual assessment of the wound? Would the clinician need to obtain an order from the physician stating the steri-strips are a “non-removable dressing” for the wound to be considered not observable in M1340? [Q&A ADDED 04/15; Previously CMS Qtrly 04/15 Q&A #3]

A.109.1. M1340 & M1342. Steri-strips are skin closures (similar in intent to sutures or staples) and not a dressing or device. Steri-strips will remain in place until they fall off, unless there is a specific clinical reason and/or physician’s order to remove them sooner. While they are in place, if the placement of the steri-strips allows sufficient visualization of the wound, the assessing clinician can determine and report on M1342 the appropriate healing status response, based on the WOCN guidance. If the steri-strips completely obscure the incision, or obscure the incision to the point that the assessing clinician is unable to visualize the incision well-enough to determine the healing status, then M1340 - Surgical Wound should be reported as Response 2 - Surgical wound known but not observable due to non-removable dressing/device, and M1342 would be skipped. Note that while steri-strips are clinically different than a dressing or a device, the limitations of the OASIS data responses make this the best response in the situation described.

Q110. [Q&A RETIRED 09/09; Outdated]

Q111. [Q&A RETIRED 08/07; Outdated due to revision of WOCN guidance]

Q.111.1. M1342 & M1350. What standards are used to assess cemented surgical wounds when answering OASIS items M1342, Healing status and M1350, Skin lesion/Open wound? [EDITED 06/14; ADDED 09/09; Previously CMS OCCB 10/08 Q&A #4]

A111.1. M1342: When assessing a surgical incision that has been cemented rather than sutured, continue to follow the WOCN OASIS Wound Item Guidance applicable to the surgical incision, located at <http://www.wocn.org/>.

1. If the wound can be visualized, it is observable. Only surgical wounds that have a dressing that cannot be removed by physician order and obscures visualization of the incision are considered non-observable.
2. For the purposes of determining the healing status, a surgical wound can be considered fully healed and not reportable as a current surgical wound approximately 30 days after complete epithelialization. The incision must be clean, dry and completely closed with no signs or symptoms of infection. The resulting scar would only be reported as a wound/lesion (M1350) if it received clinical intervention by the home health agency and was not reported in one of the prior OASIS wound items.
3. The Status of Most Problematic Surgical Wound that is Observable (M1342) is determined by assessment of the skilled clinician following the WOCN OASIS Wound Item Guidance.

M1350: If the wound that is cemented meets the OASIS criteria to be a skin lesion or open wound for M1350, (a lesion or open wound excluding bowel ostomies, other than those described in prior OASIS wound items, that is receiving clinical intervention by the home health agency), then it would be considered a skin lesion or open wound for M1350. If the OASIS criteria excluded the wound type from being reported in M1350 (i.e., bowel ostomy), then the wound would not be reported on M1350, regardless of the type of closure utilized.

Q112. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q112.1, 112.2 & 112.3. [Q&A RETIRED 09/09; Outdated]

Q112.4. M1342. If staples remain in a surgical wound, would it be considered as not healing? [Q&A ADDED 09/09; Previously CMS OCCB 07/08 Q&A #9]

A112.4. A surgical wound with staples in place would only be considered not healing if it meets the WOCN Guidance on OASIS Skin and Wound Status M0 Items' definition of not healing. The WOCN guidance can be found at www.wocn.org. Presences of staples, in and of themselves, do not meet the WOCN criteria for non-healing.

Q112.4.1. M1342. When sutures are removed from surgical wounds healing by primary intention, how does it affect the healing status of the wound? [Q&A EDITED 06/14; Previously CMS OCCB 01/11 Q&A #9]

A112.4.1. For the purposes of scoring the OASIS item, M1342, Status of Most Problematic Surgical Wound that is Observable, openings in the skin, adjacent to the incision line, caused by the removal of a staple or suture, are not to be considered part of the surgical wound when determining the status of the surgical wound. The status of these sites would be included in the comprehensive assessment clinical documentation.

When determining the healing status of the incision, follow the current WOCN Guidance on OASIS Integumentary Items, in addition to other relevant current CMS Q&As. The status of "Not

healing" would only be selected if the wound, excluding the status of the staple/suture site(s), meets the WOCN descriptors.

Q112.5. [Q&A RETIRED and replaced with Q&A #112.5.1.]

Q112.5.1. [Q&A RETIRED 01/12; Guidance located in Ch.3]

Q112.5.2. M1342. In reference to M1342, Status of Most Problematic Surgical Wound that is Observable, for surgical incisions healing by primary intention is it true that the only correct responses are “0-newly epithelialized” and “3-Not healing” as there are no open wound beds with granulation tissue? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #13]

A112.5.2. Surgical incisions healing by primary intention do not granulate. Because of this the only response that could be appropriate for a surgical wound healing by primary intention would be 0-Newly epithelialized or 3-Not healing. “Newly epithelialized” should be chosen if the surgical incision has epidermal resurfacing across the entire wound surface, and no signs/symptoms of infection exist.

Q112.6. M1342. Once the needle is removed from an implanted venous access device, before a scab has formed, the wound bed may be clean but non-granulating. Is it true that based on the WOCN Guidance, the wound would be reported as Response 3 - Not healing for M1342? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 10/08 Q&A #7]

A112.6. When a needle is inserted and removed from an implanted venous access device, it is possible that the skin that was pierced by the needle could have a resulting wound that would heal by secondary intention. Usually, with good access technique and current needle technology there will be no perceptible wound. Occasionally, if there was an extremely large bore needle or traumatic entry or removal, there may be a resulting wound that heals by secondary intention. In this situation, the accessing clinician would rely on the WOCN's OASIS Wound Guidance document to determine the healing status. Note that a scab is a crust of dried blood and serum and should not be equated to either avascular or necrotic tissue when applying the WOCN guidelines. Therefore while the presence of a scab does indicate that full epithelialization has not occurred in the scabbed area, the presence of a scab does not meet the WOCN criteria for reporting the wound status as "Not healing".

Q112.6.1. M1342. How do I mark the healing status of a Q-port that has needle access always in place? Would it be “non-healing”? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #14]

A112.6.1. The assessing clinician must determine the healing status of a wound following guidance in Chapter 3 of the current OASIS Guidance 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, cannot fully granulate and may remain "non-healing" while the line or needle is in place.

Q112.6.1.1.M1342. I have a question about M1340. I have a patient receiving peritoneal dialysis every night. I understand that the peritoneal dialysis catheter site is considered a surgical wound (4b Q102.1) . What would the site’s healing status be for M1342? [Q&A ADDED 10/16; Previously CMS Qtrly 07/16 Q&A #5]

A112.6.1.1. Assuming the assessing clinician determines the peritoneal catheter site is the most problematic observable surgical wound, the clinician would determine the healing status of the wound following the definitions provided in the OASIS Guidance Manual, Chapter 3, M1342 Status of Most Problematic Surgical Wound that is Observable Response-Specific Instructions

located at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html>. The peritoneal catheter exit site cannot fully granulate and/or epithelialize because of the presence of the catheter. In this scenario Response 3 – Not healing for M1342 would be appropriate.

Q112.6.10. M1342 & 1350. Where in the OASIS do I report staple insertion sites and the related edema and bruising that result after surgery? [Q&A ADDED 01/12; Previously CMS OCCB 07/11 Q&A #10]

A112.6.10. The staple sites are expressly excluded from consideration as a surgical wound. Since they are not a surgical wound, they may be reported in M1350, Wounds/Lesions if they are receiving intervention from the agency.

Edema or bruising that result secondary to a surgical insult that is integral to the surgical wound and requires no additional interventions would not be considered separately. If the assessing clinician determines the bruising or edema requires additional intervention, separate from the surgical wound interventions, it would be reported in M1350.

Q112.6.11.M1342. 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? [Q&A ADDED 04/15; Previously CMS Qtrly 10/14 Q&A #9]

A112.6.11. 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.

Q112.6.12.M1340 & M1342. If a surgical wound dehisces at opposite ends, with an area of intact/healed skin between, is this still addressed in OASIS as one surgical incision? Secondly, if still considered a single surgical wound - if one of the dehisced areas is granulating, and the other covered in slough - would the overall percentage of wound bed be considered when determining healing status, rather than applying percentages to two separate wounds? [Q&A ADDED 10/16; Previously CMS Qtrly 04/16 Q&A #7]

A112.6.12. When a portion of the surgical wound is intact/healed, and a portion of the wound is open and healing by secondary intention, to determine the healing status consider the portion of the wound bed that is healing by secondary intention when applying the WOCN criteria of "% of the wound bed covered with granulation tissue" or "% of wound bed covered with avascular tissue". If the surgical wound has more than one area healing by secondary intention, separated by one or more areas of intact/healed tissue, all open areas healing by secondary intention would be included as the "wound bed", when applying the percentages to determine healing status. See the WOCN

Guidance on OASIS Skin and Wound Status Items at www.wocn.org.

Q112.7. M1350. How many different types of skin lesions are there anyway? [Q&A EDITED 09/09; Formerly Q&A #79]

A112.7. Many different types of skin lesions exist. These may be classified as primary lesions (arising from previously normal skin), such as vesicles, pustules, wheals, or as secondary lesions (resulting from changes in primary lesions), such as crusts, ulcers, or scars. Other classifications describe lesions as changes in color or texture (e.g., maceration, scale,

lichenification), changes in shape of the skin surface (e.g., cyst, nodule, edema), breaks in skin surfaces (e.g., abrasion, excoriation, fissure, incision), or vascular lesions (e.g., petechiae, ecchymosis).

Note that for the purposes of scoring M1350 you will only report if the patient has a skin lesion or open wound that is receiving intervention by your agency, other than those already described in the other OASIS wound items, excluding bowel ostomies.

Q112.8. M1350. Is a pacemaker considered a skin lesion? [Q&A EDITED 06/14; Formerly Q&A #80]

A112.8. A pacemaker itself is an implanted device but is not an implanted infusion or venous access device. The (current) surgical wound or scar created when the pacemaker was implanted is reported in M1350 only if it is receiving clinical intervention and had not already been described in M1340, Does this patient have a Surgical Wound or M1342, Status of Most Problematic Surgical Wound that is Observable.

Q112.9. M1350. How should M1350 be answered if the wound is not observable? [Q&A EDITED 09/09; Formerly Q&A #81]

A112.9. The definition of the term "nonobservable" varies depending on the specific OASIS item being assessed. If you know from referral information, communication with the physician, etc. that a wound exists under a nonremovable dressing and it is receiving clinical intervention by the home health agency and it had not already be reported in a prior OASIS wound item, then the wound is considered to be present for M1350, and the item would be answered "Yes."

Q112.10. M1350. Is a new suprapubic catheter, new PEG site, or a new colostomy considered a wound or lesion? [Q&A EDITED 06/14; Formerly Q&A #82]

A112.10. A new suprapubic catheter site (cystostomy) and a new PEG site (gastrostomy) would be considered a skin lesion or wound at M1350, if they were receiving clinical intervention. Bowel ostomies are excluded from consideration in responding to M1350. Ostomies are not reported as surgical wounds in M1340, Does this patient have a Surgical Wound or M1342, Status of Most Problematic Surgical Wound that is Observable.

Q112.10.1. M1350. Are gastrostomies and jejunostomies considered bowel ostomies for the purposes of M1350, Skin Lesion or Open Wound? [Q&A ADDED 01/11; Previously CMS OCCB 10/10 Q&A #10]

A112.10.1. M1350 excludes bowel ostomies for elimination, such as a colostomy or an ileostomy. A jejunostomy or gastrostomy utilized for enteral nutrition is not considered a bowel ostomy for the purposes of OASIS data collection.

Q112.11. M1350. Are implanted infusion devices or venous access devices considered skin lesions at M1350? [Q&A EDITED 12/12; Formerly Q&A #86]

A112.11. Implanted infusion devices and venous access devices are considered surgical wounds when scoring the OASIS Integumentary items. If the infusion device was external (not implanted) or the venous access device was peripherally inserted (not implanted), they would not be considered surgical wounds and would be reported in M1350 if they were receiving clinical intervention by the home health agency.

Q112.12. [Q&A RETIRED 06/14; No longer applicable]

Q112.13. [Q&A RETIRED 06/14; No longer applicable]

Q113. M1400. How should I best evaluate dyspnea for a chairfast (wheelchair-bound) patient? For a bedbound patient? [Q&A EDITED 09/09]

A113. M1400 asks when the patient is noticeably short of breath. In the response options, examples of shortness of breath with varying levels of exertion are presented. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest. If the patient does not have shortness of breath with moderate exertion, then either Response 0 or Response 1 is appropriate. If the patient is not short of breath on the day of assessment, then Response 0 applies. If the patient only becomes short of breath when engaging in physically demanding transfer activities, then Response 1 seems most appropriate.

In the case of the bedbound patient, the level of exertion that produces shortness of breath should also be assessed. The examples of exertion given for Responses 2, 3, and 4 also provide assessment examples. Response 0 would apply if the patient were never short of breath on the day of assessment. Response 1 would be most appropriate if demanding bed-mobility activities produce dyspnea.

Q113.1. M1400. What is the correct response for the patient who is only short of breath when supine and requires the use of oxygen only at night, due to this positional dyspnea? The patient is not short of breath when walking more than 20 feet or climbing stairs. [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #31]

A113.1. Since the patient's supplemental oxygen use is not continuous, M1400 should reflect the level of exertion that results in dyspnea without the use of the oxygen. The correct response would be "4 – At rest (during day or night)". It would be important to include further clinical documentation to explain the patient's specific condition.

Q113.2. M1400. What is the correct response to M1400, Dyspnea, if a patient uses a CPAP or BiPAP machine during sleep as treatment for obstructive sleep apnea? [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #12]

A113.2. Sleep apnea being treated by CPAP is not the same as dyspnea at rest (Response 4 for M1400). M1400 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 M1400. 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.

Q113.3. M1400. 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 M1400, #4 At Rest or 0, Not SOB? [Q&A EDITED 04/15; ADDED 08/07; Previously CMS OCCB 07/07 Q&A #13]

A113.3. M1400 reports what is true on the day of the assessment (the 24 hours immediately preceding the home visit and the time spent by the clinician in the home). If the patient has not demonstrated or reported shortness of breath during that timeframe, the correct response would

be “0-Not short of breath” even though the environment or patient activities were modified in order to avoid shortness of breath.

Q113.4. M1400. In regards to M1400, Dyspnea, can you explain what is meant by the phrase “performing other ADLs” in Response 3 with minimal exertion (e.g., while eating, talking or performing other ADL's)? If we had a client that had dyspnea when they bent over to tie shoes, or when they bent over to pick up something from the floor, would they be a “3”? [Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #10]

A113.4. When completing M1400, Dyspnea, the assessing clinician will assess and report what caused the patient to experience dyspnea on the day of the assessment. The responses represent increasing severity of shortness of breath and include examples that the clinician can use in order to make the determination regarding the amount of effort that caused the patient's dyspnea.

The examples included in Responses 2 and 3 are used to illustrate the degree of effort represented by the terms moderate and minimal. Response 3 - With minimal exertion or agitation includes the examples of eating, talking or performing other ADLs. The reference to other ADLs means activities of daily living that only take minimal effort to perform like grooming. The assessing clinician can use the examples to make the determination regarding the amount of effort that caused the patient's dyspnea. The clinician is not limited to selecting Response 2, moderate exertion, if the patient becomes short of breath while dressing if just minimal effort was exerted and resulted in dyspnea. For example, if a patient lifted their arm to insert it into the sleeve of the shirt and this minimal amount of effort caused the patient to become short of breath, the appropriate response would be Response 3-minimal exertion, even though they became short of breath during the process of dressing. This patient would more than likely also have become short of breath while eating or performing other activities requiring only minimal exertion. The assessing clinician will consider the examples as a guide when determining whether it was moderate or minimal exertion that caused the patient's dyspnea.

A patient who became short of breath after just bending over to pick something up or tie a shoe could be considered a Response 3-with minimal exertion, if in the clinician's judgment, the patient became dyspneic after exerting just minimal effort.

Q114. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q114.1. M1410. If patient is on a ventilator, do you mark O2 & ventilator or is the O2 inclusive with the ventilator in this question? [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/07 Q&A #14]

A114.1. M1410 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.

Q114.2. [Q&A RETIRED 06/14; No longer applicable]

Q115. [Q&A RETIRED 08/07; Duplicative of Archived Chapter 8 guidance]

Q116. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q116.1. M1501. Explain the response “Not assessed” and give an example of when it might be used when completing M1501. [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #17]

A116.1. When completing M1501, Symptoms in Heart Failure Patients, the Response "Not assessed" means the patient with a diagnosis of heart failure was not assessed for symptoms of

heart failure at the time of or at any time since the most recent SOC/ROC assessment. This would not be a best practice. As stated in the Item Intent, the best practices/assessments stated in the item are not necessarily required in the Conditions of Participation.

An example of when "Not assessed" would be used would be a situation where the assessing clinician is completing a Transfer OASIS on a heart failure patient shortly after recertification, where CHF was not the focus of care, and there is no evidence in the clinical record that an assessment of lung sounds, weight gain, dyspnea, orthopnea or lower extremity edema was performed at the time of or since the recertification. Another example: a patient with CHF is admitted to the hospital and discharged with a new diagnosis such as hip fracture. The ROC visit and next visit focused on interventions related to the hip fracture, and no documentation of the heart failure assessment. Patient is unable to remain in the home and is transferred to a SNF. No CHF assessment between ROC and Transfer would mean that M1501 at Transfer would be "2-Not assessed".

Q116.1.5. M1501 & M1511. The nurse is notified by family that her patient, who has a diagnosis of heart failure, was admitted to the hospital due to increased shortness of breath due to CHF. The patient had not exhibited s/s of heart failure since SOC. Since the family chose not to call the agency, no visit was made to assess the patient for s/s of CHF on the day he went in the hospital. How do we answer M1501, Heart Failure Symptoms and M1511, Heart Failure Follow-up in this situation? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 01/11 Q&A #11]

A116.1.5. When M1501, Heart Failure Symptoms, is answered at Transfer or Discharge, "1-Yes" is the appropriate response if the patient had a diagnosis of heart failure and exhibited symptoms of heart failure at the time of or at any time since the most recent SOC/ROC assessment. In your scenario, the patient had a diagnosis of heart failure and the record review revealed that the patient experienced SOB which resulted in a qualifying hospitalization since the SOC assessment. When completing the Transfer OASIS, the clinician would answer M1501 "1-Yes", even though the agency did not have the opportunity to assess the symptoms during a visit. When answering M1511, Heart Failure Follow-up, you report the actions your agency took in response to the heart failure symptoms and if none were taken, Response "0-No action taken" would be appropriate. Include an explanation of the "No" in the clinical record.

Q116.1.6 M1501/M1511. If a patient does not have a diagnosis of heart failure when admitted for home health, but is first diagnosed with heart failure when transferred to the hospital from your agency, how should M1501 and M1511 be answered on the transfer OASIS? [Q&A ADDED 10/16; Previously CMS Qtrly 07/15 Q&A #7]

A116.1.6 If the patient has a physician-confirmed diagnosis of heart failure at the time of the transfer to the inpatient facility, the clinician completing the transfer data collection would consider the patient as having the diagnosis of heart failure, and for M1501 select a response reflecting whether symptoms of heart failure were exhibited since the most recent SOC/ROC assessment. In M1511, the clinician would report all actions taken by the agency in response to heart failure symptoms, at the time of or any time since the most recent SOC/ROC assessment.

Q116.2. M1511. In order to select M1511 - Heart Failure Follow-up "Response 1-Patient's physician contacted the same day", must the physician respond back the same day also? If so, is "same day" interpreted as by midnight of the next calendar day as in other similar M items? [Q&A EDITED 10/16; Q&A ADDED 01/11; Previously CMS OCCB 07/10 Q&A #10]

A116.2. When completing M1511 - Heart Failure Follow-up, Response 1 is an appropriate response only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions on the *same day*.

Same day in this item means by the end of *this* calendar day.

Q116.2.1. M1511. What is meant by "physician-ordered patient-specific established parameter for treatment"? If my patient has a diuretic in her medication regimen and I ask her if she took it as ordered, did I implement a physician-ordered patient-specific established parameter for treatment? [Q&A EDITED 10/16; Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #22]

A116.2.1. Establishment of "patient-specific established parameters for treatment" means the physician has provided an order that identifies specific parameters or guidelines for implementing treatment to the patient based on the patient's condition. An example would be an order for the patient to take an additional 2 mg. p.o. dose of a diuretic if the patient gains 3 pounds in two days or if patient develops rales in bilateral bases, give 1 mg of the diuretic IV. Reminding the patient to take a diuretic that has been ordered q day with no allowance for dose adjustment based on the patient's changing condition, does not qualify as a physician-ordered patient-specific established parameter for treatment

Q116.2.2. M1511. Our therapists do not feel qualified to educate patient's regarding the management of heart failure. If it is a therapy only case and the patient has chronic heart failure symptoms, would it be appropriate to answer M1511, Heart Failure Follow-up, as 4-Patient education or other clinical interventions, if the therapist only handed printed heart failure education materials to the patient? [Q&A EDITED 10/16; Q&A ADDED 01/11; Previously CMS OCCB 10/10 Q&A #12]

A116.2.2. Simply providing a patient printed materials regarding heart failure without assessment of their understanding of the material could not be considered an educational intervention.

Q116.2.3. M1511. Can I mark M1511, Heart Failure Follow-up, Response "1-Patient's physician contacted the same day", if the physician calls the patient back, not the agency, on the same day heart failure symptoms were identified with instructions regarding heart failure symptoms? (The agency identified the symptoms and left a message with the physician's office staff on the same day, but the physician called the patient back, not the agency, on the same day with instructions.) [Q&A EDITED 10/16; Q&A ADDED 01/12; Previously CMS OCCB 04/11 Q&A #6]

A116.2.3. No, you may not select Response 1 if instructions were communicated by the physician directly to the patient/caregiver. In order to select Response 1, the agency must have communicated the heart failure symptoms to the physician or their designee and received instructions or further advice from the physician or their designee by the end of the same day the symptoms were identified. If it was communicated by the physician to the patient or their caregiver, the agency must confirm the accuracy of the information with the physician on the same day to select Response 1.

Q116.2.4. M1511. The RN went out to see a heart failure client who reported she had experienced heart palpitations and increased dyspnea the previous day. The RN instructed the client to call the agency or go to ER if the symptoms reoccur. On the discharge assessment, would you mark response #2 on M1511? The RN called the client the following day to see how she was doing, and asked if she had any further palpitations or dyspnea. Could she mark response #4 also based on an extra phone call? [Q&A EDITED 10/16; Q&A ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #15]

A116.2.4. Response “2–Patient advised to get emergency treatment (e.g., call 911 or go to emergency room)” is not appropriate in the situation described. Response 2 should be selected when the patient exhibits symptoms of heart failure that require immediate attention in an emergency room and is advised to do so. It is not selected, when a patient is educated to go to the ER or call 911 based on pre-established parameters. In the scenario you presented, Response 4–Patient education or other clinical interventions would be appropriate to describe the follow-up phone call to re-assess after reported symptoms.

Q116.5. M1511, M2003, M2005, M2250. Some process measure items refer to providing and/or receiving communication to/from the physician or physician-designee (M2003 & M2005), another refers to the physician or other primary care practitioner (M1511) while another (M2250) includes only the physician. Please define physician-designee and primary care practitioner. Do they include physician extenders, like physician assistants and nurse practitioners? When an item refers to “physician-ordered”, would that include DOs? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #32]

A116.5. For process measure items reporting communication to/from the physician or physician-designee, (such as reporting heart failure symptoms for M1511, reporting a positive depression screen for M2250d, or communication to report/resolve medication issues for M2003) communication can be directly to/from the physician, or indirectly through physician’s office staff on behalf of the physician, in accordance with the legal scope of practice.

For process measure items requiring physician orders, (e.g., M2250 Plan of Care Synopsis), the Plan of Care/orders must be “physician-ordered” including orders from MDs, Doctors of Osteopathic Medicine (DOs), and Doctors of Podiatric Medicine (DPMs) practicing within their legal scope of practice. M2250 includes only physicians as defined here.

Q116.6. M1600. My patient has an order for Sulfa BID x5 days, during the first five days of every month. Upon my SOC assessment on 11/1, the patient complained of s/s of UTI. The physician was notified, but no order was obtained for a urinalysis since the patient was just beginning her prophylactic treatment that day. How should I answer M1600? [Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #12]

A116.6. M1600, Urinary Tract Infection, is asking if the patient has been treated for a urinary tract infection (UTI) in the past 14 days. If the patient was ordered to take Sulfa during the first five days of each month as a prophylactic treatment and developed a UTI, Response “1-Yes”, would be the appropriate response. The physician must determine the diagnosis of a UTI, in order to select Response “1-Yes”. A UTI is not assumed to be present based on the presentation of a symptom(s). In the scenario above, the appropriate response would be “NA–Patient on prophylactic treatment” in absence of a physician diagnosis of UTI.

Q117. M1610. Is the patient incontinent if she only has stress incontinence when coughing?

A117. Yes, the patient is incontinent if incontinence occurs under any situation(s).

Q118. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q119. M1610. A patient is determined to be incontinent of urine at SOC. After implementing clinical interventions (e.g., Kegel exercises, biofeedback, and medication therapy) the episodes of incontinence stop. At the time of discharge, the patient has not experienced incontinence since the establishment of the incontinence program. At discharge, can the patient be considered continent of urine for scoring of M1610, to reflect improvement in status? [Q&A ADDED 06/05; M number updated 09/09; Previously CMS OCCB 03/05 Q&A #5]

A119. Assuming that there has been ongoing assessment of the patient's response to the incontinence program (implied in the question), this patient would be assessed as continent of urine. Therefore Response 0-No incontinence or catheter, is an appropriate response to M1610.

Timed-voiding was not specifically mentioned as an intervention utilized to defer incontinence. If, at discharge, the patient was dependent on a timed-voiding program to defer incontinence, the appropriate response to M1610 would be 1 (patient is incontinent), followed by Response 0 to M1615 (timed-voiding defers incontinence).

Q119.1. M1610. How long would a patient need to be continent of urine in order to qualify as being continent? [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #23]

A119.1. 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.

Q119.2. M1610. How should we answer M1610 for a patient with a nephrostomy tube? Can we interpret M1610 to mean if the urinary diversion is pouched with an ostomy appliance it is not a catheter but if it is accessed with a tube or catheter (external or otherwise) then the patient has a catheter? What about the patients with continent urinary diversions? They have a stoma but are accessing with intermittent catheterizations. Would they be reported as having a catheter on M1610? [Q&A EDITED 12/12; ADDED 09/09; Previously CMS OCCB 04/08 Q&A #11]

A119.2. When a patient has urinary diversion, with or without a stoma that is pouched for drainage the appropriate M1610 response would be "0-No incontinence or catheter". The appropriate response for a patient with urinary diversion, with or without a stoma, that has a catheter or "tube" for urinary drainage would be "2 -Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic)." A patient that requires intermittent catheterization would be represented by Response 2, even if they have continent urinary diversions.

Q119.2.01. M1610. How would M1610 be answered on ROC for a patient that has a nephrostomy tube that is now capped off? The tube is still present but is not attached to a bag. Is it still considered a urinary catheter? [Q&A ADDED 06/14; Previously CMS Qtrly 01/13 Q&A #10]

A119.2.01. M1610, Response "2-Requires a urinary catheter", may be selected if the patient has a catheter or tube that is utilized for urinary drainage, even if drainage is intermittent. If, however, there is a catheter or tube inserted in a urinary diversion and it is capped, with no plan to drain urine, even intermittently, Response 2 should not be selected.

Q119.2.1. M1610. Urinary Incontinence or Urinary Catheter Presence guidance indicates that if a catheter was inserted and discontinued during the comprehensive assessment we should mark either 0, No incontinence or catheter or 1, Patient is incontinent. Does this mean that intermittent catheterization is no longer considered under Response 2, as

essentially this is what you do, insert and d/c during the visit? [Q&A Edited 06/14; ADDED 01/12; Previously CMS OCCB 04/11 Q&A #7]

A119.2.1. No. M1610 Response 2-Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) remains the appropriate response if a patient requires intermittent catheterization. The current OASIS Guidance Manual Chapter 3 M1610 Response-specific instructions statement "If a catheter was discontinued during the comprehensive assessment or if a catheter is both inserted and discontinued during the comprehensive assessment, Response 0 or 1 would be appropriate, depending on whether or not the patient is continent" is referring to an indwelling catheter.

Q119.2.2 M1610. My patient has an order for a nurse to perform a straight catheterization to obtain a urine specimen for C&S because my patient has symptoms of a UTI. There are no other orders for urinary catheterization. Would this be considered a “condition” requiring catheterization as noted in the item intent for M1610? Or does catheterization in M1610 relate to catheterization for urinary drainage only? [Q&A ADDED 10/16; Previously CMS Qtrly 07/15 Q&A #8]

A119.2.2 A patient requiring a one-time catheterization for the sole purpose of obtaining urine for laboratory testing or other diagnostic procedure would not be considered having a “catheter for urinary drainage” when responding to M1610 Urinary Incontinence or Urinary Catheter Presence. Response 0 or 1 would be appropriate depending on whether or not the patient is continent.

Q119.3. M1610. Do I mark response “2-During the night only” if my patient voluntarily urinates into a diaper at night only for convenience? She ambulates to the toilet during the day, but states she is tired at night and doesn’t like getting up. [Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #24]

A119.3. M1610 reports the presence of urinary incontinence for any reason. Urinary incontinence is defined as involuntary leakage of urine. If the nightly urination is voluntary, meaning the patient has the cognitive and physical ability to urinate in a toilet, etc. but chooses to use a diaper, the patient would not be reported as incontinent in M1610, and M1615 would therefore be skipped.

Q119.4. M1610. We have a patient whose incontinence is managed utilizing a penis pouch. This external device has the appearance of an ostomy bag and drains with a tube like a typical catheter bag. For purposes of M1610 – Urinary Incontinence or Urinary Catheter Presence, which response should be selected? [Q&A ADDED 04/15; Previously CMS Qtrly 04/15 Q&A #4]

A.119.4. M1610. When a penis pouch is utilized (for example, with a patient with a retracted penis who cannot effectively wear an external catheter), the assessing clinician should consider the device “like” an external catheter and select Response 2 - Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) for M1610.

Q120. M1615. How should I respond to M1615, When does Urinary Incontinence Occur, for the patient with an ureterostomy? [Q&A EDITED 12/12]

A120. If the patient had an ureterostomy, M1610 should have been answered with Response 0 (no incontinence or catheter) if it was pouched and Response 2, (patient requires a urinary catheter) if it had a catheter or tube inserted for urinary drainage. From both of these responses, you are directed to skip M1615, When does Urinary Incontinence Occur?

Q121. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q121.1. M1615. If a patient is utilizing timed-voiding to defer incontinence and they have an “accident” once-in-a-while, can you still mark M1615 “0 – Timed-voiding defers incontinence”? [Q&A EDITED 06/14; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #32]

A121.1. If the patient utilizes timed-voiding but still has an “occasional” accident, the appropriate response may be “1-Occasional stress incontinence”, which is defined in Chapter 3 of the current OASIS Guidance Manual as a patient who is unable to prevent escape of relatively small amounts of urine when coughing, sneezing, laughing, lifting, moving from sitting to standing position, or during other activities (stress) which increase abdominal pressure.

If incontinence happens with regularity, then Response 2, 3, or 4 would be appropriate, based on when the incontinence occurs.

Once implementing timed-voiding as a compensatory mechanism to manage urinary incontinence, clinical judgment will be required to determine if the last urinary accident is in the relevant past or if the patient’s current use of timed-voiding is 100% effective and therefore should be marked as “Timed-voiding defers incontinence”.

Q121.2. M1615. How do I respond to this item if the stress incontinence only happens during the day? Do I mark two responses? [Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #25]

A121.2. M1615 is not a “Mark all that apply” item. If your patient only experiences occasional stress incontinence, the correct response is “1-Occasional stress incontinence” regardless of the time of day it occurs. If your patient is experiencing urinary incontinence on a regular basis, meaning almost every day, then “2, 3, or 4” would be reported.

Q122. M1620. How should you respond to this item if the patient is on a bowel-training program? How would that be documented in the clinical record?

A122. A patient on a regular bowel evacuation program most typically is on that program as an intervention for fecal impaction. Such a patient may additionally have occurrences of bowel incontinence, but there is no assumed presence of bowel incontinence simply because a patient is on a regular bowel program. The patient’s elimination status must be completely evaluated as part of the comprehensive assessment, and the OASIS items answered with the specific findings for the patient. The bowel program, including the overall approach, specific procedures, time intervals, etc., should be documented in the patient’s clinical record.

Q122.1. M1620. Please clarify what time frame we are looking at when assessing bowel incontinence in M1620, Bowel Incontinence Frequency. Our agency has been told the SOC is day 0 and we look back 7 days to answer this question. Is that correct? [Q&A ADDED 06/14; Previously CMS Qtrly 07/13 Q&A #13]

What about this scenario? At the SOC assessment no bowel incontinence is reported for the past 7 days, at a repeat visit within the 5 day window, the patient has experienced bowel incontinence since the SOC. Can we amend M1620 to #1 or #2 and also update the M0090 date to reflect this additional assessment information?

A122.1. The timeframe under consideration is day of assessment and relevant past. This timeframe is directed by Response options “0-Very rarely or never has bowel incontinence” and “1-Less than once weekly.” Considering these two options, the assessing clinician would need to consider bowel incontinence that was experienced beyond the past 7 days. The assessing clinician must use clinical judgment to determine how far into the past would be relevant to this home care admission.

The SOC comprehensive assessment must be completed within 5 days after the SOC date, M0030. In the scenario above, the assessing clinician may elect to re-assess bowel incontinence within the allowed timeframe and change her/his original response as well as M0090, Date Assessment Completed.

Q123. M1630. If a patient with an ostomy was hospitalized with diarrhea in the past 14 days, does one mark Response 2 to M1630? [M number updated 09/09]

A123. Response #2 is the appropriate response to mark for M1630 in this situation. By description of the purpose of the hospitalization, the ostomy was related to the inpatient stay.

Q123.1.M1630. Is an A.C.E. considered an ostomy for the bowel elimination for M1630 – Ostomy for Bowel Elimination?

A123.1. The Antegrade Colonic Enema (A.C.E.) 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".

Q123.9. M1700 & M1710. What is the difference in what is measured in M1700 – Cognitive Functioning and M1710- When Confused? [Q&A ADDED 12/12; Previously CMS Qtrly 07/12 Q&A #6]

A123.9. M1700, Cognitive Functioning, is intended to report the patient's cognitive functioning, as evidenced by their level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands on the day of assessment (at the time of the assessment and in the preceding 24 hours).

M1710, When Confused, is intended to identify the time of day or situations when the patient experienced confusion, if at all, during the past 14 days (Day of assessment and prior 14 days). M1710, Confusion, may not directly relate to M1700, Cognitive Functioning. Confusion is defined in Mosby's Medical Dictionary as "a mental state characterized by disorientation regarding time, place, person, or situation. It causes bewilderment, perplexity, lack of orderly thought, and inability to choose or act decisively and perform the activities of daily living. It is usually symptomatic of an organic mental disorder, but it may accompany severe emotional stress and various psychological disorders."

If a patient is demonstrating confusion on the day of the assessment, it would be reported both in M1700 and M1710. If a patient was NOT confused on the day of assessment, but had experienced confusion during the prior 14 days, it would only be reported in M1710.

If a patient has a cognitive impairment on the day of the assessment, that does NOT result in confusion, e.g., forgetfulness, learning disabilities, concentration difficulties, decreased intelligence, it would only be reported in M1700.

Q124. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q124.01. M1710. My patient was confused both when encountering a new situation and on awakening in the morning. Since M1710, When Confused, is not a "Mark All That Apply" item, please clarify when the response options should be selected. [Q&A ADDED 12/12; Previously CMS Qtrly 10/12 Q&A #5]

A124.01. The response options for M1710, When Confused, identify the time of day or situations when the patient experienced confusion, if at all, within the last 14 days. Response 0

is selected if the patient had no confusion in the last 14 days. Responses 1 - 4 are selected if the patient has experienced confusion and each response represents a worsening of confusion. Response 1 is selected when the patient's confusion is isolated to a new or a complex situation, e.g. the patient became confused when a new caregiver was introduced or when a complicated procedure was taught for the first time. Response 2, 3, & 4 are selected when confusion occurs without the stimulus of a new or complex situation, or when confusion which initially presented with a new or complex situation persists days after the new or complex situation become more routine. Responses 2, 3 & 4 differ from each other based on the time when the confusion occurred. Response 2 is selected if the confusion only occurred when the patient was awakening from a sleep or during the night. Response 3 is selected if the confusion occurs during the day and evening, but is not constant. If confusion was not constant, but occurred more often than just upon awakening or at night, select Response 3.

Q124.1. M1710 & M1720. What does unresponsive mean? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #33]

A124.1. It means the patient is unable to respond or the patient responds in a way that you can't make a clinical judgment about the patient's level of orientation. A patient who only demonstrates reflexive or otherwise involuntary responses may be considered unresponsive. A patient with language or cognitive deficits is not automatically considered "unresponsive". A patient who is unable to verbally communicate may respond by blinking eyes or raising a finger. A patient with dementia may respond by turning toward a pleasant, familiar voice, or by turning away from bright lights, or by attempting to remove an uncomfortable clothing item or bandage. A patient who simply refuses to answer questions should not automatically be considered "unresponsive". In these situations, the clinician should complete the comprehensive assessment and select the correct response based on observation and caregiver interview.

Q124.2. M1710 & M1720. May the clinician use clinical judgment to determine if the confusion or anxiety is relevant to this home health episode or should they report all confusion during the past 14 days, (e.g., my patient was anxious 14 days ago and was started on an anti-anxiety drug and has not experienced anxiety for the last 12 days)? [Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #26]

A124.2. When completing M1710, When Confused and M1720, When Anxious, the clinician should report any episodes of confusion or anxiety that meet the descriptors contained in the item that occurred during the last 14 days, without regard to the cause or potential relevance of the confusion/anxiety to this episode of care.

Q124.4. M1730. If I mark a process measure assessment item "Yes" (that the assessment was done), is that sufficient documentation or do I have to explain which tool I used and how I came to the decision regarding my patient's level of risk? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #15]

A124.4. Whether the clinician uses a standardized, validated assessment or a combination of clinical factors for assessment of fall risk, pain severity, depression, or pressure ulcer risk, it is expected that the clinical record would detail the clinical factors or tool that was used and the related findings and analysis to support the OASIS response selected.

Q124.5. M1730. We are seeking clarification about the PHQ-2 depression screening tool and whether it can be used in certain situations. Instructions for PHQ2 imply that screening entails interview of the patient. However, the “Specific Instructions” in the OASIS manual state: “depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or other.” [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #18]

- 1. Is it acceptable to use the PHQ-2 to screen for depression by asking the questions of a caregiver if the patient is unable to respond to the two questions?**
- 2. Is it acceptable for the home health clinician to complete the PHQ-2 based on observations if the patient is unable to respond to the two questions?**

A124.5. No, it is not acceptable to use the PHQ-2 to screen for depression by asking the questions of a caregiver, or to respond to the two questions based on clinician observations. The PHQ-2 tool is a standardized, validated screening tool in which the patient is the source of report. The PHQ-2 instructions clearly define how the tool should be administered. The clinician is to ask the patient a specific question related to two problems. The information may also be self-reported, precluding the need for the interview.

When evaluating the patient, the clinician must first assess whether the PHQ-2 is the appropriate depression screening tool. If the PHQ-2 is appropriate (the patient appears to be cognitively and physically able to respond), then the instrument may be used. If, however, the patient is unable to answer the specific PHQ-2 questions when asked by the assessing clinician, e.g. the patient can't quantify how many days they have experienced the problems, the clinician can report in M1730 that the PHQ-2 was administered (Response 1), and select N/A - Unable to respond. Response 1-Yes may NOT be selected if the patient refuses to hear the questions or states they are too personal.

If the PHQ-2 is not appropriate due to limitations such as cognitive status or communication deficits, the clinician may choose to administer a different standardized, validated depression screening tool with instructions that may allow for information to be gathered by observation and caregiver interview as well as self-report. In this case, the clinician would select Response 2 or 3 for M1730, depending on the outcome of the assessment. If the clinician chooses not to assess the patient (because there is no appropriate depression screening tool available or for any other reason), Response 0, “No” should be selected.

Note that patients who have been assessed as “Unresponsive”, based on M1710, When Confused and/or M1720, When Anxious, will not be included in the process measure for depression screening.

Q124.5.1. M1730. I don't understand when I would ever select "NA - Unable to respond" in the PHQ-2 in M1730, Depression Screening. Please clarify. [Q&A EDITED 12/12; ADDED 01/12; Previously CMS OCCB 10/11 Q&A #8]

A124.5.1. The PHQ-2 is only used for patients that appear to be cognitively and physically able to answer the two included questions. After determining the PHQ-2 is an appropriate tool, the patient may be unable to answer the questions, e.g. the patient may not be able to quantify how many days they have experienced the problems. In this case, the clinician could report in M1730 that the PHQ-2 was administered (Response 1), and select N/A – Unable to respond as the PHQ-2 finding.

Q124.5.2. M1730. If the ROC comprehensive assessment with OASIS was completed after the CMS-allowed 48 hour time frame, do all the best practice questions need to be

answered “NA”? [Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #13; 06/14 edit based on CMS Qtrly 10/13 Q&A#2]

A124.5.2. The ROC comprehensive assessment must be completed within 48 hours of discharge following a qualifying inpatient stay or within 48 hours of knowledge of a qualifying stay in an inpatient facility. If the ROC assessment is late, "Yes" may still be selected for the best practices in M2250, Plan of Care Synopsis, if the relevant orders were present within the 48 hour ROC time frame. Likewise, M1240, Pain Assessment, M1300, Pressure Ulcer Risk Assessment, M1730, Depression Screening, and/or M1910, Falls Risk Assessment may also be reported with "Yes" responses, if the relevant standardized assessments were conducted by the assessing clinician within the 48 hour time frame, even if the ROC comprehensive assessment was completed after the 48 hour time frame. When the assessing clinician takes credit on M1240, M1300, M1730 and/or M1910 for standardized, validated assessments completed within the 48 hour time frame and the M0090 date indicates that the ROC comprehensive assessment was completed late (beyond the 48 hour time frame), clarifying documentation to support the reported OASIS responses is expected.

If the relevant standardized, validated assessment was completed greater than 48 hours after inpatient facility discharge or greater than 48 hours after gaining knowledge of a qualifying stay in an inpatient facility, M1240, M1300, M1730 and M1910 must be answered "No".

The agency should make every effort to complete the ROC assessment within the 48 hours from the discharge home. If the patient refuses or isn't available, the ROC assessment should be completed as soon as possible, with any physician communication and circumstance details documented in the clinical record.

Q124.5.3. M1730. During the admission visit, the nurse attempts to administer the PHQ-2 to screen for depression but the patient refuses to answer the questions. She has no cognitive issues and states “This is none of your business”. Should the response to M1730 be 0-No or 1-Yes (NA)? [Q&A ADDED 06/14; Previously CMS Qtrly 01/13 Q&A #11]

A124.5.3. M1730, Response 1 - Yes, NA may be selected for the patient who is cognitively intact and physically able to answer questions but is unable to answer the specific PHQ-2 questions when asked by the assessing clinician, (e.g. the patient can't quantify how many days they have experienced the problems). Response 1-Yes may NOT be selected if the patient refuses to hear the questions or states they are too personal. Response 2 or 3 may be selected if the assessing clinician is able to administer a different standardized, validated depression screening. If the clinician chooses not to assess the patient (because there is no appropriate depression screening tool available or for any other reason), Response 0 – No should be selected.

Q124.5.5. M1740. If a patient is alert and oriented, but decides not to use their cane because they think they don't need it (they are unsafe without it) or they decide they aren't going to take their diuretic because they are going to the doctor and don't want to have any accident, would you select Response “2 – Impaired decision-making”? [Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 01/11 Q&A #13]

A124.5.5. The intent of M1740, Cognitive, behavioral, and psychiatric symptoms, is to capture specific behaviors that are a result of significant neurological, cognitive, behavioral, developmental or psychiatric limitations or conditions. It is not the intent of M1740 to report non-adherence or risky choices made by cognitively intact patients who are free of the aforementioned conditions. The assessing clinician will have to determine if the patient has a disorder that is causing her non-adherence or is the patient making a choice not to comply completely with physician's orders, cognizant of the implications of that choice.

Q124.5.5.1.M1740. Would "hoarding" be considered disruptive behavior triggering a "yes" response on M1740 – Cognitive, behavioral, and psychiatric symptoms? [Q&A ADDED 04/15; Previously CMS Qtrly 01/15 Q&A #7]

A124.5.5.1. M1740 identifies specific behaviors associated with significant neurological, developmental, behavioral, or psychiatric disorders that are demonstrated at least once a week. If a patient had a diagnosis, such as hoarding disorder, and the clinician determined the associated behaviors resulted in concern for the patient and/or caregiver's safety or wellbeing, then it would meet the intent of M1740. In such a case, the assessing clinician may determine that the hoarding behaviors meet the intent of Response 2 – Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions and/or Response 5 – Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions).

Q124.5.6. M1740. When reporting on the behaviors to be considered for M1740, Cognitive, behavioral, and psychiatric symptoms, what time period should we consider? Does it include the recent past, if so, please define what is officially considered "recent" past. [Q&A ADDED 01/12; Previously CMS OCCB 04/11 Q&A #8]

A124.5.6. The time frame under consideration for M1740, Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week, is defined in the wording of the item - "at least once a week". The phrase "at least once a week" means that a behavior was demonstrated multiple times in the recent, relevant past and the frequency of the occurrence was at least one time a week prior to and including the day of assessment. The assessing clinician will determine "recent, relevant past" based on the patient/caregiver interview, referral information, assessment findings, diagnoses and recent history of medical treatment and its effectiveness.

Q124.6. M1740 & M1745. Is M1745 - Frequency of Disruptive Behavior Symptoms, only based on disruptive behavior: physical, verbal or other disruptive/dangerous symptoms? Or is this item based on what we answer with M1740? [Q&A ADDED 01/11; Previously CMS OCCB 07/10 Q&A #11]

A124.6. M1740 - Cognitive, behavioral, and psychiatric symptoms, and M1745 - Frequency of Disruptive Behavior Symptoms are not directly linked to one another. There may be behaviors reported in M1740 that are not reported in M1745 and vice versa. For example, a patient may express excessive profanity or sexual references that cause considerable stress to the caregivers and be reported in M1740, but in the clinician's judgment, the behavior does not jeopardize the safety and well-being of the patient or caregiver, therefore is not reported in M1745. Answer each question individually. M1740 contains a list of specific behaviors associated with significant neurological, developmental, behavioral or psychiatric disorders and asks if they are demonstrated by the patient at least once a week. M1745 is not reporting on a specific list of behaviors, but rather any behaviors that are disruptive or dangerous to the patient or the caregivers.

Q124.7. M1740 & M1745. When completing M1745 - Frequency of Disruptive Behavior Symptoms, do we have to take into consideration if the patient has a fulltime caregiver to watch over her, or do we address it without including the caregiver's presence? [Q&A ADDED 01/11; Previously CMS OCCB 07/10 Q&A #12]

A124.7. The environment in which the patient lives and the skills of the caregiver may impact the scoring of M1740 - Cognitive, behavioral, and psychiatric symptoms, and M1745 - Frequency of Disruptive Behavior Symptoms. For example, if a patient has dementia, they may exhibit a number of behaviors listed in M1740, but may not be reported in the OASIS item if they

live in a setting specifically designed to care for patients with dementia. The same would be true for M1745. Look to the descriptors for the behaviors that are reportable for both M1740 and M1745 to determine if the behavior would be reportable.

Q124.8 M1740/M1745. 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? [Q&A ADDED 10/16; Previously CMS Qtrly 10/15 Q&A #2]

A124.8 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.

Q125. M1745. Are the behaviors to be considered in responding to this item limited to only those listed in M1740? [Q&A EDITED 08/07]

A125. No, there are behaviors other than those listed in M1740 that can be indications of alterations in a patient's cognitive or neuro/emotional status resulting in behaviors of concern for the patient's safety or social environment. Other behaviors such as wandering can interfere with the patient's safety, and if so, the frequency of these should be considered in responding to the item.

Q126. [Q&A RETIRED 01/11; No longer applicable]

Q126.1. M1750. If there are no orders on the referral for psych nursing services, should the skilled nurse answer M1750 "Yes" if she identifies a psych issue on her initial assessment and plans to obtain physician's orders for the agency's Mental Health Nurse? Can she answer "Yes" even if the visit by the Mental Health Nurse will not be completed in the 5 day assessment window? [Q&A ADDED 01/ Previously CMS OCCB 04/11 Q&A #9]12;

A126.1. In order to select "Yes" for M1750, Psychiatric Nursing Services, you must have a physician order for psychiatric nursing services on the Start of Care/Resumption of Care plan of treatment. It is not required that the clinician completing the comprehensive assessment be a qualified psychiatric nurse. The first visit by the qualified psychiatric nurse does not have to occur in the time frame allowed for completing the comprehensive assessment, but you must have an order for the psychiatric nursing services to answer "Yes."

Q126.2. M1750. How should an agency respond to M1750 if psychiatric nursing services are being provided by a separate entity such as a community mental health center or other provider, and the home health agency is providing services that are not directly related to the psychiatric issue(s) but could be affected by them? [Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 07/12 Q&A #7]

A126.2. M1750, Psychiatric Nursing Services, reports if the patient is receiving psychiatric nursing services in the home at the time of the SOC/ROC assessment. This is referring to qualified personnel of the home health agency, per physician orders, specifically for the assessment and treatment of psychiatric conditions. When completing the SOC/ROC comprehensive assessment, if an order exists on the Plan of Care for the agency to provide psychiatric services, then respond "Yes" to M1750. The assessing clinician does not have to be the agency's qualified psych nurse that is/will be providing the psychiatric nursing services.

Q127. M1800-M1900. At OASIS items M1800-M1900, what does IADL mean and what's the difference between IADLs and ADLs? [Q&A EDITED 01/12]

A127. ADL stands for 'activities of daily living' while IADL stands for 'instrumental activities of daily living'. ADLs refer to basic self-care activities (e.g., bathing, dressing, toileting, etc.), while IADLs include activities associated with independent living necessary to support the ADLs (e.g., use of telephone, ability to plan and prepare meals, etc.).

Q127.1. M1800-M1900. Are service animals considered a form of assistance? [Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #27]

A127.1. If required for a patient's safe function, service animals should be considered an assistive device for purposes of selecting responses to the OASIS items. Service animals should not be considered as assistance; in other words, should not be equated to human assist (as in "someone must assist"...)

Q127.2. M1800-M1900. OASIS excludes shampooing of hair from Bathing and Grooming...Is this captured any other place? [Q&A EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #10]

A127.2. Shampooing of the hair is excluded from both the Bathing and Grooming items in the OASIS data set. Shampooing may be included as one of the ADLs in M2102, Types and Sources of Assistance, as this question is concerned broadly with types of assistance, not just the ones specified in other OASIS items.

Q127.3. M1800 – M1900. About M1800 – M1900 - ADLs/IADLs: I don't understand the difference between "willingness" and "adherence" (which do not impact OASIS scoring) and "cognitive/mental/emotional/behavioral impairment" (which may impact OASIS scoring). For instance, if a person is unwilling to bathe appropriately, resulting in poor hygiene, an offensive odor and increased risk for infection, isn't the patient suffering from some sort of cognitive, mental, behavioral or emotional problem that would cause this unwillingness and non-adherence? It seems that such unwillingness is a symptom of a deeper psychological problem. Please clarify. [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 07/10 Q&A #13]

A127.3. In absence of pathology, patients may make decisions about how and when they perform their activities of daily living that may differ from what the clinician determines to be acceptable. A patient may choose to shave and brush his teeth infrequently because he doesn't value doing it at a frequency that the clinician deems as socially appropriate. There are differences in the frequency at which grooming or bathing is performed, or expected to be performed based on age, religion, culture and familial practices, and this is not necessarily indicative of pathology.

A patient may demonstrate that they can safely ambulate while using a walker, but then as a *matter of choice*, decide to walk without it. Another patient may demonstrate that they can safely ambulate while using a walker, but then consistently walk without it, *forgetting* that they have a walker. For the purposes of OASIS scoring, non-conformity or non-adherence should not automatically be considered indicative of a deeper psychological impairment. The assessing clinician will have to use clinical judgment to determine if the patient's actions are more likely related to impairment, or to personal choice made in awareness of the potential related risk.

Q127.4. M1800-M1900. When the M item response states "assisted or supervised by another person" is that referring to a single person? [Q&A ADDED 01/12; Previously CMS OCCB 07/11 Q&A #11]

A127.4. The response related to "assistance of another person" includes those patients, actively participating in performing a task, but needing assistance of one or more person(s) to safely complete included tasks.

Q127.5. M1800-M1900. My staff are confused about when a patient's ability to access the location and/or implements needed to complete the ADL/IADL tasks should be considered when scoring the OASIS items. For instance, should I include a patient's ability to get to the tub for M1830 Bathing, or to get to the kitchen to prepare a meal for M1880, or to get to the phone for Phone Use in M1890? [Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 04/13 Q&A #7]

A127.5. The OASIS ADL/IADL items consider the patient's ability to access the needed items and/or location where the task is performed unless item guidance specifically excludes these from consideration. The 5 ADL/IADL items where there are exclusions are:

M1830, Bathing - The focus is on the patient's ability to access the tub/shower, transfer in and out, and bathe the entire body once the needed items are within reach. The ability to access bathing supplies and prepare the water in the tub/shower are excluded from consideration when assessing the patient's bathing ability.

M1845, Toileting Hygiene - The focus is on the patient's ability to access needed supplies and implements, and manage hygiene and clothing once at the location where toileting occurs. The ability to access the toilet or bedside commode, transfer on and off the bedpan and to use the urinal are excluded from consideration when assessing the patient's toileting hygiene ability.

M1870, Feeding/Eating - The focus is on the patient's ability to eat, chew and swallow once the meal is placed in front of the patient and needed items are within reach. The ability to access the location where the meal is prepared and consumed, and transporting food to the table are excluded from consideration when assessing the patient's feeding/eating ability.

M1880, Planning & Preparing Light Meals - The focus is on the patient's ability to plan and prepare meals once the patient is in the meal preparation location. The ability to access the location where meals are prepared is excluded from consideration when assessing the patient's meal planning and preparation ability.

M1890, Telephone Use - The focus is on the patient's ability to use a phone once it is within the patient's reach. The ability to access the location where the telephone is stored is excluded from consideration when assessing the patient's ability to use the telephone.

Q128 & 128.1. [Q&A RETIRED 09/09; Outdated]

Q129. M1800. Must I see the patient comb his/her hair or brush his/her teeth in order to respond to this item?

A129. No, as assessment of the patient's coordination, manual dexterity, upper-extremity range of motion (hand to head, hand to mouth, etc.), and cognitive/emotional status will allow the clinician to evaluate the patient's ability to perform grooming activities.

Q129.1. M1800. Please confirm that the assessment of the patient's ability to perform the grooming tasks identified in M1800 also includes getting to where the grooming utensils are stored. [Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 10/12 Q&A #6]

A129.1. Patient access must be considered when determining grooming ability (e.g., grooming aids, mirror, sink). If there is an environmental barrier preventing safe access or the patient has

an impairment that causes him/her to require someone's assistance to gain access to needed items or locations, whether the assistance was to take the items to the patient, or to assist the patient to get to the items, Response "1-Grooming utensils must be placed within reach before able to complete grooming activities" would be appropriate, assuming the patient could then groom independently in a majority of the more frequently performed grooming tasks.

The current OASIS Guidance Manual M1800 Item Intent states "These items address the patient's ability to safely perform grooming given the current physical and mental/emotional/cognitive status, activities permitted and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by ...environmental barriers (e.g., accessing grooming aids, mirror and sink)."

Q130. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q130.1. M01800 & M1830. Is hair washing/shampooing considered a grooming task, a bathing task, or neither? [Q&A ADDED 08/07; M numbers updated 09/09; Previously CMS OCCB 07/06 Q&A #34]

A130.1. The task of shampooing hair is not considered a grooming task for M1800. Hair care for M1800 includes combing, brushing, and/or styling the hair. Shampooing is also specifically excluded from the bathing tasks for M1830, therefore the specific task of shampooing the hair is not included in the scoring of either of these ADL items.

Q131. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q132. M1810. What if the patient must dress in stages due to shortness of breath? What response must be marked? [M number updated 09/09]

A132. If the patient is able to dress herself/himself independently, then this is the response that should be marked, even if the activities are done in steps. If the dressing activity occurs in stages because verbal cueing or reminders are necessary for the patient to be able to complete the task, then Response 2 is appropriate. (Note that the shortness of breath would be addressed in M1400.)

Q132.1. M1810 & M1820. 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? [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #25]

A132.1. M1810 & M1820, 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.

Q132.2. M1810 & M1820. For M1810 & M1820, 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"? [Q&A EDITED 06/14; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #26]

A132.2. Your understanding of the majority rule is correct. If a patient's ability varies among the tasks included in a single OASIS item (like M1810, Upper Body Dressing or M1820, Lower Body Dressing), 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 clothing items a patient can independently obtain, put on and take off). Less objective criteria, like which clothing 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.

Q132.3. M1810 & M1820. I have a patient who could not obtain his clothes, but could dress without assistance if clothes were laid out (Response 1). If the environment was adapted (a new "usual" storage place for clothing was selected) so that the patient could obtain, put on and remove the clothing without any assistance, would the patient then be considered independent in dressing? [Q&A ADDED 09/09; Previously CMS OCCB 10/08 Q&A #8]

A.132.3. When a patient's ability varies on the day of assessment, the clinician reports what was true for a majority of the time. If the patient was unable to access clothing, but could put on and remove the majority of clothing items safely when they were laid out for him, the appropriate score would be a "1". If the environment is modified (e.g., the patient decides to start storing clothing in the dresser instead of hanging in the closet), and the patient can now access clothes from a location without anyone's help, then this new arrangement could now represent the patient's current status (e.g., clothing's new "usual" storage area and patient's ability). The appropriate score would be a "0" if the patient was also able to put on and remove a majority of his clothing items safely.

If however, the patient explained that while he is feeling weak, he will temporarily modify his dressing practice (e.g., place his clothes on the chair by his bed instead of putting them in the usual storage area - the closet), since the clothing lying on the chair is not in its "usual" storage area and the patient does not intend on making the chair his usual storage area for his clothes, then he currently is unable to obtain the clothing from its usual location, and the patient would be scored a "1". The patient could then work to gain independence in accessing clothing from its usual storage location, or decide to make long-term environmental modifications, and possibly achieve improvement in the outcome if successful.

Q132.4. M1810 & M1820. The guidance in M1810 & M1820 states that you assess the patient's ability to obtain, put on and remove the clothing items usually worn. Other guidance states that items such as prosthetics, corsets, cervical collars, hand splints, Teds, etc. are considered dressing apparel. Do we include the other items, like a splint, if the patient doesn't usually wear it? Our patient just injured their wrist and will only be wearing it for a week; he doesn't usually wear a splint. [Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 04/09 Q&A #10]

A132.4. M1810 & M1820, Upper/Lower Body Dressing, includes all the dressing items the patient usually wears and additionally any device the patient is ordered to wear, e.g. prosthetic, splint, brace, corset, Teds, knee immobilizer, orthotic, AFO, even if they have not routinely worn/used them before. If they are wearing the device/support (or ordered to wear the device/support) on the day of assessment, it is to be included when assessing and scoring M1810 & M1820.

Q132.5. M1810 & M1820. At my agency, we are asked to score M1810 and M1820 as “2 - Someone must help the patient put on upper body clothing” if the patient takes longer than the usual time to dress self even if they live alone and are perfectly capable of dressing themselves. Is this correct? [Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 04/09 Q&A #11]

A132.5. There is no requirement that a patient dress within a specific amount of time in order to be independent in dressing. A patient may take longer than “usual”, but as long as they can safely access their clothing from its usual storage location, put on and take off a majority of their routine clothing items safely, the patient is scored a “0” in Upper and Lower Body Dressing.

Q132.5.1. M1810 & M1820. Please clarify the guidance included in M1810 and M1820, Upper and Lower Body Dressing, Response-Specific Instructions which states “In cases where a patient's ability is different for various dressing upper/lower body tasks, pick the response that best describes the patient's level of ability to perform the majority of dressing upper/lower body tasks.” What does the term “dressing tasks” mean? Is it the pieces of clothing and devices the patient wears or is it the individual steps in dressing, e.g. picking up the item, lifting their arm, sliding the arm into the sleeve, buttoning the buttons, etc.? [Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 01/11 Q&A #14]

A132.5.1. When scoring M1810 and M1820, Upper and Lower Body Dressing, in cases where a patient's ability is different for various upper or lower body dressing tasks, you will select the response that best describes the patient's level of ability to perform the majority of dressing tasks. The tasks are the individual clothing items routinely worn, as well as any supportive or prosthetic devices the patient is wearing or ordered to use during the day of the assessment.

The majority of the tasks rule is not referencing the individual steps the patient must take in order to get, put on or take off clothing, but rather what is true for greater than 50% of the clothing items/devices usually worn on the upper/lower body.

Q132.5.2. M1810 & M1820. Are wound dressings included as an upper and lower body dressing task when determining a patient's ability for M1810 and M1820, Ability to Dress Upper/Lower Body? [Q&A ADDED 06/14; Previously CMS Qtrly 07/13 Q&A #14]

A132.5.2. Wound dressings are NOT one of the included dressing items when scoring M1810, Upper Body Dressing and M1820, Lower Body Dressing. Note that elastic bandages, including ACE Wrap brand, worn for support and compression should be considered as a lower body dressing item, but wraps utilized solely to secure a wound dressing would not be considered a dressing (clothing) item for M1810 or M1820.

Q132.6. M1820. If the patient has a physician's order to wear elastic compression stockings and they are integral to their medical treatment, (e.g. patient at risk for DVT), but the patient is unable to apply them, what is the correct response for M1820? [Q&A EDITED 01/10; Previously CMS OCCB 07/06 Q&A #35]

A132.6. M1820 identifies the patient's ability to obtain, put on, and remove their lower body clothing, including lower extremity supportive or protective devices. A prescribed treatment that is integral to the patient's prognosis and recovery from the episode of illness, such as elastic compression stockings, air casts, etc., should be considered when scoring M1820. The patient in this situation would be scored based on their ability to obtain, put on and remove the majority of their lower body dressing items, as the elastic compression stockings are a required, prescribed treatment.

Q132.6.1. M1820, Ability to Dress Lower Body. The patient has an order for ace wraps to their lower extremity. Should the ace wraps to the lower body be considered lower body dressing items like Ted hose are? [Q&A EDITED 06/14; Previously CMS OCCB 07/11 Q&A #12]

A132.6.1. Chapter 3 of the current OASIS Guidance Manual, M1820 Response-Specific Instructions state "Prosthetic, orthotic or other support devices to the lower body...should be considered as lower body dressing items." Elastic bandages, including ACE Wrap brand, worn for support and compression should be considered as a lower body dressing item.

Q133. [Q&A RETIRED 09/09; Outdated]

Q134. M1830. Given the following situations, what would be the appropriate responses to M1830? [Q&A EDITED 06/14; M number updated 09/09]

- a) The patient's tub or shower is nonfunctioning or is not safe for use.
- b) The patient is on physician-ordered bed rest.
- c) The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again.
- d) The patient chooses not to navigate the stairs to the tub/shower.

A134. a) The patient's environment can impact his/her ability to complete specific ADL tasks. If the patient's tub or shower is nonfunctioning or not safe, then the patient is currently unable to use the facilities. Response 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities outside the tub/shower.

b) The patient's medical restrictions mean that the patient is unable to bathe in the tub or shower at this time. Select Response 4 (Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode), 5 (Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.) or 6 (Unable to effectively participate in bathing and is bathed totally by another person), whichever most closely describes the patient's ability at the time of the assessment.

c) If the patient's fear is a realistic barrier to her ability to get in/out of the shower safely, then her ability to bathe in the tub/shower may be affected. If due to fear, she refuses to enter the shower even with the assistance of another person; either Response 4, 5, or 6 would apply, depending on the patient's ability at the time of assessment. If she is able to bathe in the shower when another person is present to provide required supervision/assistance, then Response 3 would describe her ability.

d) The patient's environment must be considered when responding to the OASIS items. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower. While this may appear to penalize the patient whose tub or shower is on another floor, it is within this same environment that improvement or decline in the specific ability will subsequently be measured.

Q134.1. M1830. My patient is allowed to bathe in the tub, but is medically restricted from getting the cast on his lower leg and foot wet. He is unable to put the water protection sleeve on, but once someone applies the protective sleeve for him, he can get into and out of the bathtub using a transfer bench and wash all of his body with a handheld shower. Does this medical restriction impact the patient's ability when scoring M1830, Bathing? [Q&A ADDED 06/14; Previously CMS Qtrly 04/13 Q&A #5]

A134.1. Medical restrictions that impact the OASIS-included bathing tasks are considered when determining the score for 1830, Bathing. Therefore, the tasks required to allow compliance with medically prescribed precautions for bathing could impact the patient's ability. In the scenario above, Response 2 is appropriate since the patient needs intermittent human assistance.

Q134.2. M1830. At SOC, the patient was not taking a shower due to a fear of falling. The patient was safely sponge bathing at the sink without assistance. She had fallen in the shower and is fearful of falling again. The RN, at SOC, had the patient get into the shower using her tub/bench and after cues for proper technique, determined the patient needed contact guard for the transfer. Once sitting, she was able to bathe herself using a long-handled sponge. How should M1830, Bathing be answered? [Q&A ADDED 06/14; Previously CMS Qtrly 10/13 Q&A #7]

A134.2. Response 4 - Unable to bathe in tub/shower but independent in bathing at sink, would be selected if, on the day of the assessment, the patient's usual status was that she was unable to bathe in the tub/shower due to fear, even with assistance, but was independent in bathing at the sink. In your scenario the patient's ability changed after clinical intervention. After the nurse's instruction, the patient could bathe herself in the tub/shower with the intermittent assistance of another person for the tub transfer only, but the new changed ability was not the patient's usual status (more than 50% of the time) on the day of assessment. At the next OASIS data collection time point, if the patient remained at that new functional level it would be appropriate to select M1830 Response 2 - Able to bathe in tub/shower with intermittent assistance.

Q135. M1830. How should I respond to this item for a patient who is able to bathe in the shower with assistance, but chooses to sponge bathe independently at the sink? [Q&A EDITED 06/14]

A135. The item 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.

Q136. M1830. Should the clinician consider the patient's ability to perform bathing-related tasks, like gathering supplies, preparing the bath water, shampooing hair, or drying off after the bath in responding to this item? [Q&A EDITED 09/09; ADDED 06/05; M number updated 09/09; Previously CMS OCCB 08/04 Q&A #12]

Q136. When responding to M1830, the patient's ability to transfer in and out of the tub/shower and then "wash the entire body" should be considered. Bathing-related tasks, such as those mentioned, should not be considered in scoring this item.

Q137. M1830. If a patient can perform most of the bathing tasks (i.e. can wash most of his/her body) in the shower or tub, using only devices, but needs help to reach a hard to reach place, would the response be “1” because he/she is independent with devices with a “majority” of bathing tasks? Or is he/she a “2” because he/she requires the assist of another “for washing difficult to reach areas?” [Q&A EDITED 01/12; ADDED 06/05; Previously CMS OCCB 8/04 Q&A #13]

A137. The correct response for the patient described here would be Response 2 "Able to bathe in the shower or tub with the assistance of another person: c) for washing difficult to reach areas," because that response describes that patient's ability at that time.

Q138. M1830. Please clarify how the patient's ability to access the tub/shower applies to M1830. [Q&A EDITED 09/09; ADDED 06/05; Previously CMS OCCB 10/04 Q&A #6]

A138. The intent of the bathing item is to identify the patient's ability to wash the entire body. Guidance for this item indicates that when medical restrictions, environmental or other barriers prevent the patient from accessing the tub/shower, his/her bathing ability will be 'scored' at a lower level. The ability to transfer into and out of the tub/shower is evaluated and also impacts the score when responding to M1830. If the patient requires assistance to transfer into or out of the tub/shower, they would be scored a 2 or 3, based on the amount of human supervision or assistance is required throughout the bath.

Q138.1.M1830. Please confirm something I heard during OASIS training at my office. They said that getting to the bathroom for bathing is also included in the data collection for bathing even though the responses for M1830 Bathing only address the transfer in and out of the shower/tub and washing the body. Is that true? For example, my patient needs assistance to get down his hallway to the bathroom, but once he is in the bathroom he can safely transfer in and out of the shower and wash his body without assistance or equipment. Until the meeting today, I would have scored him a 0 for independent, but now it seems I should be scoring him a 2-needs intermittent assistance. Which score is correct? [Q&A ADDED 10/16; Previously CMS Qtrly 04/16 Q&A #8]

A138.1. The OASIS ADL/IADL items consider the patient's ability to access the needed items and/or location where the task is performed unless item guidance specifically excludes these from consideration. For M1830 Bathing, the amount of assistance the patient requires to get to the location bathing occurs would be considered. In the scenario cited, the patient requires assistance (another person to provide verbal cueing, stand-by or hands-on assistance) to safely ambulate down the hallway and no other assistance with transfer and bathing. This is intermittent assistance, therefore M1830 Response 2 - Able to bathe in shower or tub with the intermittent assistance of another person should be reported.

Q139. [RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q140 & 141. [RETIRED 09/09; Outdated]

Q141.1. M1830. Based on my SOC comprehensive assessment, I determine that my patient requires assistance to wash his back and feet safely in the tub. At the time of the assessment, I believe the patient *could* wash his back and feet safely *if* he had adaptive devices, like a long-handled sponge. Should the initial score be “1” able to bathe in the tub/shower with equipment or “2” requires the assistance of another person to wash difficult to reach areas? [Q&A EDITED 06/14; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #36]

A141.1. Since at the time of the assessment the patient requires intermittent assist of another person to wash difficult to reach areas, then Response “2” should be selected. If the clinician

determined that the patient could become more independent (i.e., require less assistance) with the use of adaptive equipment, then such equipment could be obtained or recommended as part of the home health Plan of Care. If at discharge the patient is able to wash his entire body using the equipment provided, then Response “1” should be reported. If the patient is financially unable or otherwise refuses to obtain the recommended equipment, then the clinician would not have the opportunity to instruct or evaluate the patient’s ability to determine if the equipment improves independence. If the patient does not get the equipment, or if even with the equipment the patient continues to require intermittent assistance, then Response “2” would apply.

Q141.2. [RETIRED 09/09; Outdated]

Q141.3. M1830. For M1830 even the normal person requires a long-handled sponge or brush to wash their back. If a patient can do everything except wash their back & requires a long-handled sponge or brush, would they be marked a "1"? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #27]

A141.3. 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 M1830 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 M1830. 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.

Q141.4. M1830. If a patient uses the tub/shower for storage, is this an environmental barrier? Is the patient marked a 4 or 5 in M1830? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #28]

A141.4. 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 either as a Response 4, 5, or 6, depending on the patient’s ability at the time of assessment. Note that the responses of 4, 5, and 6 are 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.

Q142. M1840. If my patient has a urinary catheter, does this mean he is totally dependent in toileting transferring? [Q&A EDITED 09/09]

A142. M1840 does not differentiate between patients who have urinary catheters and those who do not. The item simply asks about the patient's ability to get to and from the toilet or bedside commode and their ability to transfer on and off toilet/commode. This ability can be assessed whether or not the patient uses the toilet for urinary elimination.

Q143. M1840. If the patient can safely get to and from the toilet and transfer independently during the day, but uses a bedside commode independently at night, what is the appropriate response to this item?

A143. If the patient chooses to use the commode at night (possibly for convenience reasons), but is able to get to the bathroom, then Response 0 would be appropriate.

Question 143.1. M1840. My patient lives alone. He can safely get to/from and use his bathroom toilet by himself without difficulty during the day. His daughter insists that he use the bedside commode at night in his bedroom because his vision and balance are compromised at night, resulting in a previous nighttime fall. He demonstrates safe transfers on and off the bedside commode. I think he would be safe walking to his bathroom at night with supervision but he lives alone. Do I score him based on the use of the bedside commode, or based on the need for supervision? [Q&A ADDED 10/16; Previously CMS Qtrly 04/16 Q&A #9]

Answer 143.1. For M1840, if the patient's ability or status varies on the day of assessment, report the patient's usual status, or what is true greater than 50% of the day of assessment. Day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home for the visit.

If the patient is able to get to and from the toilet safely and independently during the daytime; and if, for this patient, this represents more than 50% of the day of assessment, then M1840 would be Response 0 - Able to get to and from the toilet and transfer independently with or without a device, regardless of what the patient's status is for the remainder of the day of assessment. If the factors that make the patient not safe getting to/from the bathroom safely (vision and balance in this scenario) were to be present for more than 50% of the day of assessment, and if in your clinical judgment, during these times the patient would be safe walking to the bathroom with supervision, then Response 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer would be the appropriate response, even if the patient does not have a caregiver available.

Q144. [RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q145. [RETIRED 09/09; Outdated]

Q146. M1840. If a patient is able to safely get to and from the toilet and perform the transfer with assistance of another person, but they live alone and have no caregiver so they are using a bedside commode, what should be the response to M1840? [Q&A EDITED 09/09; ADDED 06/05; Previously CMS OCCB 03/05 Q&A #9]

A146. The OASIS item response should reflect the patient's ability to safely perform a task, regardless of the presence or absence of a caregiver. If the patient is able to safely get to and from the toilet and transfer with assistance, then Response 1 should be selected, as this reflects their ability, regardless of the availability of a consistent caregiver in the home.

Q146.1. M1840. My male patient is bedfast and can place and remove the urinal, but not the bedpan. What response should be selected for M1840, Toilet Transferring? [Q&A ADDED 01/12; Previously CMS OCCB 07/11 Q&A #13]

A146.1. If the bedfast patient needs assistance to get on/off the bedpan, the appropriate M1840 Response is "4-Is totally dependent in toileting" even if they can place and remove the urinal.

Q147. [RETIRED 09/09; Outdated]

Q147.5. M1840. We have a patient with multiple sclerosis who is transferred via a mechanical lift device, e.g. Hoyer. She is non-weight bearing. How do we answer M1840, Toilet Transferring? Except for minimal movement of the arms and holding onto the sling (which doesn't really contribute to the transfer process), she cannot participate in the transfer. Should she be scored a "1" or a "4"? [Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #15]

A147.5. Toilet Transferring Response "1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer" means the patient is able to perform the included tasks if they are "assisted" by another person. It is not the appropriate response in a case where the patient is totally dependent on another person to transport them to the toilet and transfer them on and off the toilet. In order to be scored a "1" the patient must be able to effectively participate by contributing effort toward the completion of some of the included tasks, getting to and from and getting on and off the toilet. If the patient can be moved to the toilet and transferred on and off, but cannot effectively participate in the effort required, they are scored a "4-Is totally dependent in toileting".

In your scenario, since the patient cannot effectively participate in the tasks required in the Toilet Transferring item, the patient would be scored a "4-Is totally dependent in toileting".

Q148. M1840. If a patient uses a bedside commode over the toilet, would this be considered "getting to the toilet" for the purposes of responding to M1840? [Q&A EDITED 09/09; ADDED 06/05; Previously CMS OCCB 03/05 Q&A #11]

A148. Yes, a patient who is able to safely get to and from the toilet and transfer should be scored at response levels 0 or 1, even if they require the use of a commode over the toilet. Note that the location of such a commode is not at the "bedside," and the commode is functioning much like a raised toilet seat.

Q148.01. M1840. How would we respond to M1840 Toilet Transferring in the following circumstance? Our patient has MS and is wheelchair bound, she is able to wheel herself to the bathroom, but requires her husband to lift her onto the toilet. Would this patient be considered a "1" because she requires assistance to get on and off the toilet, or a "4" because without someone putting her on and off the toilet she would be unable to use it? [Q&A ADDED 12/12; Previously CMS Qtrly 01/12 Q&A #8]

A148.01. If the patient is not participating in the transfer process and is totally dependent on someone to perform the transfer on and off the toilet, Responses 0, 1 or 2 wouldn't apply. Can the patient independently place and remove the bedpan? If so, Response 3 is appropriate. If the patient is unable to do that or does not have a bedpan in the home, then Response 4 applies.

Q148.02 M1840. If you have a patient that does not have a toilet in his home would he be dependent in toilet transfers? [Q&A ADDED 10/16; Previously CMS Qtrly 10/15 Q&A #3]

A148.02 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.

Q148.1. M1840, M1850 & M1860. Is it true that when the word "OR" appears in a question and the patient's condition meets both sides of the statement that the patient should automatically be marked at the next level down on the scale? Also, if the patient is marked as a "3" on M1860, Ambulation, can the patient be a "0" independent in toileting transferring? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/08 Q&A #21]

A148.1. When scoring the OASIS, clinicians should avoid applying "always", "never", or "automatically" rules. Each item, the response options contained in the item, and additional available guidance in the form of Q&As and from Chapter 3 should be reviewed and the most accurate response should be selected. It is not a universally true statement to say that if conditions on both sides of the word "OR" pertain to the patient, then the patient should be automatically scored at the next level down. For instance, Response "0" for M1830 Bathing says "Able to bathe self in shower or tub independently, including getting in and out of tub/shower". If the patient was able to bathe in the shower independently AND also able to bathe in the tub independently, it would not be appropriate to score them at the next level down simply because conditions on both sides of the word "OR" are met.

When scoring M1860, Ambulation/Locomotion, Response 3 is selected when the patient requires human supervision or assistance at all times in order to ambulate safely. Response 0 is selected if the patient requires no human assistance and no assistive devices to ambulate safely on even and uneven surfaces. All other combinations of needing assistance intermittently are reported as a 1 or 2.

For M1850, Transferring, Response 1-Able to transfer with minimal human assistance or with use of an assistive device, it is true that if the patient requires BOTH minimal human assistance AND an assistive device to transfer safely, then the response option 2 should be selected (See CMS OASIS Q&A Category 4b Question 151.4.)

If a patient requires constant human supervision or assistance in order to ambulate safely, they are scored a "3" for M1860, Ambulation/Locomotion. A patient can only be scored a "0" for M1840, Toileting Transferring, if they can get to and from the toilet and transfer independently with or without a device. It would be possible for a patient to be a "3" for M1860, Ambulation/Locomotion and also be reported as a "0" for M1840, Toilet Transferring, if the patient required assistance at all times to ambulate, but was able to get to and from the toilet and transfer safely and without assistance using a wheelchair.

Q148.2. M1840 & M1850. Regarding M1840 Toilet Transferring– Response 1 (reminded, assisted, or supervised by another person) & M1850 Transferring– Response 1 (minimal human assistance or with assistive device), what exactly do the terms “assisted” & “minimal human assistance” mean? In the therapy world, minimal assistance means the caregiver must provide less than 25% of the effort required to assist the patient in completing the task safely. Is this what the clinician is suppose to look at or could minimal human assistance mean verbal cueing or stand by assist only? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #19]

A148.2. The current OASIS Guidance Manual, Chapter 1, Conventions explains "When an OASIS item refers to assistance, this means assistance from another person unless otherwise specified within the item. Assistance is not limited to physical contact, but includes both verbal cues and supervision."

When completing M1840, Toilet Transferring, if the patient can participate, but requires any degree of hands-on assistance and/or standby assistance and/or verbal cueing/reminders to get

to/from the toilet and/or transfer on/off the toilet safely, select Response 1. An example of Response "1" could be a patient who requires verbal cues regarding safe use of walker while ambulating to the toilet.

When completing M1850, Transferring, minimal human assistance referenced in Response 1 would include a minimal degree of any combination of verbal cueing, environmental set-up and/or actual hands-on assistance. In order for the assistance to be considered minimal, it would mean the individual assisting the patient is contributing less than 25% of the total effort required to perform the transfer.

An example of Response "1" could be a patient that requires hands-on assistance during the change in position from supine to sitting at the edge of bed, where the effort contributed by the individual assisting is less than 25% of total effort required to change position.

Q149. [RETIRED 09/09; Duplicative of Q&A #151.3]

Q150. M1850. If other types of transfers are being assessed (e.g., car transfers, floor transfers), should they be considered when responding to M1850? [Q&A EDITED 01/10]

A150. Because standardized data are required, only the bed to chair/chair to bed transfer should be considered when responding to the item.

Q150.1. M1850. When completing M1850, Transferring, do I consider the patient's gait impairment if they must ambulate 12 feet from the bed to get to the closest sitting surface and the need for assistance of another person? [Q&A EDITED 12/12; ADDED 01/12; Previously CMS OCCB 10/11 Q&A #9]

A150.1. The need for assistance with gait may impact the M1850, Transferring score if the closest sitting surface applicable to the patient's environment is not next to the bed.

M1850 reports the patient's ability to move from the supine position in bed (or the current sleeping surface) to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a sitting surface at the bedside. If there is no chair at the bedside, report the ability to transfer from the sleeping surface to whatever sitting surface is applicable to the patient's environment and need. If the sleeping surface is in the bedroom and the sitting surface is down the hall in the bathroom and the patient is independent moving from the supine to sitting position, sitting to standing, and then standing to sitting, but requires minimal human assistance or an assistive device to ambulate from the bed to the sitting surface, the appropriate M1850 score would be a "1". If the patient requires more than minimal assistance or requires both minimal human assistance and an assistive device to be safe, the appropriate score would be a "2".

Q151. M1850. If a patient takes extra time and pushes up with both arms, is this considered using an assistive device? [Q&A EDITED 09/09]

A151. Taking extra time and pushing up with both arms can help ensure the patient's stability and safety during the transfer process but does not mean that the patient is dependent. If standby human assistance were necessary to assure safety, then a different response level would apply.

Q151.1. M1850. When scoring M1850, Transferring, response “1” indicates that that patient requires minimal human assistance or the use of an assistive device to safely transfer. What constitutes an “assistive device” for the purposes of differentiating “truly independent” transferring (response “0”) from “modified independent” transferring (response “1”) or transferring with equipment)? [Q&A EDITED 01/12; ADDED 08/07; Previously CMS OCCB 08/04 Q&A #16]

A151.1. CMS does not provide a definitive list of assistive devices to apply when determining relevant OASIS responses. Use your clinical judgment and examples of devices included in OASIS ADL items and related Q&As in determining what are considered assistive devices when scoring OASIS items.

Q151.2. M1850. If a patient requires a little help from the caregiver to transfer (e.g., verbal cueing, stand by assist, contact guard), would the score for M1850 Transferring be “1” (requires “minimal human assistance”) or a “2” (“unable to transfer self”)? Both seem to apply. [Q&A ADDED 08/07; M item updated 09/09; Previously CMS OCCB 07/06 Q&A #38]

A151.2. If the patient is able to transfer self but requires standby assistance or verbal cueing to safely transfer, Response “1” would apply. If the patient is unable to transfer self but is able to bear weight and pivot when assisted during the transfer process, then Response “2” would apply.

Q151.3. M1850. A quadriplegic is totally dependent, cannot even turn self in bed, however, he does get up to a gerichair by Hoyer lift. For M1850, is the patient considered bedfast? [Q&A ADDED 08/07; M item updated 09/09; Previously CMS OCCB 05/07 Q&A #29]

A151.3. 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.

Q151.4. M1850. How do you select a score for M1850 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? [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/07 Q&A #15]

A151.4. 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-Able to transfer 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–Able to bear weight and pivot during the transfer process but unable to transfer self” (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.

Q151.5. [Q&A RETIRED 09/09; Outdated]

Q151.6. M1850. When scoring M1850, Transferring, the assessment revealed difficulty with transfers. The patient was toe touch weight bearing on the left lower extremity and had pain in the opposite weight bearing hip. The patient had a history of falls and remained at risk due to medication side effects, balance problems, impaired judgment, weakness, unsteady use of device and required assistance to transfer. The concern is the safety of the transfers considering all of the above. Would "2" or "3" be the appropriate response? [Q&A ADDED 09/09; M item updated 09/09; Previously CMS OCCB 10/07 Q&A #22]

A151.6. Safety is integral to ability, if your patient requires more than minimal human assistance or they need minimal assistance and an assistive device to safely transfer, and can bear weight and pivot safely, Response 2 should be reported. If you determine the bearing weight and pivoting component of the transfer is not safe even with assistance, then the patient is not able to bear weight or pivot and the appropriate selection would be Response 3 – Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

Q151.6.1. M1850. When answering M1850, Transferring, do the responses that reference weight bearing and pivoting include an individual that uses a sliding board and would be weight bearing and pivoting using only the upper extremities, not the lower? [Q&A ADDED 06/14; Previously CMS Qtrly 07/13 Q&A #15]

A151.6.1. The term "bear weight and pivot" in M1850, Transferring, may include both a standing pivot transfer and multiple sitting pivot transfers, such as those utilized when performing a bed-to-chair transfer with a sliding board.

If the patient does not have use of the lower extremities and transfers with the use of a sliding board, but no human assistance, select Response “1-Able to transfer with minimal human assistance or with use of an assistive device.” If the patient requires both minimal human assistance and the sliding board to transfer safely, select Response “2-Able to bear weight and pivot during the transfer process but unable to transfer self.” If the patient can bear weight and pivot utilizing their upper extremities, but requires more than minimal human assist, Response 2 should be marked. The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, select Response “3-Unable to transfer self and is unable to bear weight or pivot when transferred by another person.”

Q151.7. M1850. For M1850, Transferring, does the transfer from bed to chair include evaluation from a seated position in bed to a seated position in a chair or from supine in bed to seated in a chair? [Q&A ADDED 09/09; EDITED 01/10; Previously CMS OCCB 07/08 Q&A #15]

A151.7. The bed to chair transfer includes the patient's ability to get from the bed to a chair and from the chair back into bed. For most patients, this will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair.

Q151.7.1. M1850. Is M1850 Transferring assessed for the patient who has slept for years in a recliner? [Q&A EDITED 12/12; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #13]

A151.7.1. M1850, Transferring, must be assessed for all patients requiring OASIS data collection. The item includes assessment of the bed to chair/chair to bed transfers. If your patient no longer sleeps in a bed (e.g. sleeps in a recliner or on a couch), you will assess the patient's ability to move from the supine position on their current sleeping surface to a sitting position and then transfer to another sitting surface, like a bedside commode, bench, or chair.

Q151.7.2. M1850. How do we score M1850, Transferring, when the patient is temporarily sleeping in the recliner because there is a physician's order not to climb stairs and the patient's bed is located on the second floor? [Q&A ADDED 06/14; Previously CMS Qtrly 04/13 Q&A #6]

A151.7.2. In the situation described, the medical restriction against climbing stairs does not impact the patient's ability. The assessing clinician will report the patient's ability to move from the supine position on the current sleeping surface to a sitting position at the side of the sleeping surface, then some type of standing, stand-pivot, or sliding board transfer to a sitting surface at the side of the sleeping surface.

Certain medical restrictions could impact ability, e.g. an order to maintain strict bed rest means the patient is scored as bedfast. Other medical restrictions that may prevent access to the usual sleeping surface DO NOT impact ability as M1850 reports the patient's ability to move from the bed or current sleeping surface, e.g. an order not to climb stairs or an order to sleep in hospital bed.

Q151.8. M1840, M1850 & M1860. Is it true that when the word "OR" appears in a question and the patient's condition meets both sides of the statement that the patient should automatically be marked at the next level down on the scale? Also, if the patient is marked as a "3" on M1860, Ambulation, can the patient be a "0" independent in toileting transferring? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/08 Q&A Q #21]

A151.8. When scoring the OASIS, clinicians should avoid applying "always", "never", or "automatically" rules. Each item, the response options contained in the item, and additional available guidance in the form of Q&As and from Chapter 3 should be reviewed and the most accurate response should be selected. It is not a universally true statement to say that if conditions on both sides of the word "OR" pertain to the patient, then the patient should be automatically scored at the next level down. For instance, Response "0" for M1830 Bathing says "Able to bathe self in shower or tub independently, including getting in and out of tub/shower". If the patient was able to bathe in the shower independently AND also able to bathe in the tub independently, it would not be appropriate to score them at the next level down simply because conditions on both sides of the word "OR" are met.

When scoring M1860, Ambulation/Locomotion, response option 3 is selected when the patient requires human supervision or assistance at all times in order to ambulate safely. Response 0 is

selected if the patient requires no human assistance and no assistive devices to ambulate safely on even and uneven surfaces. All other combinations of needing assistance intermittently are reported as a 1 or 2.

For M1850, Transferring, Response 1-Able to transfer with minimal human assistance or with use of an assistive device, it is true that if the patient requires BOTH minimal human assistance AND an assistive device to transfer safely, then the response option 2 should be selected (See CMS OASIS Q&A Category 4b Questions 151.4.)

If a patient requires constant human supervision or assistance in order to ambulate safely, they are scored a "3" for M1860, Ambulation/Locomotion. A patient can only be scored a "0" for M1840, Toileting Transferring, if they can get to and from the toilet and transfer independently with or without a device. It would be possible for a patient to be a "3" for M1860, Ambulation/Locomotion and also be reported as a "0" for M1840, Toilet Transferring, if the patient required assistance at all times to ambulate, but was able to get to and from the toilet and transfer safely and without assistance using a wheelchair.

Q151.14. M1850 & M1860. How is “bedfast” defined for M1850, Transferring and M1860, Ambulation/Locomotion? Do I only count what my patient could do during the visit?

[Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 04/11 Q&A #10]

A151.14. M1850, Transferring and M1860, Ambulation/Locomotion report the patient's ability on the day of the assessment. Day of assessment is the 24 hours before the clinician arrives in the patient's home and the time spent in the home performing the comprehensive assessment. Ch. 3 of the current OASIS Guidance Manual in the M1850 Response-Specific Instructions defines bedfast. "Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed." If the patient can tolerate being out of bed, they are not bedfast unless they are medically restricted to the bed. The patient is not required to be out of bed for any specific length of time. The assessing clinician will have to use her/his judgment when determining whether or not a patient can tolerate being out of bed. For example, a severely deconditioned patient may only be able to sit in the chair for a few minutes and is not considered bedfast as she/he is able to tolerate being out of bed. A patient with Multiple System Atrophy becomes severely hypotensive within a minute of moving from the supine to sitting position and is considered bedfast due to the neurological condition which prevents him from tolerating the sitting position.

Q.151.20.GG0170C. It appears that OASIS-C2 item GG0170C only measures the patient's performance for Lying to Sitting on Side of Bed. However, the response options available include 05 – Setup or Clean-up. Does this item address more tasks that just the bed mobility activity? [Q&A ADDED 10/16; Previously CMS Qtrly 07/16 Q&A #6]

A151.20. GG0170C- Functional Abilities and Goals only includes evaluating the activity of lying to sitting at the side of the bed with feet flat on the floor, and with no back support. If a patient required setup assistance to complete this bed mobility task, Response 05 would be selected.

Q.151.21.GG0170C. The patients we see in our agency often sleep in a recliner and not in bed. We currently have a patient who sleeps on a mattress on the floor. The new GG0170c item is about bed mobility and describes a patient who sleeps in a bed and requires sitting at the side of the bed, with feet flat on the floor. How do we assess this new GG0170C item for our patients who do not sleep in a bed, like the ones I described? Or patients who are unable to reach the floor sitting at the bedside, due to bed height/leg length? [Q&A ADDED 10/16; Previously CMS Qtrly 10/16 Q&A #18]

A.149.1. If the patient uses a recliner, sofa, or mattress on the floor as the patient's "bed" (preferred or necessary sleeping surface), assess the patient's need for assistance using that sleeping surface when determining ability in GG0170C - Lying to sitting on side of bed.

If the patient's feet do not touch the floor because the patient's feet do not reach the floor, and the patient performs the activity of getting from lying to sitting independently and safely, the patient can be scored as 06 – Independent. If the assessing clinician feels the patient is not safe sitting at the bedside without their feet on the floor and requires assist to lower the bed prior to the transfer, or to place a foot stool prior to the transfer, the patient can be scored as 05 – Setup or clean-up assistance.

Report the help that the patient needs to complete the lying to sitting transfer, understanding that in some cases, clinical judgment will be required.

Q152. M1860. What if my patient has physician-ordered activity restrictions due to a joint replacement? What they are able to do and what they are allowed to do may be different. How should I respond to this item?

A152. The patient's medical restrictions must be considered in responding to the item, as the restrictions address what the patient is able to safely accomplish at the time of the assessment.

Q153. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q154. M1860. If a patient uses a wheelchair for 75% of their mobility and walks for 25% of their mobility, then should they be scored based on their wheelchair status because that is their mode of mobility >50% of the time? Or should they be scored based on their ambulatory status, because they do not fit the definition of "chairfast?" [Q&A EDITED 09/09; ADDED 06/05; Previously CMS OCCB 08/04 Q&A #17]

A154. Item M1860 addresses the patient's ability to ambulate, so that is where the clinician's focus must be. Endurance is not included in this item. The clinician must determine the level of assistance is needed for the patient to ambulate and choose Response 0, 1, 2, or 3, whichever is the most appropriate.

Q154.1.M1860. Does the usual status convention apply to all patients: ambulatory, chairfast and bedfast, when scoring M1860, Ambulation/Locomotion? [Q&A ADDED 04/15; Previously CMS Qtrly 07/14 Q&A #6]

A154.1. Because of the structure of the response options, the usual status convention (what is true greater than 50% of the time) does not apply for M1860 Ambulation/Locomotion. For the ambulatory patient who needs assistance ambulating during any part of the day of assessment, but at times or in certain circumstances on the day of assessment can ambulate safely without assist, Response 2 is selected. A patient's ability must be that he/she is safe when independent of human assistance at all times during the day of assessment in order to select either Response 0 or 1. Response 3 is selected when, on the day of assessment, a patient needs human assistance at all times in order to safely ambulate.

For a non-ambulatory patient who is not bedfast, Response 4 - Chairfast, unable to ambulate but is able to wheel self independently is selected if the patient does not require any assistance wheeling self at any time during the day of assessment. Response 5-Chairfast, unable to ambulate and unable to wheel self is selected if the patient requires any assistance to wheel self on the day of assessment. If the patient can wheel self safely for part of the day but requires assistance at times, Response 5 is selected.

In order to be considered bedfast, a patient must be medically restricted to the bed or unable to tolerate being out of bed.

Q155. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q155.1. M1860. My patient does not have a walking device but is clearly not safe walking alone. I evaluate him with a trial walker that I have brought with me to the assessment visit and while he still requires assistance and cueing, I believe he could eventually be safe using it with little to no human assistance. Currently his balance is so poor that ideally someone should be with him whenever he walks, even though he usually is just up stumbling around on his own. What score should I select for M1860? [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #39]

A155.1. It sounds as though your assessment findings cause you to believe the patient should have someone with them at all times when walking (Response “3”). When scoring M1860, clinicians should be careful not to assume that a patient, who is unsafe walking without a device, will suddenly (or ever) become able to safely walk *with* a device. Observation is the preferred method of data collection for the functional OASIS items, and the most accurate assessment will include observation of the patient using the device. Often safe use will require not only obtaining the device, but also appropriate selection of specific features, fitting of the device to the patient/environment and patient instruction in its use.

Q155.1.01.M1860. My patient does not have an assistive device, but demonstrates the ability to walk safely constantly holding on to his caregiver. His neighbor loaned him a walker to try out during our assessment visit. My patient liked it and was safe walking on level surfaces with no help, but still needed help on the stairs. I have ordered a walker for the patient, and it will be delivered in 2 days. How do I score M1860 for the day of assessment? With or without the use of a walker? [Q&A ADDED 10/16; Previously CMS Qtrly 04/16 Q&A #10]

A155.1.01. For M1860, the clinician must consider what the patient is able to do on the day of the assessment, which is the 24 hours that precedes the visit plus the time in the home. If at the time of assessment, (and prior to any teaching or interventions), the patient demonstrates the ability to ambulate safely with a walker and no assistance, then Response 2 - Requires use of a two-handed device to walk alone on level surfaces should be reported, as this is the patient's status on the day of assessment. This is true even if the walker does not belong to the patient and may not remain in the home. The clinician should not assume that the patient would be safe walking with a walker if no walker is available to allow assessment of the patient's status.

Q155.1.1. M1860. When looking at the use of a cane to ambulate - how would the canes used by the blind to navigate be considered when scoring M1860, Ambulation/Locomotion? [Q&A ADDED 01/12; Previously CMS OCCB 10/11 Q&A #10]

A155.1.1. If a patient needs no human assistance, but must use a cane to ambulate safely and independently on even and uneven surfaces and negotiate stairs, Response 1 would be appropriate when scoring M1860. This is true for blind patients utilizing a cane to ambulate safely, canes used for weight bearing, and a white cane used to detect objects in the path of the user.

Q155.2. M1860. For M1860, 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? [Q&A EDITED 01/10; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #30]

A155.2. “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 3), needs no human assistance or assistive device on any of the encountered surfaces (Response 0), needs a one-handed device but no human assistance, (Response 1) or needs a two-handed device and/or human assistance at times but not constantly (Response 2).

Response 0, Able to independently walk on even and uneven surfaces and negotiate 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>.

Q155.3. M1860. A patient is able to ambulate independently with a walker, but the patient chooses to not use the walker, therefore not being safe. When selecting a response for M1860 Ambulation/Locomotion, should I select Response #2, that the patient is able to ambulate safely with the walker or should I select Response #3 that the patient is only safe when walking with another person at all times, because he chooses to not use his walker? [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 01/09 Q&A #12]

A155.3. The OASIS items should report the patient’s physical and cognitive ability, not their actual performance, adherence or willingness to perform an activity. You state the patient is able to ambulate independently with a walker, so we will assume you meant that the patient is able to ambulate without human assistance safely with the walker. This would be scored a “2” for M1860 Ambulation/Locomotion. You state the patient’s actual performance is that he is unsafe ambulating because he chooses not to use his walker. This patient would still be scored a “2” unless, as you pointed out, the clinician identified some other physical, cognitive or environmental barrier that prevents the patient from utilizing his walker to assist with ambulation, e.g. fear, memory impairment, undisclosed pain associated with walker use, or other emotional, behavioral or physical impairments. If there was a barrier preventing the patient from safely utilizing the walker during ambulation, the clinician would need to determine if the patient needed someone to assist at all times in order to ambulate safely and if so, the appropriate score for M1860 would be a “3”. If the patient only needed assistance intermittently, the correct response would be a “2”.

Q155.3.1. M1860. We have a patient who is ambulating in the home. The clinician assesses that the patient is not safe ambulating with an assistive device, even with the supervision of another person at all times. The patient does not have a wheelchair in the

home. What is the appropriate response to M1860, Ambulation/Locomotion, for this patient? [Q&A ADDED 01/12; Previously CMS OCCB 04/11 Q&A #11]

A155.3.1. A patient is considered chairfast if they cannot be made safe ambulating even with the combination of a device and the assistance of another person at all times. They are not bedfast unless they are medically restricted to the bed or cannot tolerate being out of bed. If there is no wheelchair in the home, the assessing clinician cannot make assumptions about their ability to propel it safely. The appropriate M1860 response in this case is "5-Chairfast, unable to ambulate and is unable to wheel self".

Q155.3.2. M1860. What is the correct response for M1860, Ambulation/Locomotion, for a patient who ambulates safely with a straight cane, but requires a stair lift to get up and down stairs in her home? [Q&A ADDED 12/12; Previously CMS Qtrly 01/12 Q&A #9]

A155.3.2. In the situation described, if the patient requires no human assistance while ambulating and negotiating the stairs, but requires a stair lift to traverse the stairs safely, she would be scored a "2" for M1860 if she needs two hands to use the stair lift and a "1" if she only needs one hand to safely use the stair lift.

Q155.3.3. M1860. Our patient requires maximum assistance to ambulate (over 75% of the effort necessary for ambulation is contributed by someone other than the patient) and only ambulates with the therapist during gait training activities. The patient is extremely unsafe when attempting to ambulate without the therapist's assistance. Is this patient considered ambulatory for M1860 and scored as "3" (with constant assistance) or is this patient chairfast and scored as "4" or "5", at this time? [Q&A ADDED 06/14; Previously CMS Qtrly 01/13 Q&A #12]

A155.3.3. If the assessing clinician determines the patient is safe ambulating with constant human assistance, they are ambulatory. This is true whether the assistance needed is verbal cueing, reminders, contact guard, or any level of hands-on assistance. If the patient is not bedfast, and is not safe ambulating even with a combination of continuous assistance and a device, they are chairfast. If the patient can only take a couple of steps safely, they are not ambulatory.

Q155.3.4 M1860. If a patient is safely using a knee scooter to facilitate non-weight bearing on one lower extremity, what response would be selected for M1860 - Ambulation? [Q&A ADDED 10/16; Previously CMS Qtrly 07/15 Q&A #9]

A155.3.4 To determine the accurate response for M1860, the assessing clinician must determine if the knee scooter will be considered an assistive device for the purpose of ambulation. If the assessing clinician determines the knee scooter is an assistive device, then the clinician must determine if the patient is safe without the assistance of another person and assess the number of hands (one-hand or two-hands) the patient requires to safely use the device.

Q155.3.5 M1860. 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? [Q&A ADDED 10/16; Previously CMS Qtrly 10/15 Q&A #4]

A155.3.5 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; or 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.

Q155.4. M1840, M1850 & M1860. Is it true that when the word "OR" appears in a question and the patient's condition meets both sides of the statement that the patient should automatically be marked at the next level down on the scale? Also, if the patient is marked as a "3" on M1860, Ambulation, can the patient be a "0" independent in toileting transferring? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/08 Q&A #21]

A155.4. When scoring the OASIS, clinicians should avoid applying "always", "never", or "automatically" rules. Each item, the response options contained in the item, and additional available guidance in the form of Q&As and from Chapter 3 should be reviewed and the most accurate response should be selected. It is not a universally true statement to say that if conditions on both sides of the word "OR" pertain to the patient, then the patient should be automatically scored at the next level down. For instance, Response "0" for M1830 Bathing says "Able to bathe self in shower or tub independently, including getting in and out of tub/shower". If the patient was able to bathe in the shower independently AND also able to bathe in the tub independently, it would not be appropriate to score them at the next level down simply because conditions on both sides of the word "OR" are met.

When scoring M1860, Ambulation/Locomotion, response option 3 is selected when the patient requires human supervision or assistance at all times in order to ambulate safely. Response 0 is selected if the patient requires no human assistance and no assistive devices to ambulate safely on even and uneven surfaces. All other combinations of needing assistance intermittently are reported as a 1 or 2.

For M1850, Transferring, Response 1-Able to transfer with minimal human assistance or with use of an assistive device, it is true that if the patient requires BOTH minimal human assistance AND an assistive device to transfer safely, then the response option 2 should be selected (See CMS OASIS Q&A Category 4b Questions 151.4.)

If a patient requires constant human supervision or assistance in order to ambulate safely, they are scored a "3" for M1860, Ambulation/Locomotion. A patient can only be scored a "0" for M1840, Toilet Transferring, if they can get to and from the toilet and transfer independently with or without a device. It would be possible for a patient to be a "3" for M1860, Ambulation/Locomotion and also be reported as a "0" for M1840, Toilet Transferring, if the patient required assistance at all times to ambulate, but was able to get to and from the toilet and transfer safely and without assistance using a wheelchair.

Q156. [RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q156.1. M1870. If a patient is receiving TPN and is also taking in nutrients orally, is the correct answer for M1870 Feeding or Eating - 0, 1 or 2? They do not have a tube in place. [Q&A ADDED 01/12; Previously CMS OCCB 07/11 Q&A #14]

A156.1. M1870, Feeding or Eating, identifies the patient's ability to feed him/herself food and does not include total parenteral nutrition (TPN). If the patient is receiving TPN and is also taking in nutrients orally, the answer will be 0, 1, or 2. Response 5 would apply if the patient is

not able to take in nutrients orally or by tube feeding and is receiving all nutrition intravenously or for patients who are only receiving IV hydration.

Q156.2. M1870. My patient was recently hospitalized for aspiration pneumonia. She can feed herself but needs to be closely observed/supervised during the entire meal because she tends to pocket food, forgets to swallow and then sometimes dozes while eating. How should I answer M1870, Feeding or Eating? [Q&A ADDED 01/12; Previously CMS OCCB 10/11 Q&A #11]

A156.2. If a patient requires constant supervision throughout the meal in order to eat or feed self safely, the appropriate M1870 response is a “2-Unable to feed self and must be assisted or supervised throughout the meal/snack”.

Q157 & 157.1. [RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q158. M1880. Should a therapeutic diet prescription be considered when assessing the patient’s ability to plan and prepare light meals for M1880? For example, if a patient is able to heat a frozen dinner in the microwave or make a sandwich – but is NOT able to plan and prepare a simple meal within the currently prescribed diet (until teaching has been accomplished for THAT diet, or until physical or cognitive deficits have been resolved), would the patient be considered *able* or *unable* to plan and prepare light meals? [Q&A EDITED 08/07; ADDED 06/05; Previously CMS OCCB 10/04 Q&A #8]

A158. M1880 identifies the patient’s cognitive and physical ability to plan and prepare light meals or reheat delivered meals. While the nutritional appropriateness of the patient’s food selections is not the focus of this item, any prescribed diet requirements (and related planning/preparation) should be considered when scoring M1880. Therefore a patient who is able to complete the mobility and cognitive tasks that would be required to heat a frozen dinner in the microwave or make a sandwich, but who is currently physically or cognitively *unable* plan and prepare a simple meal that complies with a medically prescribed diet should be scored as a “1- unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations,” until adequate teaching/learning has occurred for the special diet, or until related physical or cognitive barriers are addressed. If the patient with any prescribed diet requirements is unable to plan and prepare a meal that complies with their prescribed diet AND also is unable to plan and prepare “generic” light meals (e.g. heating a frozen dinner in the microwave or making a sandwich), Response 2 – Unable to prepare any light meals or reheat any delivered meals” should be selected. This is a critical assessment strategy when considering the important relationship between this IADL and nutritional status. A poorly nourished patient with limited ability to prepare meals is at greater risk for further physical decline.

Q158.5.M1900. M1900 Prior Functioning ADLs and IADLs identifies the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care.

Sometimes a surgical procedure is what initiated the home health episode. For example, a patient was actively employed, exercising, and completely independent with ADLs/IADLs, then had decreased activity tolerance as a result of degenerative hip pain, which lasted several months until the patient underwent joint replacement surgery. Home health is now admitting. At the SOC, should the time period to consider for Prior Functioning ADL/IADL status be the period prior to the onset of joint pain, or the period just prior to the hip replacement surgery? [Q&A ADDED 04/15; Previously CMS Qtrly 01/15 Q&A #8]

A158.5. M1900 reports the patient's ability prior to the most recent illness, exacerbation or injury. In your example, the timeframe to consider would be just prior to the hip surgery.

Q158.6.M1900. We have a 92 year-old patient that has CHF, lives alone, and refuses a walker. Patient did all her own care before getting ill, but our nurse answered M1900 Prior Functioning ADL/IADL with Response 1's Needed Some Help, because based on the patient's report and demonstration, our nurse didn't believe the patient was completing the tasks safely on her own. Our hired consulting company feels we have to mark this patient independent, as she was doing things on her own without help. Please advise on how to address this situation. [Q&A ADDED 10/16; Previously CMS Qtrly 07/16 Q&A #7]

A158.6.The clinician, through patient/caregiver interview, review of H&P, physician input, etc., would determine the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. "Independent" means that the patient had the ability to safely complete the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper. "Needed some help" means that the patient contributed effort but required help from another person to accomplish the task/activity safely. In the scenario cited, if in the clinician's judgment the patient's ability to perform the defined tasks warranted the assistance of another person, response 1 - Needed some help would be appropriate.

Q159. [Q&A RETIRED 09/09; Outdated]

Q159.1. M1910. If I mark a process measure assessment item "Yes" (that the assessment was done), is that sufficient documentation or do I have to explain which tool I used and how I came to the decision regarding my patient's level of risk? [Q&A EDITED 06/14; Previously CMS OCCB 10/09 Q&A #15]

A159.1. Whether the clinician uses a standardized, validated assessment or a combination of clinical factors for assessment of fall risk, pain severity, depression, or pressure ulcer risk, it is expected that the clinical record would detail the clinical factors or tool that was used and the related findings and analysis to support the OASIS response selected.

Q159.2. M1910. If an agency adds the TUG to a multifactor fall risk assessment, can the agency decide on how to administer the tool by selecting any one of the many publicly available administration protocols? [Q&A ADDED 01/11; Previously CMS OCCB 04/10 Q&A #21]

A159.2. The CMS requirement is that a standardized validated assessment is used, which would include use of the accompanying validated protocol for administration, including any validated protocol or scoring variations.

Q159.3. [Q&A RETIRED 12/12; Guidance found in related Q&As]

Q159.4. M1910. We are having some difficulty in verifying the need for a standardized fall risk assessment tool to answer question M1910. In the guidance section, it is stating there is NOT a mandate for the use of standardized tools. However, in the question and answer, Question 14 it is stating YES under Standardized Assessment Required. We are using a multi-factor risk assessment screening with six questions, consisting of the six areas noted in question M1910. Is this okay to do and then answer yes to this question? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #15]

A159.4. When the guidance states standardized tools are not mandated, it means CMS does not mandate their use as a Condition of Participation. However, if you want to answer the OASIS Process Measure items "Yes" or "NA", you must use a standardized, validated tool for M1240, Pain Assessment, M1730, Depression Screening, and M1910, Fall Risk Assessment, as specified in the item.

A standardized tool is one that has been scientifically tested and validated. A standardized tool includes a standard response scale, and must be appropriately administered based on established instructions. To meet the need of the pain assessment, the depression screen or the multi-factor fall risk assessment referenced in the OASIS, an agency may use a standardized, validated tool from any organization able to effectively develop, test, and validate the tool for use on a population similar to that of the patient(s) being assessed. Without the validation process, an agency may not simply create an assessment by combining clinical assessment factors, unless the OASIS item indicates that the assessment can be based on clinical judgment, such as M1300, Pressure Ulcer Risk.

For M1910, the agency can use a multi-factor, standardized, validated fall risk assessment tool, or alternatively, a standardized, validated performance assessment combined with at least one other factor, e.g. fall history, polypharmacy, impaired vision, incontinence, etc. to meet the requirements of the multifactor, standardized validated fall risk assessment. It is the agency's responsibility to determine if your tool includes these elements. If an agency has evidence (from published literature, the tool developer, or another authoritative source) that the tool they are using assesses multiple factors that contribute to the risk of falling, has been scientifically tested and validated on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, noninstitutionalized adults with disabilities, etc.) and shown to be effective in identifying people at risk for falls, and includes a standardized response scale, then the agency can consider the tool to meet the requirements for the OASIS data set's best practice assessment.

Q159.5. [Q&A RETIRED 12/12; No longer relevant]

Q159.5.1. M1910. We see that a validation study has been published for the Missouri Alliance for Home Care's Fall Risk Assessment Tool (MAHC-10). Does this mean that we can now use that tool as the single standardized, validated, multifactor tool to meet the "Yes" response for M1910? And if so, should the threshold of "4" or "6" be used to indicate fall risk? [Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 10/12 Q&A #7]

A159.5.1. Per existing guidance, if you want to report M1910 as "Yes" (that Fall Risk Assessment was conducted), you must use a multi-factor standardized tool that has been scientifically tested and validated, and the tool must be appropriately administered based on established instructions. CMS does not approve or disapprove individual tools. It is the agency's responsibility to determine if the tool you are using includes these elements. If an agency has evidence (from published literature, the tool developer, or another authoritative source) that the tool they are using assesses multiple factors that contribute to the risk of falling,

has been scientifically tested and validated on a population with characteristics similar to that of the patient being assessed, and shown to be effective in identifying people at risk for falls, and includes a standardized response scale, then the agency can consider the tool to meet the requirements for the OASIS data set's best practice assessment.

In determining if a patient is at risk for falls, the standardized tool should have a standardized response scale, and/or established and validated threshold at which fall risk exists. A tool may have multiple thresholds identifying various levels of risk (i.e., "no risk", "low risk", "high risk"). Select Response 1 if the standardized response scale rates the patient as no-risk, low-risk, or minimal risk. Select Response 2 if the standardized response scale rates the patient as anything above low/minimal risk. If the tool does not provide various levels, but simply has a single threshold separating those "at risk" from those "not at risk", then patients scoring "at risk" should be reported as Response 2.

Q159.5.2. M1910. If during the comprehensive assessment, I complete the MAHC-10 (reported by MAHC to be validated on 10/9/12) and a TUG test; one indicates the patient is at risk for falls and one does not, what is the appropriate response to M1910? [ADDED 06/14; Previously CMS Qtrly 01/13 Q&A #13]

A159.5.2. The response to M1910 should be based on whether a tool that meets the best practice criteria (validated, standardized, multifactor) was used to assess the patient. If more than one validated, standardized, multifactor tool was used and the findings differed, the clinician should err on the side of safety and report that the tool identified the patient as "at risk" for falls.

In your example, two validated tools were used to assess fall risk, a single factor assessment tool and a multi-factor assessment tool. In this case, the M1910 response is based on the multi-factor tool's risk finding.

If the agency combines a single factor, validated assessment tool with another factor or non-validated tool in order to meet the CMS requirement of a multi-factor assessment, M1910 should be Response 1 or Response 2, depending on whether or not risk was identified by the validated assessment tool.

If NO validated, standardized, multifactor assessment tool were positive, (e.g., the MAHC-10 indicates the patient is NOT at fall risk, but some other factor (patient history, a mobility assessment tool, clinical observation, etc.) indicates the patient is AT risk, M1910 should be Response 1 indicating no risk, but the clinician should document any concerns in the clinical record and use their judgment about the need for falls interventions. Care planning decisions to reduce fall risks should be based on clinical judgment.

Q159.6. M1910. I'm looking for guidance related to answering M1910 in a patient who is nonambulatory, bedbound and/or cognitively impaired. Would it be appropriate to use a standardized, validated tool that measures cognition or another factor of falls risk, such as the Folstein Mini-Mental Status Exam or the Gloth Frail Elderly Functional Assessment questionnaire, instead of the Tinetti, Functional Reach or Timed Up and Go, which aren't appropriate in this population? [Q&A EDITED 01/12; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #22]

A159.6. For an assessment tool to meet the criteria for a "Yes" response on M1910, the assessment would need to have been validated as a tool that specifically measures risk for falls. If the patient is not able to participate in tasks required to allow the completion and scoring of the assessment(s) that the agency chooses to utilize, "0 – No multi-factor fall risk assessment conducted" should be reported. A single tool may not meet the fall risk assessment needs of all patients in the agency.

Q159.7. M1910. How do we handle M1910, Fall Risk Assessment, for the patient who is ambulatory at home on their own, but based on clinician judgment, appears to require assistance to ambulate in order to be SAFE. For example, we know the patient is at risk for falls and balance is precarious enough that the clinician needs to guard the patient during the assessment. Should the clinician ask the patient to complete the TUG regardless and use the fact that they require assist of another person to complete the test to claim “Yes” on M1910 - standard test completed and indicated risk for falls even if they completed in < 14 seconds, or should we report “No” to M1910, formal assessment not completed, and document that the patient could not safely participate in the assessment. We are afraid to answer No, because the patient is not safe or at best marginally safe to perform the test, concerned it will negatively impact our process measure outcomes for this item. [Q&A EDITED 01/12; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #23]

A159.7. The CMS requirement is that a standardized validated assessment is used, which would include use of the accompanying validated protocol for administration, including any validated protocol or scoring variations. If the patient is not able to participate in tasks required to allow the completion and scoring of the assessment(s) that the agency chooses to utilize, “0 – No multi-factor fall risk assessment conducted” should be reported. A single tool may not meet the fall risk assessment needs of all patients in the agency.

Q159.7.1. M1910. CMS OASIS Q&A 159.6 states that if the patient is not able to participate in tasks required to allow the completion and scoring of the assessment, then “0” is the correct response. Does this mean that, using the TUG for example, if the patient is not able to get up from the chair AND walk AND return to the chair AND sit, then all of the tasks were not completed and a response of “0” is appropriate? What if, after 14 seconds, the patient is just standing and beginning to walk; is it appropriate to consider them a fall risk since they were in process of trying to complete the TUG and not require them to finish the assessment since they’ve already surpassed the 14-second fall-risk threshold, and answer M1910 with “2”? Or does the patient need to complete all tasks of the assessment in order for us to choose either “1” or “2” as a response? [Q&A ADDED 12/12; Previously CMS Qtrly QA 07/12 Q&A #8]

A159.7.1. The patient would have to be able to complete enough of the tasks in the standardized assessment in order to generate a risk factor finding. The risk factor finding is based on the scoring protocols of the assessment utilized, and depending on the assessment tool used, this may or may not require them to complete all the tasks. It is up to the individual provider/agency to determine which tool(s) will be used, and what the valid administration and scoring protocols are for each tool considered.

Q159.8. M1910. Does the Tinetti test by itself meet the requirement of using a standardized, validated, multifactor fall risk assessment? My understanding was that it does since the Tinetti has a separate gait and balance score (2 or more factors). [Q&A EDITED 12/12; Previously CMS OCCB 07/11 Q&A #15]

A159.8. There are a number of standardized assessments validated for use with community dwelling elders that have multiple mobility-related components such as gait, balance, etc., but they only assess one factor, mobility. You must assess at least one other non-mobility factor to make the fall risk assessment *multi-factorial*, such as vision, polypharmacy, environment, etc.

Q159.8.1. M1910. If the ROC comprehensive assessment with OASIS was completed after the CMS-allowed 48 hour time frame, do all the best practice questions need to be answered “NA”? [Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #13; 06/14 edit based on CMS Qtrly 10/13 Q&A#2]

A159.8.1. The ROC comprehensive assessment must be completed within 48 hours of discharge following a qualifying inpatient stay or within 48 hours of knowledge of a qualifying stay in an inpatient facility. If the ROC assessment is late, "Yes" may still be selected for the best practices in M2250, Plan of Care Synopsis, if the relevant orders were present within the 48 hour ROC time frame. Likewise, M1240, Pain Assessment, M1300, Pressure Ulcer Risk Assessment, M1730, Depression Screening, and/or M1910, Falls Risk Assessment may also be reported with "Yes" responses, if the relevant standardized, validated assessments were conducted by the assessing clinician within the 48 hour time frame, even if the ROC comprehensive assessment was completed after the 48 hour time frame. When the assessing clinician takes credit on M1240, M1300, M1730 and/or M1910 for standardized, validated assessments completed within the 48 hour time frame and the M0090 date indicates that the ROC comprehensive assessment was completed late (beyond the 48 hour time frame), clarifying documentation to support the reported OASIS responses is expected.

If the relevant standardized, validated assessment was completed greater than 48 hours after inpatient facility discharge or greater than 48 hours after gaining knowledge of a qualifying stay in an inpatient facility, M1240, M1300, M1730 and M1910 must be answered "No".

The agency should make every effort to complete the ROC assessment within the 48 hours from the discharge home. If the patient refuses or isn't available, the ROC assessment should be completed as soon as possible, with any physician communication and circumstance details documented in the clinical record.

Q159.8.2. M1910. Per OASIS guidelines, M1910 should be assessed at SOC and ROC. Per tool instructions, the MAHC-10 Fall Risk Assessment Tool is to be assessed at SOC and Re-certification. Which set of time periods is correct? [Q&A ADDED 06/14; Previously CMS Qtrly 10/13 Q&A #8]

A159.8.2. CMS requires OASIS item M1910, Fall Risk Assessment, to be completed at the SOC and ROC time points. You, as an assessing clinician or agency, will decide if you want to carry out the best practice of performing a fall risk assessment as part of your comprehensive assessment. If you elect to perform a multi-factor fall risk assessment using a standardized and validated tool at the CMS required time points of SOC and ROC, you may answer M1910 "Yes" on the relevant assessments. You may decide not to perform the fall risk assessment and answer the item "No". Based on the tool's administration protocols, or on changes in patient condition, you, as an assessing clinician or agency, may decide to perform a fall risk assessment at time points other than the SOC/ROC assessments. However, it should be noted that fall risk assessments conducted outside of the SOC or ROC assessment time frames should not be considered when selecting a response for M1910.

For questions related to how and why MAHC-10 administration time frames of SOC and Recertification were determined, consider contacting the tool's developer.

Q160. [Q&A RETIRED 09/09; Outdated]

Q160.1. M2001. For the purposes of answering M2001 - Drug Regimen Review, is oxygen considered a medication? [Q&A EDITED 10/16; Q&A ADDED 01/11; Previously CMS OCCB 07/10 Q&A #14]

A160.1. Yes, oxygen is included as a medication when answering M2001 - Drug Regimen Review.

Q160.2. M2001. In M2001 - Drug Regimen Review, are all drug interactions considered "potential clinically significant medication issues"? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 07/10 Q&A #15]

A160.2. No, the current OASIS Guidance Manual states that potential clinically significant medication issues may include serious drug-drug, drug-food and drug-disease interactions.

The Manual further states that a potentially clinically significant medication issue is defined as an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest).

The determination of whether a medication issue meets this threshold should be based on the clinician's judgment in conjunction with agency guidelines and established standards for evaluating drug reactions, side effects, interactions, etc. Online resources for these standards can be found in Chapter 5 of the current OASIS Guidance Manual.

Q160.3. [Q&A RETIRED 06/14; Duplicate of Q&A 160.2]

Q160.3.1. M2001. In therapy only cases, can an LPN in the office work cooperatively with the therapist to complete the Drug Regimen Review by performing elements of the drug regimen review that the therapist will not be completing? [Q&A EDITED 10/16; Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #16]

A160.3.1. No. Only registered nurses, physical therapists, speech language pathologists and occupational therapists are qualified to perform comprehensive assessments. LPNs are not qualified to perform comprehensive assessments, so they may not work cooperatively with therapists in order to complete the drug regimen review.

Q160.3.2. M2001. On therapy only cases, can the therapist collaborate with a pharmacist when completing the Drug Regimen Review? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 07/11 Q&A #16]

A160.3.2. In a therapy only case, it would be acceptable for the therapist to collaborate with a pharmacist when performing the drug regimen review. Agency policy and practice will determine how the pharmacist participates in the drug regimen review process and how it is documented.

Q160.3.3. M2001. For therapy only cases, can we have our therapist complete the entire comprehensive assessment, except the Drug Regimen Review (DRR), and then have our agency send a nurse out to complete the entire DRR, including answering the medication related questions on the OASIS? [Q&A EDITED 10/16; Q&A EDITED 04/15; ADDED 06/14; Previously CMS Qtrly 10/13 Q&A #9]

A160.3.3. No. The comprehensive assessment must be completed by one clinician, the "assessing clinician". Collaboration, however, is allowed on the medication/DRR tasks and items. One example of collaboration allows the assessing clinician to visit the patient at home and conduct the actual patient assessment, compiling the medication list and evaluating the patient's status (e.g., presence of potential ineffective drug therapy, side effects or patient nonadherence). A "collaborating clinician" in the office might evaluate the medication list to

assist with reconciling discrepancies between the facility discharge med list and meds available in the patient's home.

In another example of collaboration, the "collaborating clinician" might contact the patient by phone, to discuss issues with the patient regarding side effects they may be experiencing, or effectiveness of the medication. In any case, it is the assessing clinician who is ultimately responsible for ensuring a complete DRR was performed and for reporting the appropriate responses for medication related OASIS items.

Note that collaboration options do NOT allow a second clinician to contribute to the drug regimen review by utilizing information gathered from a second clinician's in-home assessment.

Agency policy and practice will determine the agency's processes and documentation expectations. The M0090 date reports the date the assessment is completed and should include any time the assessing clinician took to collaborate with others in order to gather all needed assessment data and determine all relevant OASIS responses.

It should be noted that in situations where nursing is admitting for a therapy only patient, the nurse could not complete or even start the comprehensive assessment (including drug review tasks) prior to the SOC date.

Q160.3.4. M2001. Can we answer M2001, Drug Regimen Review, "Yes" if we did not check for drug-to-drug interactions? We did most of the review, so it seems like we should get credit. [Q&A EDITED 10/16; Previously CMS Qtrly Q&A 10/16 #19; Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 07/13 Q&A #16]

A160.3.4. You must perform a complete drug regimen review, as defined in current OASIS Guidance Manual, M2001 Response-specific Instructions, in order to select Response "0-No - no issues found during review" or "1-Yes - issues found during review". If elements of the drug regimen review were skipped, for example, as you stated, drug-to-drug interactions, a dash (–) should be reported, indicating the drug regimen review was not completed.

Q160.4. M2001 & M2003. The assessing clinician identifies a problem with medications. The patient has not picked up a prescription because she was not sure she absolutely needed it. If the assessing clinician's education results in the resolution of the situation prior to the completion of the comprehensive assessment, can the clinician indicate on M2001 that there is no clinically significant problem, eliminating the need to address it in M2003 Medication Follow-up? [Q&A EDITED 10/16; Previously CMS Qtrly Q&A 10/16 #20; Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #33]

A160.4. If a medication related problem is identified and resolved by the agency staff not requiring physician/physician-designee contact by midnight of the next calendar day, the problem does not need to be reported as an existing clinically significant problem in M2001.

Q160.4.1. [Q&A Retired 10/16; replaced with new C2 manual guidance]

Q160.5. M2003. If a clinically significant medication issue is identified on a weekend, and the agency phones the physician on-call, who does respond but because he doesn't really know the patient directs the agency to contact the primary care physician on Monday, can the clinician select Response 1 Yes – Physician or physician-designee was contacted by midnight of the next calendar day and prescribed/recommended actions were taken in response to the identified clinically significant medication issue? [Q&A EDITED 10/16; Previously CMS Qtrly Q&A 10/16 #21; Q&A ADDED 01/11; Previously CMS OCCB 01/10 Q&A #16]

A160.5. When completing M2003, Medication Follow-up, if the physician or physician designee responds by midnight of the next calendar day and there is a resolution to the clinically

significant medication issue, Response "1-Yes" should be entered. In your scenario, you describe a situation where the physician was contacted and informed of the medication issue, but the due to the contacted physician's unfamiliarity with the patient, you were directed to contact the primary care practitioner on Monday. In cases where the physician/physician-designee recommends an action that will take longer than the allowed time to complete, then Response "1-Yes" should be entered as long as by midnight of the next calendar day the agency has taken whatever actions are possible to comply with the recommended action.

Q160.5.1. M2003. I am aware that in order to mark response "1 - Yes", the two-way communication AND prescribed/recommended actions must be completed by midnight of the next calendar day after the problem was identified. Does that "next calendar day" have to be within the 5 days after the SOC? That is if the nurse finds a problem with the patient's meds while completing the comprehensive assessment on day 5 after the SOC, and the physician is notified and the problems are resolved but not until day 6 after the SOC, (although it is within the one calendar day), can "1 - Yes" be marked? [Q&A EDITED 10/16; Previously CMS Qtrly Q&A 10/16 #22; Q&A EDITED 04/15; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #17]

A160.5.1. M2003, Medication Follow-up, is only collected at the SOC and ROC. The item must be answered within the timeframe allowed at the SOC/ROC to ensure compliance with the Condition of Participation regarding the completion of the comprehensive assessment. If a problem is identified, the communication and completion of prescribed/recommended actions must occur by midnight of the next calendar day after identification and before the end of the allowed timeframe in order to answer "1 - Yes."

If a medication issue is identified on day 5 after the SOC, the physician is contacted by midnight of the next calendar day and responds back with a plan to resolve the problem on day 6 after the SOC, this 2-way communication could not be captured at the SOC.

Q160.6. M2003 & M2005. Must the physician acknowledgement of the agency's communication, and completion of prescribed/recommended actions occur in the specified time frame (by midnight of the next calendar day), in order to select response "1" for M2003 or M2005? [Q&A EDITED 10/16; Q&A EDITED 04/15; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #34]

A160.6. Yes, in order to select Response 1, the two-way communication AND completion of prescribed/recommended actions must be completed by midnight of the next calendar day after the problem was identified.

Q160.6.1. M2003 & M2005. Some process measure items refer to providing and/or receiving communication to/from the physician or physician-designee (M2003 & M2005), another refers to the physician or other primary care practitioner (M1511) while another (M2250) includes only the physician. Please define physician-designee and primary care practitioner. Do they include physician extenders, like physician assistants and nurse practitioners? When an item refers to "physician-ordered", would that include DOs? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #32]

A160.6.1. For process measure items reporting communication to/from the physician or physician-designee, (such as reporting heart failure symptoms for M1511, or communication to report/resolve medication issues for M2003) communication can be directly to/from the physician, or indirectly through physician's office staff on behalf of the physician, in accordance with the legal scope of practice.

For process measure items requiring physician orders, (e.g., M2250 Plan of Care Synopsis), the Plan of Care/orders must be “physician-ordered” including orders from MDs, Doctors of Osteopathic Medicine (DOs), and Doctors of Podiatric Medicine (DPMs) practicing within their legal scope of practice. M2250 includes only physicians as defined here.

Q160.6.2. M2003 & M2005. Multiple clinically significant medications issues were identified as I completed the SOC assessment. Only one was resolved by midnight of the next calendar day. How do I answer M2003 and then M2005? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 01/11 Q&A #17]

A160.6.2. In order to select "1-Yes" to M2003, Medication Follow-up, the physician must have been notified by midnight of the next calendar day regarding all clinically significant medication issues that were identified during the SOC/ROC comprehensive assessment. In addition to the physician notification, you must have completed any prescribed/recommended actions by midnight of the next calendar day to answer "1-Yes".

In order to select "1-Yes" for M2005, Medication Intervention, all clinically significant medication issues that were identified at the time of or at any time since the SOC/ROC must have been resolved in the same manner as stated above.

Q160.7.M2001, M2003, M2005. M2010. M2020. Our patient has nine herbal supplements that have been prescribed by her physician. Are herbal supplements considered medications when answering the OASIS items? [Q&A EDITED 10/16; Q&A ADDED 04/15; Previously CMS Qtrly 07/14 Q&A #7]

A160.7. Herbal products, when prescribed or taken as a medication, are considered medication when completing the OASIS items. For example, Echinacea taken daily by mouth to stimulate the immune system, would be considered a medication.

Q161. [RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q161.1. M2005. It was discovered at a home visit that the patient had experienced an adverse reaction to one of her meds, for which she chose to go to ER where the medication was discontinued by physician. The agency learned of the events 3 days after the fact and there was no opportunity for the agency to contact the physician. Do we have to answer “No” on M2005 even though the patient went to the ER and chose not to call the agency first, as educated? [Q&A EDITED 10/16; Q&A ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #18]

A161.1. Correct, "No" would be the appropriate response at discharge, even though you were made aware of the clinically significant medication issue after it was resolved by the hospital's emergency department staff.

Q161.2. M2010. Regarding M2010 Patient/Caregiver High Risk Drug Education, if the assessing clinician discovered the patient was taking a discontinued high risk medication in error and then correctly educated the patient to discontinue it and follow the current medication orders, which did not include any high-risk medications. How should the clinician complete M2010? Our dilemma focused on whether the clinician should consider only those medications currently prescribed, or, in this case, include high risk medications being taken but not presently prescribed for his/her use. [Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 04/14 Q&A #10]

A161.2. The current OASIS Guidance Manual M2010 Ch. 3 guidance states that M2010 identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes. High-risk medications are those identified by quality organizations as having considerable potential for causing significant patient harm when they are used erroneously.

If the patient was taking a high risk medication in error, as you described, and was educated by your staff to discontinue the medication as well as the special precautions they need to take and how and when to report a problem that occurs as a result of taking that medication, M2010 may be answered "Yes".

161.3. M2010 & M2016. How would Patient/Caregiver Drug Education for M2010 and M2016 be impacted for patients living in assisted living where the medications are managed by facility staff? [Q&A EDITED 10/16; Q&A ADDED 01/11; Previously CMS OCCB 01/10 Q&A #19]

A161.3. When completing the OASIS process measures that address patient/caregiver education, M2010, Patient/Caregiver High Risk Drug Education and M2016, Patient/Caregiver Drug Education, for patient's residing in an assisted living facility, it may be appropriate to educate the patient and/or the staff administering the medication on the topics included in each item. As with patients who live at home, the decision to direct the teaching to the patient, caregiver, or both should be made by the assessing clinician, based on the specific circumstances. For the purposes of selecting a response, the facility staff would be considered caregivers.

Q161.4. M2010 & M2016. It states in Chapter 3 for M2010 and M2016 "If agency staff other than the clinician responsible for completing the SOC/ROC OASIS provided education to the patient/caregiver on high-risk medications, ...this collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and ultimately must be completed by one clinician." Could this education include an office nurse giving the education over the phone to the patient? [Q&A EDITED 10/16; Q&A EDITED 04/15; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #20]

A161.4. A clinician other than the assessing nurse or therapist may provide drug education by phone to the patient and/or caregiver. When agency staff other than the clinician responsible for completing the OASIS assessment provided medication education to the patient/caregiver, this information must be communicated to the clinician responsible for completing the OASIS assessment so that the appropriate response for M2010 (or M2016, whichever applies) may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of and ultimately must be completed by one clinician.

Q161.5.M2010. 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? [Q&A EDITED 10/16; Q&A ADDED 04/15; Previously CMS Qtrly 10/14 Q&A #12]

A161.5. 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 M2016 – 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 the time of, or at any time since the most recent SOC/ROC".

Q162. [RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q162.1. M2016. If a Transfer OASIS was done 2 days after the completion of a SOC or ROC OASIS comprehensive assessment, would the answer to M2016 - Patient/Caregiver Drug Education Intervention, be “Yes” or “No” if the drug education occurred on the admission visit (Yes to M2010). [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 07/10 Q&A #17]

A162.1. M2016 - Patient/Caregiver Drug Education Intervention, reports if, at the time of or at any time since the most recent SOC/ROC assessment, the patient and/or caregivers were educated regarding ALL their medications (not just the high risk medications), including how and when to report problems that may occur. If this specified education was accomplished for all medications at the time of the most recent SOC/ROC assessment, the appropriate response for M2016 would be “Yes”.

Q162.2. [Retired 10/16; changed look back period in C2]

Q162.3. M2016. M2016, Patient/Caregiver Drug Education Intervention, asks "was the patient/caregiver instructed by agency staff or other health care provider"---A patient is seen in an assisted living facility (ALF) by the physical therapist. The patient is unable to manage their medications independently. Facility staff provides medication management and have been instructed by facility supervisors on side effects, etc. In this situation, should we consider the ALF staff to be caregivers who are instructed by "other health care providers?" [Q&A EDITED 10/16; Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #18]

A162.3. You may answer "1-Yes" to M2016, Patient/Caregiver Drug Education Intervention, in this specific situation, if there was documentation in the medical record that the ALF staff, who are the patient's caregivers, had been instructed by on-site health care providers and it was demonstrated to the assessing clinician that they knew how to monitor the effectiveness of all drug therapy (prescribed, as well as all over-the-counter medications), drug reactions, and side effects, and how and when to report problems that may occur.

Q162.4. M2016. For M2016, Patient/Caregiver Drug Education Intervention----Does "other healthcare provider" include a pharmacist? [Q&A EDITED 10/16; Q&A ADDED 01/12; Previously CMS OCCB 04/11 Q&A #12]

A162.4. Yes. If assessment of the patient/caregiver's baseline knowledge reveals the patient received the education specified in M2016, Patient/Caregiver Drug Education Intervention, from the pharmacist, you can include this education in M2016. This would require that the pharmacist educated the patient/caregiver to monitor the effectiveness of all drug therapy (prescribed, as well as all OTC), drug reactions, and side effects, and how and when to report problems that may occur to the appropriate care provider. Note that just including written materials in the bag with the medications at the time the medication is dispensed may not provide the specified education. The education of the patient may also be a collaborative effort, in which the pharmacist may provide part of the education, with other healthcare providers.

Q163. M2020. I have had several patients who use a list of medications to self-administer their meds. Would this be considered a drug diary or chart? [Q&A EDITED 08/07]

A163. Yes, this is considered a drug diary or chart. The statement for response 1b (another person develops a drug diary or chart) pertains to someone other than the patient developing the aid. What you need to assess is whether the patient must use this list to take the medications at the correct times. If he/she does require the list and also requires someone else to create it, then Response 1 is the appropriate choice.

Q164. M2020. Some assisted living facilities require that facility staff administer medications to residents. If the patient appears able to take oral medications independently, how would the clinician answer M2020? [M number updated 09/09]

A164. M2020 refers to the patient's ability to take the correct oral medication(s) and proper dosage(s) at the correct times. Your assessment of the patient's vision, strength and manual dexterity in the hands and fingers, as well as cognitive ability, will allow you to evaluate this ability, despite the facility's requirement. You would certainly want to document the requirement in the clinical record.

Q.164.1. M2020 & M2030. A patient resides in an ALF with around the clock assistance (M1100 Patient Living Situation = 11 - Patient lives in congregate situation with around the clock assistance available), and the ALF staff is administering medications to the patient, per facility policy. If the assessing clinician determines that the patient could administer their own medications (pills and injections) but is not being allowed to do so by the facility, how should M2020 Management of Oral Medications and M2030 Management of Injectable Medications be answered? [Q&A ADDED 04/15; Previously CMS Qtrly 04/15 Q&A #5]

A.164.1. M2020 & M2030. M2020 reports the patient's ability to take the correct oral medication(s) and proper dosage(s) at the correct times. M2030 reports the patient's ability to take all injectable medication reliably and safely at all times. In situations where facility policies restrict medication access to residents, thereby creating an artificial barrier for the patient to self-administer their own medications, the assessing clinician will rely on his/her assessment of the patient's vision, strength and manual dexterity in the hands and fingers, as well as cognitive ability and general mobility, and any other relevant barriers, and use clinical judgment and make an inference regarding the patient's current ability. The clinician could gather information by report and/or observation, including asking the patient to describe the oral and injectable medications they take and when, and asking the patient to demonstrate the steps for administration, including needle disposal for injectable medications.

Q165. [Q&A RETIRED 09/09; Outdated]

Q166. M2020. When scoring M2020, Management of Oral Medications, should medication management tasks related to filling and reordering/obtaining the medications be considered? [Q&A EDITED 09/09; ADDED 06/05; Previously CMS OCCB 08/04 Q&A #19]

A166. No.

Q167. [RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q167.1. M2020. 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 M2020 be answered? [EDITED 01/12]

A167.1. M2020 assesses the patient's ability to prepare and take oral medications reliably and safely. Tasks include the ability to obtain the medication from where it is routinely stored, 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.

Q167.2. M2020. 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? [Q&A EDITED 06/14; ADDED 08/07; Previously CMS OCCB 07/07 Q&A #18]

A167.2. M2020 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 obtain the medication from where it is routinely stored, the ability to read the label (or otherwise identify the medication correctly, e.g. patients who cannot read and/or write 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.

Q167.3 & 167.4. [Q&A RETIRED 09/09; Outdated]

Q167.5. M2020. What is the appropriate response to M2020, Management of Oral Medications, when the nurse sets up a medication dispenser that has a visual alarm (flashing light) and an automated verbal message reminding the patient to take the medication? This medication dispenser also calls to alert a caregiver if the patient does not respond to the alarms by taking the medication from the dispenser. [Q&A EDITED 04/15; ADDED 09/09; ; Previously CMS OCCB 10/08 Q&A #9]

A167.5. If the patient requires another person (e.g., nurse, family member, friend, caregiver) to give them daily reminders AND the patient has taken all of their oral medications on the day of assessment they are considered a "2". If the patient requires an automated dispensing system with visual or audio reminders, they continue to be scored a "2" if someone other than the patient must program the device. If the patient successfully and independently programs/manages the device, and takes all oral medications appropriately on the day of assessment, the patient would be scored a "0".

Q167.5.1. M2020. Please further explain and provide examples for M2020 Response 3. [Q&A ADDED 01/11; Previously CMS OCCB 04/10 Q&A #25]

A167.5.1. Response 3, unable to take medication unless administered by another person, describes a patient who does not have the physical or cognitive ability on the day of assessment to take all their medications at the correct dose every time it is ordered to be administered, and

it has not been established (and therefore the clinician cannot assume) that set up, diary, or reminders have already been successful. The clinician would need to return to assess if the interventions, such as reminders or a med planner were adequate assistance for the patient to take all medications safely, so therefore, Response 3 would be appropriate until this is known.

Some examples of Response 3, (but not a finite list) include:

- A patient who decided not to take her new medications, because the varying doses worried her, and she was unsure of the instructions. There had not been a medi-set up, nor reminders tried. The clinician would select Response 3 because it is unclear until reassessment if the interventions will be successful.
- A patient who, upon assessment, was not able to take prescribed medications at the correct time and doses even though reminded.
- A patient who, on the day of assessment, was prescribed oral medications, but was unable to safely swallow.

Q167.5.2. M2020. If the patient does not have her prescribed medications in the home because she cannot afford them and she does not plan on getting them, what is the most appropriate response for M2020? [Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #19]

A167.5.2. When completing M2020, Management of Oral Medications, you are reporting the patient's ability to take all oral medications reliably and safely at all times on the day of the assessment. If the patient did not take her medications on the day of the assessment because they were not present in the home, you cannot make assumptions about a patient's ability to take medications she doesn't have. If the medications were not in the home, you would not be able to determine if she could take each medication at the correct time and dose. The patient's status would be reported as "3-Unable to take medications unless administered by another person".

Q167.5.2.1. M2020. Regarding CMS OASIS Q&A, Category 4b Q167.5.2 which states that a patient who doesn't have medications in the home because they can't afford them would be reported as a "3 – Unable to take medications unless administered by another person" on M2020, would a patient also be scored a "3" if he simply chooses not to fill a prescription? The assessing clinician determines the patient does not have a disorder that is contributing to his non-adherence. He is making a choice not to comply completely with physician's orders, cognizant of the implications of that choice. [Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #20]

A167.5.2.1. If a patient who is cognitively intact chooses not to take medications, and therefore does not have them delivered or picked up, the patient's non-adherent behavior would not impact their ability to manage oral medications when selecting a response for M2020. If, however, there was a barrier preventing the patient from having the medications in the home, e.g. inability to pay for drugs, delivery/pick-up of drugs was delayed, etc., it would impact their ability to manage their medications.

Q167.5.3. M2020. I have a question regarding the appropriate response for scenarios where the patient is unsteady while ambulating and requires supervision for ambulation. They possess the knowledge to take their medications reliably and safely if the bottles are placed near them, or if they have supervision while ambulating to the medication storage area. Please advise how this patient would be scored for M2020, Management of Oral Medications. The item intent instructions include guidance related to the patient's ability to access the medication, how does this play into the question when the physical

impairment causes the patient to require human supervision or assistance and not the cognitive aspect (such as for reminders)? [Q&A ADDED 01/12; Previously CMS OCCB 04/11 Q&A #13]

A167.5.3. M2020 reports a patient's ability on the day of the assessment to take the correct oral medications at all the correct times. This would include the tasks of accessing the medications from the location where they are routinely stored in the home, preparing the medications (including opening containers or mixing oral suspensions), selecting the correct dose and safely swallowing the medications, typically involving having access to a beverage.

If someone other than the patient must do some part of the task(s) that are required for the patient to access and/or take the medication at the prescribed times, then the patient would NOT be considered independent (Response 0).

If another person's assistance is required to provide set up in advance of the administration times, and with this level of assistance, the patient is capable of self-administering the correct meds at the correct times and dosages on the day of assessment, then Response 1 would apply.

The following are examples of how the need for assistance or an environmental barrier could impact ability:

Scenario: Medications are routinely stored in the refrigerator located downstairs. The patient requires someone to assist them at medication administration time to walk to the location where the medications are routinely stored, or someone must retrieve the medications and bring them to the patient; Response "3" would apply. In this situation, just someone preparing the doses in advance did not enable the patient to self-administer their medications.

Scenario: The patient requires someone to prepare the medication doses in advance (e.g. visually they can't discern the appropriate dose) and to walk with them at all times to be safe. Someone prepares the medi-planner and sets it within the patient's reach with the water they need to take the meds, the appropriate score is a "1", as the patient can access the medications from where they are routinely stored and has the water available to swallow the medication safely.

If the medications were routinely stored in the kitchen and/or the water was not available for the patient to self-administer and the patient required someone to assist them to the location where the meds were stored and or to water, the appropriate score would be a "3".

Scenario: Patient does not need doses prepared in advance, but the medications are routinely stored in a location that the patient cannot access due to a physical, sensory, or environmental barrier. The patient is scored a "3". During the episode, an environmental modification was made, e.g. changing the medication storage and water supply to a location that the patient can access, the patient could be scored a "0" at the next OASIS data collection time point.

Q167.5.4. M2020. Are inhaled meds and sublingual meds considered in M2020, Management of Oral Medications? [Q&A ADDED 12/12; Previously CMS Qtrly 10/12 Q&A #8]

A167.5.4. No. Medications given per an inhaler or sublingually are not considered when answering M2020. When you assess M2020 consider those medications which are administered per the oral (p.o.) route. P.O. medications are swallowed and absorbed through the GI system. Sublingual medications are absorbed through the mucosal membranes under the tongue.

Q167.5.5. M2020. Based on the recent guidance regarding sublingual medications and M2020, I'm not sure if we should include medications that are ordered as a swish and expectorate? [Q&A ADDED 06/14; Previously CMS Qtrly 01/13 Q&A #14]

A167.5.5. For the purposes of scoring M2020, Management of Oral Medications, the assessing clinician should only include medications placed in the mouth and then swallowed, with absorption occurring through the gastrointestinal system. Other medications with different routes of administration/absorption, e.g. sublingual, buccal, are excluded.

167.6. M2020 & M2030. It is our understanding that if the nurse is ordered to administer a medication, the patient is considered dependent for that (oral or injectable) medication. At SOC, if a patient has been in the hospital where all medications were administered by hospital nursing staff, would this make the patient dependent because the medications over the past 24 hours were administered by the acute care nurse at the hospital? [Q&A EDITED 01/12; ADDED 09/09; Previously CMS OCCB 1/09 Q&A #13]

A167.6. In the case of an admission to home care following a discharge from an inpatient facility, M2020 and M2030 should be scored based on the orders relevant to medications that will be taken/administered in the home and will not include a reporting of medications that were administered while the patient was an inpatient. Restrictions imposed during a recent hospitalization should not impact the reporting of the patient's current status.

If the patient had been discharged from an inpatient facility on the day of the assessment (24 hours immediately prior to the clinician's visit and the time spent in the home), the clinician would gather information by report regarding the patient's cognitive and physical status prior to the visit and assess the patient's status during the visit and make a determination regarding the patient's ability to manage all the medications ordered to be administered in the home at all times. At the SOC, the clinician has up to five days after the SOC date to complete the comprehensive assessment, including the patient's ability to manage medications.

The intent of M2020 is to identify the patient's ability to take all oral medications reliably and safely at all times. If the patient's ability to manage the home medications varied on the day of the assessment, the clinician would report the patient's ability to manage the medication for which the most assistance was needed.

Q167.7. M2020, M2102 e., M1030. I have a patient who has just started chemotherapy with IV access present. She is unable to take oral medications or food and has a gastrostomy tube that is being flushed with water to maintain patency. The patient is scheduled to return to the physician in two weeks for further assessment and to obtain enteral nutrition orders. How do I score M1030, M2020, M2102 at SOC? [M number updated 06/14, Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/09 Q&A #6]

A167.7. M1030, Therapies at Home - If the patient's IV access for the chemotherapy was ordered to be flushed in the home, Response 1 would be appropriate, otherwise it would be 4-NA, as the patient is not receiving one of the listed therapies at home.

M2020, Management of Oral Medications, would be NA-No oral medications prescribed.

M2102, Types and Sources of Assistance, e. Management of Equipment - Even though the patient's g-tube is only being flushed with water to maintain patency until the feeding is ordered, the patient/cg must maintain the enteral nutrition equipment, so it would be appropriate to

assess and report the level of caregiver ability and willingness to provide assistance with managing the equipment.

Q167.8. M2020. If a patient can't swallow his/her meds but is able to do all the other requirements for oral medication administration, how would you answer M2020, Management of Oral Medications? [Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 10/07 Q&A #23]

A167.8. M2020 reports the patient's ability to prepare and take (ingest) oral medications reliably and safely at the appropriate dosage and times. On the day of assessment, if the clinician discovers the patient has not been able to swallow prescribed oral medications in the past 24 hours, Response 3 - Unable to take medication unless administered by another person should be selected, as it is the best response option available. The clinician should explain the patient's inability to take their oral medications in the clinical documentation and why Response 3 was selected.

If it is identified that the route of administration of the medications (which may have originally been prescribed as "oral medications") had been changed to administration "per tube" due to the patient's inability to swallow, and this has been the patient's usual status on the day of assessment, then Response NA - No oral medications prescribed should be selected.

Q167.9. M2020. The patient is on multiple medications which span 3 times a day. Yesterday, the doctor started her on a varying dose of Prednisone. The patient admits to being confused about the directions and right dosage. The clinician observes that the med box the patient set up is filled correctly with all usual medications, but not correctly with the prescribed Prednisone administration. The clinician also notes that the medication for last evening remained in the pill planner. Upon questioning, the patient admits to being tired and forgetting to take her evening medication. The nurse discusses the use of an alarm clock to remind her to take her evening medication and fixes the Prednisone dosage for the rest of the week. Considering this patient needed help with setting up one medication (Response 1) and a reminder for another (Response 2) in the last 24 hrs, what is the correct scoring with rationale for this situation? [Q&A ADDED 01/11; Previously CMS OCCB 04/10 Q&A #24]

A167.9. The patient you described would be scored a "3-Unable to take medication unless administered by another person because on the day of the assessment, the patient did not possess the ability to take the Prednisone at the correct time and dose and demonstrated that through her report and actions. The pill planner had not enabled her to take the medications as ordered and a reminder could not have enabled the patient to take a medication when she didn't have any idea what time and dose she needed to take the medications.

Rationale: First, note you are to report your patient's ability on the day of the assessment (24 hours prior to the visit, and the time while in the home) and if ability varied, you report what was true regarding the medication that required the most assistance during that timeframe. This would mean you would not report ability after skilled intervention, as this is not a reflection of what was true in the most dependent medication during the day of assessment.

Many factors impact a patient's ability to take all medications safely and reliably at the correct dose and time on the day of assessment, including physical and mental/emotional/cognitive status, activities permitted, and environment. Another imperative component is the required knowledge of the drug's dose and administration schedule. A patient who does not possess this knowledge, does not have the ability to take the correct dose at the correct time as they lack the required education, unless other compensatory mechanisms have been placed in the home and assessed to be successful. A patient who does not have the requisite knowledge and no

existing compensatory mechanisms would be scored a "3" until after they received the required education and demonstrated to the clinician that they were able to take ALL medications at the correct dose and time or until the clinician has introduced an assistive device, such as a pill planner, and the patient has demonstrated success at taking meds as ordered, at all times.

Q168. [Q&A RECALLED 08/07]

Q168.1. M2030. The patient has B12 injections ordered monthly which are/will be given in the home. At the SOC/ROC visit, the schedule for the injection does not fall on the day of the SOC/ROC or Discharge visit. Since our assessment should reflect what is true on the day of assessment, is N/A, No Injectable medications prescribed the correct response to M2030 in this circumstance? [Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #24]

A168.1. The M2030 Response "NA-No injectable medication prescribed" would not be appropriate in the situation described because the patient has an order to receive injectable medication during the episode. Even though the medication will not be injected on the day of the assessment, the clinician would assess and report the patient's ability by following the guidance in the Chapter 3 assessment strategies. It states "If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration."

Q168.1.01. M2030. On my SOC visit, the patient did not have their insulin due to a problem at the pharmacy. How can I answer M2030, Management of Injectable Medications, when I was not able to assess my patient's ability to prepare and take the SQ medication? [Q&A ADDED 06/14; Previously CMS Qtrly 04/13 Q&A #8]

A168.1.01. When completing M2030, Management of Injectable Medications, you report the patient's ability to administer all injectable medications reliably and safely at all times, including safe needle and syringe disposal. If injectables are not in the home (whether currently due, due at a future point during the episode or prn) Response 3 - Unable to take injectable medication unless administered by another person is appropriate.

If the injectable medication is in the home, but just not needed (prn) or due today, observe simulation/ask patient to describe steps, etc. and use clinical judgment to make an inference regarding the patient's ability.

Q168.1.1. M2030. When answering M2030 at Discharge, are one-time injections and discontinued injectables included in this assessment? Consider the following scenarios: [Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 10/11 Q&A #12]

Scenario 1: The first two weeks of the episode, the patient had Lovenox SQ ordered. The patient is being discharged 4 weeks later with no injectable medications currently ordered. At discharge, is the answer NA - no injectable medications prescribed or do we assess their ability from earlier in the episode?

Scenario 2: Is the order to administer the flu vaccine at the beginning of the episode included when selecting a response for M2030 at the Discharge assessment?

At SOC/ROC/FU, M2030 includes all medications ordered to be administered IM or SQ via needle and syringe in the home, even if it is a one-time injection. At the Discharge assessment, however, if there are no current, ongoing orders for an injectable as described, the appropriate response to M2030 would be "NA."

The influenza vaccine is only included in M2030 if the patient was going to receive it in the home. An order for the patient to receive it outside the home after discharge would not be included.

Q168.2. M2030. How do I score M2030 if the physician has ordered the RN to administer the medication? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/08 Q&A #25]

A168.2. If a physician orders the nurse to administer a prescribed injectable medication, the patient's ability is reported as "3-Unable to take injectable medications unless administered by another person." The order for the nurse to administer the medication represents a medical restriction against patient self-administration. When a patient is medically restricted from performing an activity, the impact of this medical restriction on the patient's ability must be considered.

Q168.3. M2030. I need more clarification regarding what is included and not included in M2030 and what are we assessing. We have a patient that is receiving injections at her physician's office, mainly for financial reasons, do we include those injections?

A168.3. When a patient is receiving an injectable medication in the physician's office or other setting outside the home; it is not included in the assessment of M2030, Management of Injectable Medications. [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 04/08 Q&A #12]

M2030, Management of Injectable Medications, reports the patient's ability to prepare and take (inject) all prescribed injectable medications that the patient is receiving in the home while under the home health Plan of Care. M2030 requires an assessment of the patient's cognitive and physical ability to draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly.

M2030 includes all injectable medications the patient has received or will receive in the home during the home health Plan of Care. Note that if an injectable medication is given by a nurse, the clinician will need to determine if the administration by the nurse was for convenience, or if administration by the nurse was ordered by the physician which represents a medical restriction inferring that the patient is unsafe/unable to self-inject. If that was the case, the appropriate response for M2030 would be 3-Unable to take injectable medications unless administered by another person.

M2030 would also include one time injections that were ordered to occur in the home as long as the administration occurred during the period of time covered by the Plan of Care. If the patient administered the medication, the clinician would report the patient's ability to complete the included tasks on the day of the assessment. If the injection was ordered but not to be administered on the clinician's day of assessment, the clinician will use the assessment of the patient's cognitive and physical ability and make an inference regarding what the patient would be able to do.

Q168.3.1. M2030. I understand from the CMS Q&A that "M2030 requires an assessment of the patient's cognitive and physical ability to draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly." My patient, at the SOC, was throwing his used needles and syringes into the trash. He stated he was never told how to properly dispose of them. Which M2030 response would be appropriate? What if they were forgetful and sometimes disposed of the needles appropriately but at other times they didn't? [Q&A ADDED 01/12; Previously CMS OCCB 10/11 Q&A #13]

A168.3.1. If the patient lacked the knowledge regarding safe needle and syringe disposal on the day of the assessment, the patient was unable to take injectable medication unless administered by another person, Response 3. If the patient needed reminders regarding safe needle/syringe disposal, they would be scored a "2".

Q168.4. M2030. Our patient has orders for Vitamin B12 to be injected by the RN once a month and SQ Insulin to be injected by the patient 3 times a day. How would M2030 be reported in this situation? [Q&A ADDED 09/09 EDITED 01/11; Previously CMS OCCB 07/08 Q&A #17]

A168.4. When completing M2030, Management of Injectable Medications, the clinician must consider all prescribed injectable medications that the patient is receiving in the home. In situations where the patient's ability to inject their various medications varies on the day of assessment, the clinician must report what is true for the medication requiring the most assistance.

In the situation described, the patient self injects insulin 3 times a day and the Vitamin B12 injection is administered by the RN only once a month. Since the order requires the nurse to administer the Vitamin B12, the patient would be considered unable to administer that medication and would represent the patient's ability for the medication requiring the most assistance. Response 3, Unable to take injectable medications unless administered by another person, would be the appropriate response.

Q168.5. M2030. How would you respond to M2030 if a patient is able to self-inject a pre-filled injectable medication such as Lovenox? Obviously the patient cannot be observed "preparing" a pre-filled injectable. Which response best fits this scenario? [Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 1/09 Q&A #14]

A168.5. When the medication is supplied by the manufacturer/pharmacy in a pre-filled syringe, the clinician will not include assessment of the patient's ability to fill the syringe. The included tasks in this situation would be handling the syringe using aseptic and safe technique, selecting the correct location in which to inject the medication and injecting it using proper technique and disposing of the needle and syringe appropriately, and the patient could be a "0", "1", "2", or "3".

Q168.5.01. M2030. Does the need for assistance to walk to the refrigerator to obtain an injectable medication impact the score of M2030, Management of Injectable Medications? [Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 04/13 Q&A #9]

A.168.5.01. Yes. M2030, Management of Injectable Medications, reports the patient's ability to prepare and take (inject) all prescribed injectable medications that the patient is receiving in the home while under the home health Plan of Care and would include the tasks of accessing the medications from the location where they are routinely stored in the home. If the medications are routinely stored in the refrigerator and the patient requires someone to assist them at medication administration time to walk to the location where the medications are routinely stored, or someone must retrieve the medications and bring them to the patient; Response "3- Unable to take injectable medication unless administered by another person" would apply.

Q168.5.1. M2030. If we give a physician ordered one-time influenza vaccination and the patient does not have any injectable medications otherwise, is the answer to M2030 NA or #3. [Q&A ADDED 01/11; Previously CMS OCCB 04/10 Q&A #26]

A168.5.1. If there is an order for the patient to receive the influenza vaccine SQ in the home, it would be included when responding to M2030, Management of Injectable Medications, even if it was a one-time injection. Anytime the physician has ordered the RN to administer an injection, the patient's ability would be reported as a "3-Unable to take injectable medication unless administered by another person." as you must report the patient's ability to inject the medication for which the most assistance is needed and an order for the RN to administer the injection is viewed as a medical restriction, preventing the patient from self administering.

Q168.5.2. M2040. Does Row b (injectable meds) at M2040, include only those injectable medications received in the patient's home or does this data item apply to ALL injectable meds, regardless of the setting in which they were received? [Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #20]

A168.5.2. M2040, Prior Medication Management, Row b. Injectable Medications, includes only injectable medications administered via needle and syringe SQ or IM while in the home.

Q168.5.5. M2102. Do the responses for M2102, Types and sources of assistance, reflect the patient's needs on the day of assessment or another time period, like the recent past? [Q&A EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #28]

A168.5.5. When completing M2102, Types and Sources of Assistance, at the SOC/ROC, the assessing clinician will determine, to the best of his/her ability through observation and interview, what is known on the day of assessment regarding the availability and ability of caregivers to provide help in the various categories of assistance for the upcoming episode of care. For example, if Monday is the day of assessment and the patient reports her son pays her bills and brings in groceries every Friday. Even though the assistance will not be provided until Friday, the assistance is reported, as it is the anticipated availability and ability of caregiver assistance. At Discharge, the assessing clinician is reporting what is known on the day of assessment regarding the availability and ability of caregivers to provide assistance to the patient at the time of the discharge.

Q168.5.6. M2102 & M2110. If food is delivered by Meals on Wheels or other similar community organizations, how does that impact the scoring in M2102, Types and Sources of Assistance and M2110, How Often Patient Receives ADL or IADL Assistance? [Q&A EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #39]

A168.5.6. A community based service, like Meals-on-Wheels, that is providing needed assistance with meals would be considered when answering M2102 and M2110. Note that if the patient needs assistance with any aspect of a category of assistance, such as IADLs, you are to consider the aspect that represents the most need and the availability and ability of the caregiver to meet that need. If the patient, who is receiving delivered meals, is also receiving other IADL assistance, the clinician must determine the IADL that requires the most need and then the availability and ability of the caregiver to meet that need.

Q168.5.7.M2102. Guidance is clear that for M2102 –Types and Sources of Assistance that “caregiver” refers to non-agency caregivers and excludes care by agency staff. What if the agency has two provider numbers, one for Medicare Skilled Home Health and one as a Medicaid In-Home provider? Does this item also exclude staff from the Medicaid In-Home side? [Q&A ADDED 04/15; Previously CMS Qtrly 01/15 Q&A #9]

A168.5.7. If the agency has a different provider identification number for each provider type, Medicare Skilled Home Health and Medicaid In-Home, the care provided by the staff employed by the Medicaid In-Home provider would be considered non-agency caregivers for the purpose of responding to M2102. The entities must be separate and distinct agencies.

Q168.5.8 M2102a. 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. [Q&A ADDED 10/16; Previously CMS Qtrly 10/15 Q&A #5]

A168.5.8 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.

Q168.6. M2102 e., M1030, M2020. I have a patient who has just started chemotherapy with IV access present. She is unable to take oral medications or food and has a gastrostomy tube that is being flushed with water to maintain patency. The patient is scheduled to return to the physician in two weeks for further assessment and to obtain enteral nutrition orders. How do I score M1030, M2020, M2102e. at SOC? [Q&A EDITED & M number updated 06/14; ADDED 09/09; Previously CMS OCCB 07/09 Q&A #6]

Q168.6. M1030, Therapies at Home - If the patient's IV access for the chemotherapy was ordered to be flushed in the home, Response 1 would be appropriate, otherwise it would be 4-NA, as the patient is not receiving one of the listed therapies at home.

M2020, Management of Oral Medications, would be NA-No oral medications prescribed.

M2102, Types and Sources of Assistance, e. Management of Equipment - Even though the patient's g-tube is only being flushed with water to maintain patency until the feeding is ordered, the patient/cg must maintain the enteral nutrition equipment, so it would be appropriate to assess and report the level of caregiver ability and willingness to provide assistance with managing the equipment.

Q169. M2102e. I am unsure how to respond to M2102 e. if my patient has an epidural infusion of pain medication? A subcutaneous infusion? [Q&A EDITED & M number updated 06/14]

A169. Patients receiving epidural infusions or subcutaneous infusions are receiving IV/infusion therapy; therefore, M2102e. should be answered based on the caregiver's ability and willingness to use associated equipment as ordered. For M2102e., the caregiver's ability to set up, monitor and change equipment reliably and safely, including adding appropriate fluids or medication, cleaning/storing/disposing of equipment and supplies should be assessed.

Q170 & 170.1. [Q&A RETIRED; Outdated]

Q170.2. M2102e. Is dialysis thru a central line considered for this question? [Q&A EDITED & M number updated 06/14; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #31]

A170.2. Dialysis through a central line is included in M2102e. as long as the dialysis occurs in the home. M2102e. reports the caregiver's ability and willingness to manage the equipment as ordered and includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment of supplies, continuous passive motion machine, wheelchair, hoist lift, etc. Dialysis is an infusion therapy.

If the patient were receiving such therapy outside the home, (e.g. at a dialysis center), then M2102e. would be marked "0-No assistance needed – patient is independent or does not have needs in this area", assuming the patient care did not include use of any other included services at home (oxygen, enteral nutrition, etc.).

Q170.3. M2102e. When completing M2102e., Types and Sources of Assistance; Management of Equipment, is there a consideration for people who use the larger portable oxygen tanks versus the smaller tanks? Some of our patients use liquid oxygen and have the equipment available in the home to refill their tanks. Other patients get the larger oxygen tanks from the DME company. A person may have the ability to fill a larger tank but it is not feasible to have this equipment available in the home. The same question could apply to the various types of IV bags, equipment or solutions used for IV/infusion therapy. [Q&A EDITED & M number updated 06/14; ADDED 09/09; Previously CMS OCCB 07/08 Q&A #18]

A170.3. M2102 e., Types and Sources of Assistance; Management of Equipment, reports the caregiver's ability and willingness to set up, monitor and change the equipment that is in the home on the day of the assessment. You do not report what the patient would be able to do if different size tanks or different IV bags or solutions were available. Report the patient's ability on the day of assessment with the equipment they currently have.

Q170.4. M2102e. I was wondering on how to handle M2102e. regarding equipment when we are only performing a flush. I understand from the CMS guidance that a flush is considered an infusion for M1030, as long as it is provided in the home. Would I then consider the syringe as the equipment for M2102e.?

Also, we recently had a patient with a fully implanted subcutaneous infusion device. There was no external equipment to assess. Since this was an ongoing infusion, the patient did receive this in the home, and therefore we answered response "1" in M1030- but since there is no equipment to even assess, how do we answer M2102e.? [Q&A EDITED & M number updated 06/14; ADDED 09/09; Previously CMS OCCB 01/09 Q&A #15]

A170.4. M2102e. assesses the caregiver's ability and willingness to safely use equipment as ordered.

If the only equipment utilized to administer an infusion/flush is a needle and syringe, the clinician will assess the caregiver's ability and willingness to select the appropriate syringe and needle, fill the needle with the appropriate solution utilizing safe and appropriate technique, handle the needle and syringe appropriately as they access the port, monitor the administration of the infusion/flush to ensure it is appropriate and safe, change the needles and syringes safely and appropriately and dispose of the needle and syringe safely and appropriately.

In a situation where the infusion is administered via an implanted pump and there is no equipment accessible to the patient or which requires management in the home, the correct

response for M2102e. would be “0-No assistance needed – patient is independent or does not have needs in this area.”

Note that per Response-Specific Instructions, if the patient is using more than one type of equipment; consider the equipment for which the most assistance is needed.

Q170.5. M2102e. For M2102-e - Types and Sources of Assistance, Management of Equipment, are canes and walkers considered equipment? [Q&A EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB 07/10 Q&A #20]

A170.5. Yes, if the patient requires assistance with their cane or walker it would be included in M2102e. CMS is not intending to provide an exhaustive list of all medical equipment that could be used in the home health setting, but rather expects the clinician to determine what is considered medical equipment, using the examples provided in the item and good clinical judgment.

Q170.6. M2102. For M2102, Types and Sources of Assistance, do I only include equipment, treatments or procedures ordered by the physician when considering types and sources of assistance in M2102? For example, if my therapy only patient has a dressing on a chronic wound that needs no skilled intervention and is not included in the Plan of Care, do I include it when selecting a response to M2102 d. Medical procedures? [Q&A EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #38]

A170.6. M2102, Types and Sources of Assistance includes all tasks included in the broad categories included, even if there is not a specific physician's order for the task. For example, a patient may need a caregiver's assistance with eating, but there may very well not be a specific physician's order for the caregiver to provide the assistance.

Q170.7. M2102 a. d. e. When completing M2102 for a patient with a Foley catheter, what areas, under type of assistance, should be considered? [Q&A EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #27]

A170.7. The types of assistance that a foley catheter patient might need may be captured in multiple rows in M2102, Types and Sources of Assistance, as described below:

- a- ADL assistance as part of toileting hygiene? - Examples: cleansing around the catheter/peri care
- d- Medical procedure? Examples: insertion/removal of catheter, e.g. self cath or intermittent catheterization
- e- Management of equipment? - Examples: emptying the bag, changing the bag

Note that if a patient needs assistance with multiple tasks included in one of the broad categories of assistance, the response selected should be based on the area requiring the most need.

Q170.8. M2102b. When answering M2102b, our clinicians often answer “1 – Non-agency caregiver(s) currently provide assistance”, based on the patient’s “greatest need” for assistance with housekeeping and/or shopping.

Please confirm if “0” is the correct response for M2102b in situations where the patient is independent with eating, planning/ prep meals and phone use – as documented in OASIS Assessments M1870 (Feeding/Eating) = “0” (independent) and M1880 (Plan/Prep Meals) = “0” (independent) and M1890 (Phone use) = “0” (independent).

We are having a problem with agency computer system not allowing us to enter “1” response to M2102 when M1870, M1880 and M1890 are all assessed as “0”. This seems contradictory to clinical guidance. [Q&A EDITED 04/15; M number updated 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #29]

A170.8. For M2102b, IADL assistance, if more than one response applies, you are to report the response that reflects the patient's "greatest need". In your example, the patient needs help with housekeeping and/or shopping, and with these needs met by the caregivers, the response should be "1 – Non-agency caregiver(s) currently provide assistance". Software vendors can add edits or flags in the comprehensive assessments to aide clinicians in their consistency of data collection. An edit in the instance you described may be an appropriate warning, directing the clinician to confirm the response selected, but should still allow the clinician to still choose Response "1" when appropriate. You are encouraged to contact your software vendor in cases where provided edits are questionable.

Q170.9. M2102c. How do I answer M2102 c - Medication Administration, at Discharge for a patient who has a caregiver assisting with management of oral medication but will now receive their B12 injections at the physician's office? [Q&A EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB 07/10 Q&A #19]

A170.9. M2102 Row c - Medication Administration, includes all medications, by any route administered in the home and does not include medications received at physician's offices or other locations outside the home setting.

Q170.9.1. M2102c. A patient has B-12 injectables in the home that her physician administers when she visits monthly. The patient is not getting the medication on the SOC day. Is Response “3-Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance” appropriate for this situation? [Q&A EDITED & M number updated 06/14; ADDED 12/12; Previously CMS Qtrly 10/12 Q&A #9]

A170.9.1. M2102c, Types and Sources of Assistance, determines the level of caregiver ability and willingness to provide needed assistance with medication administered in the home. If the patient does not require assistance with medications administered in the home, Response “0-No assistance needed-patient is independent or does not have needs in this area” would be the appropriate response.

Q170.9.2. M2102c. How is medication administration defined for M2102c? Is it the same definition and tasks described for M2020 Management of Oral Medication? Would it include the need for a caregiver to fill a medication box? [Q&A EDITED & M number updated 06/14; ADDED 12/12; Previously CMS Qtrly 10/12 Q&A #10]

A170.9.2. M2102c asks the clinician to determine the level of caregiver ability and willingness to provide assistance with the administration of medications by any and all routes. The broad category of Medication administration includes all tasks related to the patient's ability to self-administer all prescribed and OTC medications, by any route. Tasks included in M2020, Management of Oral Medications and M2030, Management of Injectables as defined in current CMS guidance would be included, along with any other assistance provided/needed with any medication, by any route. The clinician must use clinical judgment to determine if the patient needs assistance with any medication and if so, describe the caregiver's ability and willingness to provide the needed assistance.

In your example, it would be correct to select Response "2-Non-agency caregiver(s) need training/supportive services to provide assistance" if the caregiver needs help to correctly fill a medication box.

Q170.10. M2102 d, e. Which category of assistance would taking care of a wound VAC fall under...Row (d) Medical Procedures or would it be considered Row (e) Management of Equipment? [Q&A EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #22]

A170.10. The application/changing/removal of the wound dressing, including the foam and drape used with a wound VAC would constitute a "Medical procedure" as other dressing changes do. This would be considered and reported under Row d, Medical procedures. The emptying of the VAC canister or the disconnection/reconnection to the VAC for short times to allow certain activities would be considered management of the equipment and would be included under Row e, Management of equipment.

Q170.11. M2102. What is the appropriate response for M2102, Types and Sources of Assistance, in cases where the physician has ordered the RN to provide the treatment, e.g. a wound VAC procedure?

A170.11. Response "3 - Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance" is the appropriate response for M2102, Types and Sources of Assistance, in situations where the physician has ordered the skilled clinician perform a treatment or procedure. In this situation, the patient needs assistance and the physician has indicated by his/her order that it must be performed by a skilled clinician, in which case the caregiver should be considered unable to provide the needed care. If there is no caregiver involved with the patient who needs assistance, the appropriate response would be a "4 - Assistance needed, but no non-agency caregiver(s) available". [Q&A EDITED & M number updated 06/14; ADDED 01/12; Previously CMS OCCB 01/11 Q&A #21]

Q170.12. M2102. How is "Assistance needed, but no Caregiver(s) available" defined? Would it apply to a son who is managing equipment and assists with ADLs safely and independently, but is unwilling to assist with medication administration and is unable to take the patient to doctor's appointments? [Q&A EDITED 04/15; M number updated 06/14; ADDED 01/12; Previously CMS OCCB 04/11 Q&A #15]

A170.12. "4 - Assistance needed, but no non-agency caregiver(s) available" means the patient has no one involved in providing any level of care to them at all. If there is a non-agency caregiver providing assistance for any activity, Response 4 cannot be selected for ANY row. In your example, the patient has a son who is providing some level of caregiver assistance; therefore, Response 4 would not be an appropriate response. If the son was willing and able to manage equipment and assist with ADLS, the appropriate responses for Row a and Row e would be "1- Non-agency caregiver(s) currently provide assistance". If the son was unwilling to assist with medication administration and unable to take the patient to doctor's appointments, the appropriate responses for Row c, Medication administration and Row g, Advocacy or facilitation would be " Response "3 – Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance" because this response is defined as including situations where the caregiver is unwilling or unable to provide the needed care.

Q170.13. M2102. When answering M2102 - Types and Sources of Assistance, do we include the assistance provided to the patient at an Adult Day Care center? [Q&A EDITED & M number updated 06/14; ADDED 01/12; Previously CMS OCCB 04/11 Q&A #14]

A170.13. M2102, Types and Sources of Assistance, is referring to the assistance needed by the patient in the home and the availability and ability of a caregiver to meet those needs. It does not capture assistance provided to the patient outside of the home setting such as they might receive at Adult Day Care or a dialysis center. Assistance needed to transport the patient out of

the home, (e.g., to/from medical appointments) is included, but services received once outside the home setting should not be considered.

Q170.14. M2102d. Are vital signs, blood glucose or blood pressure considered a "procedure" when scoring M2100, Row d? [Q&A EDITED & M number updated 06/14; Previously CMS Qtrly 04/14 Q&A #11]

A170.14. Measurement of vital signs and blood glucose are considered medical procedures.

Q.170.15. M2102. At the SOC, my patient's daughter is present. She lives out of town and has been staying with my patient for 1 week. She will be leaving in 3 days, after which there will not be a regular caregiver in the picture. How should M2102 – Types and Sources of Assistance be answered? [Q&A ADDED 04/15; Previously CMS Qtrly 04/15 Q&A #6]

At SOC/ROC, the assessing clinician should report on M2102 what is known on the day of assessment regarding ability and willingness of caregivers to provide help in the various categories of assistance listed, for the upcoming episode of care. The assessing clinician would utilize his/her clinical judgment to determine the type of assistance needed by the patient, the ability and willingness of caregivers (other than home health agency staff) to provide the needed assistance, and how long the episode of care is expected to be. In the scenario described the assessing clinician is knowledgeable that the daughter is leaving within the week and would consider not only the daughter's anticipated absence, but also how long the care is expected to continue, when determining the appropriate response for M2102.

If the relative is staying to care for the patient for a week, and the clinician expects to see the patient for 5-6 weeks, then the assessing clinician may use clinical judgment and determine that the relative's temporary presence should not be considered when selecting a response for M2102. If the relative is staying to care for the patient for a week, and the clinician expects the patient to transition to outpatient services within a week or two, the clinician may use clinical judgment and determine that the relative's temporary presence should be considered for M2102.

Q171 through 171.5. [RETIRED 09/09; Outdated]

Q171.5.1. M2110. Will the answer to M2110 always correlate to the M2102 Types and Sources of Assistance response? For example, if a patient needs assistance with ADLs and IADLs but the caregiver is unable/unwilling to assist with bathing and medications, would the scoring be based on the items that the patient needs the most assistance with but the caregiver is unable/unwilling to provide or would it be based on what assistance the caregiver provides regardless of patient need? [Q&A EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #30]

A171.5.1. M2102, Types and Sources of Assistance, reports the source of assistance in a number of broad categories of activities (including ADLs, IADLs, Medication administration, Equipment Management, etc.) M2110, Frequency of Assistance, only addresses ADLs and IADLs, and provides more specific information related to the frequency with which assistance is provided for these broad tasks. You are correct that in M2102 you report the response that represents the most need and the availability and ability of the caregiver to meet that need. In M2110, simply report the frequency that the patient receives assistance with any ADLs/IADLs. Because of the different approaches with these items, a logical "tie" between the two may not always be apparent.

Q171.5.2. M2110. Is M2110 asking how many days the patient receives help or how many times someone visits and provides help? My patient has two daughters. Daughter 1 visits

and helps with laundry on Sunday morning, daughter 2 visits Sunday afternoon and Wednesday to help her mother in and out of the bathtub. Should I select “2-Three or more times a week” because 3 visits were made or “3-One to two times per week” because the patient received help on two days? [Q&A ADDED 01/12; Previously CMS OCCB 10/11 Q&A #14]

A171.5.2. M2110, Frequency of ADL/IADL Assistance, reports how many times a week a caregiver provides some level of assistance with any ADL or IADL. In your scenario, the appropriate response would be “2-Three or more times a week” since there was 3 distinct times that someone provided assistance with an ADL/IADL.

Q171.6. M2200 & M0110. If we determine that we answered M2200, Therapy Need or M0110, Episode Timing, incorrectly at SOC, ROC or Recert, what actions do we have to take? [Q&A EDITED 04/15; EDITED 06/14; ADDED 09/09; M number updated 09/09; Previously CMS OCCB 10/07 Q&A #10]

A171.6. In the Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Final Rule available at: <http://www.cms.gov/center/hha.asp> it states:

“The CWF will automatically adjust claims up or down to correct for episode timing (early or later, from M0110) and for therapy need (M2200) when submitted information is found to be incorrect. No canceling and resubmission on the part of HHAs will be required in these instances. Additionally, as the proposed rule noted, providers have the option of using a default answer reflecting an early episode in M0110 in cases where information about episode sequence is not readily available.”

Since medical record documentation standards require a clinician to correct inaccurate information contained in the patient’s medical record, if it comes to the clinician’s attention that the OASIS response for M0110 - Episode Timing is incorrect, the original assessment may be corrected following the agency’s correction policy. Agencies can make this non-key field change to their records and retransmit the corrected assessment to the OASIS system. For example, if the clinician chose “Early” and during the episode, s/he learned that the patient was in a “Later” episode, M0110 may be corrected. Alternatively, in order to maintain compliance with standard medical record accuracy expectations, the clinician or agency could otherwise document the correction in a narrative correction note, or other format, since CMS is not specifically requiring the correction to be made to the OASIS assessment.

It is quite possible that providers may underestimate or overestimate the number of therapy visits M2200 that will be required in the upcoming episode. Because M2200 is an estimation of an exact number of therapy visits the agency expects to provide and the CWF will automatically adjust claims if the estimation is found to be incorrect, there will be no need to go back to the original OASIS assessment and change the M2200 response and resubmit the data.

The clinician cannot be expected to correct what is unknown to them and since in these specific cases the Common Working File (CWF) will automatically adjust claims found to be incorrect, no extraordinary efforts need to be taken after the original data collection to determine the accuracy of the data specific to M0110 and M2200.

Q171.7. M2200 & M0110. How would an agency report M0110 and M2200 when the patient has a HMO/MCO insurance (and is managed by Medicare) when they require a HIPPS code? What if they *don’t* require a HIPPS Code? [Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 01/08 Q&A #12]

A171.7. If the payer requires an HHRG/HIPPS, M0110 should be answered Early, Later or Unknown and M2200 should reflect the number of reasonable and necessary therapy visits

planned for the episode. If the payer does not need the HHRG/HIPPS, M0110 and M2200 should be answered NA.

The agency will need to communicate with their non-Medicare Traditional Fee-for-Service (PPS) patient's payer to determine if they require a HHRG/HIPPS.

Q171.8. M2200 & M0110. I have entered an assessment into HAVEN, it is ready to be locked and exported, but when I try to calculate the HIPPS Code I receive a message that grouper returned blank values. Why is this? [Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 01/08 Q&A #13]

A171.8. If M0110 or M2200 are marked as 'Not Applicable' then the Grouper will not return a value for the HIPPS Score. To determine how these fields should be completed please contact your state's OASIS Education Coordinator.

Q171.9. M2200. We are having a huge discussion as to what the meaning of the new M2200 question implies. At present if the admission is done by nursing any rehabilitation service is put on the 485 (Plan of Care) as a 1 day 1 for evaluation and treatment. Then later the rehabilitation service enters their own orders and frequency as a verbal order after they have completed therapy evaluation. The way the new M2200 reads, some feel the nurse must put on the 485 a total of rehabilitation visits to match the OASIS number placed in the blank even though the rehabilitation service may or may not have made their evaluation visit to the patient by the time the POT and OASIS are to be completed. We realize CMS will adjust the actual number of visits later as the claim is processed but are we expected to put the guess on the 485 at the start of care? Is this a compliance issue? [Q&A EDITED 06/14; ADDED 09/09; M numbers updated 09/09; Previously CMS OCCB 01/08 Q&A #26]

A171.9. Chapter 3 of the current OASIS Guidance Manual states under the Response-Specific Instructions, "Therapy visits must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapist(s); and (b) be reasonable and necessary to the treatment of the patient's illness or injury." It further states under Assessment Strategies "If the number of visits that will be needed is uncertain, provide your best estimate."

Q171.10. M2200. I am uncertain how to answer M2200 in the following situations, please clarify: [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 04/08 Q&A #15]

a. At ROC?

b. When patient has multiple payers and some therapy services are covered under the Medicare home health benefit and other therapy services are not (e.g. patient in a long term home health care program (LTHHCP) or one who pays privately for therapy beyond what is considered reasonable and necessary)?

c. When I add therapy services mid-episode?

A171.10.

a. At ROC: M2200 is an OASIS item with a single use of facilitating payment under the Home Health Prospective Payment System. Typically, at the SOC (RFA 1) and Recertification (RFA 4), data from M2200 (along with other relevant OASIS items) are used to determine the payment under PPS for the current or upcoming episodes respectively. In addition to SOC and Recert, M2200 is also collected at the ROC (RFA3) time point. Typically, data from this ROC is not used for PPS payment determination and in cases where the data is not needed for payment, Response NA - Not Applicable: No case mix group defined by this assessment could be reported on M2200. Alternatively, providers may choose to report the total of therapy visits

that have been provided during the episode to date, added to the number of therapy visits planned to be provided during the remainder of the current episode. If the ROC assessment will not be used to determine payment, then it does not matter which of the above approaches an agency chooses.

While data from the ROC time point does not usually affect PPS payment, there is a specific situation in which it does; that is when a patient under an active home health Plan of Care is discharged from an inpatient facility back to the care of the home health agency in the last five days of the certification period. In that situation, CMS allows the agency to complete a single ROC assessment to meet the requirements of both the resumption of care and of the pending recertification. When a ROC assessment will be "used as a recert" (i.e., used to determine payment for the upcoming 60 day episode), then the ROC data will be necessary to define a case mix (payment) group, in which case the total number of therapy visits planned for the upcoming 60 day episode should be reported.

b. Therapy services that are not covered by the Medicare HH benefit: M2200 should reflect the total number of reasonable and necessary therapy visits (e.g. therapy visits that meet the Medicare home health coverage criteria) that the agency plans to provide during the payment episode. If the agency intends on providing therapy visits that do not meet the Medicare home health coverage criteria (e.g. more frequent than necessary, custodial or repetitive in nature), including those which the agency intends to bill to another (non Medicare PPS) payer, only those visits that meet the Medicare home health benefit coverage should be reported in M2200.

c. Therapy services added mid-episode: When therapy services are ordered within the episode, the RFA 5 (other follow up) assessment may be required, depending on your agency's established policy and practice. The number of visits reported in M2200 on the RFA 5 assessment will in no way impact the episode payment under Medicare PPS. Upon submission of the final claim (which will indicate the number of therapy visits provided) the claims processing system will autocorrect the payment to reflect the actual number of therapy visits provided and reimburse the agency accordingly, even if more therapy visits were provided during the episode than were projected at any of the OASIS data collection time points that capture M2200. The agency does not have to go back and make any changes or corrections to M2200 at the SOC or other time points.

Q171.11. M2200. In responding to M2200, Therapy Need, if a physician provides a specific order for therapy services and the therapist who performs the evaluation does not feel the patient will require that number of visits, should the response for M2200 be the physician-ordered number of visits or the therapist's evaluation of the patient's therapy needs? [Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #22]

A171.11. M2200 should reflect the total number of reasonable and necessary therapy visits (e.g. therapy visits that meet the Medicare home health coverage criteria) that the agency plans to provide during the payment episode, even if that number is less than the physician's orders. It would be important for the therapist to include documentation of the number of covered therapy visits in the clinical documentation.

Q172. [Q&A RETIRED 09/09; Outdated]

Q172.1. M2250. Regarding the physician-ordered Plan of Care, when documenting that orders were obtained in the Plan of Care Synopsis, is it acceptable to incorporate the general wording of the current process measures into the Plan of Care or are orders expected to be more specifically documented? (e.g. SN to monitor and mitigate pain,

instruct on fall prevention measures, etc.) [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #31]

A172.1. When completing M2250, Plan of Care Synopsis, it is not required that you include the exact words used in the M2250 item, just that interventions representing the specified best practice be included in the physician-ordered Plan of Care. In some cases, if all you included were the exact words, it would not meet the requirements. For example, if the order read “Monitor and mitigate pain”, the phrase “mitigate pain” would not be a specific intervention that could be followed in an effort to relieve pain. It would be expected that an order for a specific intervention be included, e.g. Tylenol 500 mg q6h, teach guided imagery techniques to relieve pain, etc. However, in other cases, using the exact words from the M item would suffice, e.g. “Monitor lower extremities for lesions and teach patient/caregiver proper diabetic foot care.”

Q172.2. M2250. When you are completing M2250 - Plan of Care Synopsis, at the ROC and the initial orders for fall risk, pressure ulcers, etc. were received at SOC from the physician and have not been discontinued, meaning they remain as a current order, does the RN doing the ROC need to rewrite these orders? Does the RN need to contact the physician to see if it is OK to continue them? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 07/10 Q&A #21]

A172.2. The OASIS data set process measures are not changing the expectations and requirements related to physician's orders. If, at ROC, orders received at SOC remain as current orders, then the presence of those orders can be reported in M2250.

Q172.3. M2250. Many of the areas related to M2250 - Plan of Care Synopsis follow evidence-based practice. Use of fall prevention interventions, instruction in proper foot care for diabetic patients, pressure ulcer prevention education, and ongoing pain assessment/monitoring are all good clinical practices that routinely implement without specific physician's orders. Are we now required to obtain physician's orders for these general care practices? [Q&A ADDED 01/11; Previously CMS OCCB 01/10 Q&A #24]

A172.3. It is understood that some of the best practices captured in M2250 includes care that might be routinely provided to a patient without a specific order. For instance, you may be admitting a patient for wound care, and in the process of your assessment, encounter a fall risk, like clutter on the floor. You might resolve the issue through intervention or education, all without obtaining a physician's order. However, if your agency wants to “get credit” for conducting this fall prevention intervention (by marking “Yes” on M2250 (c), you must have an order for fall prevention interventions.

Q172.4. M2250. Some process measure items refer to providing and/or receiving communication to/from the physician or physician-designee (M2003 & M2005), another refers to the physician or other primary care practitioner (M1511) while another (M2250) includes only the physician. Please define physician-designee and primary care practitioner. Do they include physician extenders, like physician assistants and nurse practitioners? When an item refers to “physician-ordered”, would that include DOs? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #32]

A172.4. For process measure items reporting communication to/from the physician or physician-designee, (such as reporting heart failure symptoms for M1511, or communication to report/resolve medication issues for M2003) communication can be directly to/from the physician, or indirectly through physician's office staff on behalf of the physician, in accordance with the legal scope of practice.

For process measure items requiring physician orders, (e.g., M2250 Plan of Care Synopsis), the Plan of Care/orders must be “physician-ordered” including orders from MDs, Doctors of Osteopathic Medicine (DOs), and Doctors of Podiatric Medicine (DPMs) practicing within their legal scope of practice. M2250 includes only physicians as defined here.

Q172.4.1. M2250. If the ROC comprehensive assessment with OASIS was completed after the CMS-allowed 48 hour time frame, do all the best practice questions need to be answered “NA”? [Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #13; 06/14 edits based on CMS Qtrly 10/13 Q&A#2]

A172.4.1. The ROC comprehensive assessment must be completed within 48 hours of discharge following a qualifying inpatient stay or within 48 hours of knowledge of a qualifying stay in an inpatient facility. If the ROC assessment is late, "Yes" may still be selected for the best practices in M2250, Plan of Care Synopsis, if the relevant orders were present within the 48 hour ROC time frame. Likewise, M1240, Pain Assessment, M1300, Pressure Ulcer Risk Assessment, M1730, Depression Screening, and/or M1910, Falls Risk Assessment may also be reported with "Yes" responses, if the relevant standardized, validated assessments were conducted by the assessing clinician within the 48 hour time frame, even if the ROC comprehensive assessment was completed after the 48 hour time frame. When the assessing clinician takes credit on M1240, M1300, M1730 and/or M1910 for standardized, validated assessments completed within the 48 hour time frame and the M0090 date indicates that the ROC comprehensive assessment was completed late (beyond the 48 hour time frame), clarifying documentation to support the reported OASIS responses is expected.

If the relevant standardized, validated assessment was completed greater than 48 hours after inpatient facility discharge or greater than 48 hours after gaining knowledge of a qualifying stay in an inpatient facility, M1240, M1300, M1730 and M1910 must be answered "No".

If orders are not present by the end of the allowed 48 hour ROC time frame, M2250, Plan of Care Synopsis responses would be answered "No" unless the best practice is not applicable to the patient, in which case the response would be "NA". Refer to Ch. 3 of the current OASIS Guidance Manual for qualifiers that indicate when the best practices are not applicable, (e.g. Row b, diabetes best practice, the patient must be free of the diagnosis of diabetes mellitus or have no lower extremities.)

Q172.5. M2250a. If we are using standardized agency parameters, do they have to be listed specifically in the Plan of Care or can the order read “Notify MD of VS as per agency’s patient clinical parameter guidelines”? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 07/10 Q&A #22]

A172.5. The specific parameters must be included. The physician has to be aware of what he/she is agreeing to and cannot possibly be aware of every home health agencies standardized parameters.

Q172.5.1. M2250a. If we add our agency’s standardized parameters to every Plan of Care for every patient we admit, without first communicating with the physician, we can always answer “Yes” to M2250a - Plan of Care Synopsis, Patient Specific Parameters? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 07/10 Q&A #23]

A172.5.1. No. In order to answer "Yes" to the responses, the Plan of Care must include patient-specific parameters provided/approved by the physician, or inclusion of your agency specific parameters, which the physician has agreed meet the individual needs of this specific patient. As with any physician orders, these must be approved either through verbal or written approval by the physician prior to providing care.

If the agency utilizes agency standardized guidelines without specific physician approval and orders, then "NA" should be reported for M2250a.

Q172.5.2. M2250a. A clinician assesses the patient at SOC and calls the physician with a report and to discuss the POC. The clinician asks if the physician would like a report of abnormal vital signs during the episode and recites the parameters found in the agency's standardized guidelines. The physician says "Yes" and the order with the parameters are printed on the POC for his signature. Is this considered "patient specific parameters" resulting in a YES response for row a? [Q&A ADDED 01/11; Previously CMS OCCB 01/10 Q&A #28]

A172.5.2. If the physician agrees that the agency's standardized parameters would meet the needs of this specific patient, they would become patient specific parameters.

Q172.5.3. M2250a. If our patient's physician agrees that the American Heart Association (AHA) guidelines for physician notification would be appropriate for his patient, is it sufficient for the order on the Plan of Care to read "Follow AHA guidelines for physician notification"? [Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 04/11 Q&A #16]

A172.5.3. In order to select "Yes" for M2250a, Patient-Specific Parameters, the physician-ordered Plan of Care must include specific parameters, e.g. notify physician if INR <2.0 or >3.0. Just including the name of a set of guidelines, e.g. AHA guidelines, ABC Agency guidelines, ADA guidelines, etc. would not meet the requirements of this best practice.

Q172.6. M2250b. If a patient has Diabetes Insipidus, would the appropriate response be "NA" for M2250b - Plan of Care Synopsis, Diabetic foot care? [Q&A ADDED 01/11; Previously CMS OCCB 07/10 Q&A #24]

A172.6. Yes, "NA" is the appropriate response for a patient that has Diabetes Insipidus, not Diabetes Mellitus. M2250b best practice interventions are intended for patients with Diabetes Mellitus.

Q172.8. M2250d. If the patient has a diagnosis of depression but no symptoms per the standardized tool, can the clinician choose "NA"? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #23]

A172.8. No. NA is only appropriate if the patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.

Q172.8.1. M2250d. A patient has depressive symptoms as identified by a PHQ-2 score of "4", but the patient has no diagnosis or current treatment for depression. If the clinician notifies the physician of the depressive symptoms and is instructed to continue to monitor the patient, with no orders for specific treatment, what response would be selected for M2250d? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/10 Q&A #14]

A172.8.1. After reporting the patient's positive depression screening to the physician, "Yes" may be selected. A physician order to continue to assess for signs of depression could be considered an intervention for depression and would also meet the criteria for the "Yes" response for M2250d but would not be required as long as the physician was notified that the patient had screened positive for depression.

Q172.8.2. [06/14 Renumbered 172.9.09]

Q172.8.3. M2250d. For M2250d, except for situations of physician notification of a positive depression screening, do I have to obtain a physician's order for an intervention in order to answer "Yes"? [Q&A ADDED 04/15; Previously CMS Qtrly 07/14 Q&A #10]

A172.8.3. Yes, other than for situations of physician notification regarding a positive depression screen, a physician's order for the depression intervention is required.

Q172.9. M2250d & M2401c. Does the inclusion of existing ordered antidepressant medications on the medication profile equate to a "Yes" response to Depression Interventions on M2250 and/or M2401? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #26]

A172.9. M2250, Plan of Care Synopsis and M2401, Intervention Synopsis, report whether the physician ordered Plan of Care includes depression interventions. If the patient has a diagnosis of depression, the presence of an existing antidepressant medication in the medication profile/Plan of Care is considered a depression intervention. If there is an anti-depressant ordered and no diagnosis of depression, the assessing clinician would need to confirm why the medication was prescribed as anti-depressants are often indicated for diagnoses other than depression. If the medication was not prescribed specifically for depression, it would not be considered a depression intervention.

Q172.9.01. M2250d & M2401c. Should the diagnosis of bipolar disease be considered a diagnosis of depression for the M2250d/M2401c Plan of Care/Intervention Synopsis items? [Q&A EDITED 10/16; Q&A ADDED 12/12; Previously CMS Qtrly 10/12 Q&A #11]

A172.9.01. M2250d and M2401c are applicable to all patients with a diagnosis of depression (clearly documented in their medical record and/or confirmed by a physician), including diagnoses with depression as a stated or intended component (e.g., bipolar disorder with depression, bipolar disorder - mixed depression and mania, Alzheimer's with depression). The depression best practice is also applicable to all patients who have been screened for depression and exhibit symptoms that require further evaluation for depression, even if a formal diagnosis of depression has not been made.

Q172.9.02. M2250d. During a SOC visit, the assessing clinician determines the patient is not depressed, has no symptoms of depression and no diagnosis of depression. Because she has assessed for signs & symptoms of depression as part of her initial comprehensive assessment and will continue to assess the patient for signs & symptoms of depression as part of her psychosocial assessment during her revisits, she selects the intervention "Skilled observation and assessment of signs and symptoms of depression " on her Plan of Care. May we answer "Yes" on M2250, Row d since the Plan of Care has a depression intervention? [Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 01/14 Q&A #9]

A172.9.02 If the clinician determines it would be appropriate for a specific patient and obtains an order for "Skilled observation and assessment for signs and symptoms of depression" from the physician during the SOC or ROC allowed timeframe, M2250d may be answered "Yes" even if the formal assessment was negative and/or the patient has not been formally diagnosed with depression.

Note, just checking off an intervention on a Plan of Care does not equate to "obtaining a physician order."

Q172.9.03. M2250d & M2401c. In M2250, Plan of Care Synopsis, Row d, best practice interventions include "referral for other treatment". If the patient's depression screen

was positive and the assessing clinician suggests the patient join a depression support group or schedule an appointment with a psychiatrist, would this be considered a “referral for other treatment”? [Q&A EDITED 10/16; Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 04/14 Q&A #12]

A172.9.03. In M2250d, a referral for services for further evaluation or treatment meets the criteria for a response of “Yes” only if there is an order in the physician-ordered Plan of Care for the referral prior to the end of the SOC/ROC comprehensive assessment time period. The order in the physician-ordered Plan of Care can be a referral for agency services (such as an evaluation by psychiatric nursing or social work). Alternatively, it can be an order for a referral to an external provider or organization (such as for evaluation or treatment by a psychiatrist or to a community mental health center). Merely suggesting the patient seeks further evaluation or treatment, however, does not constitute providing a referral. The agency must provide the patient with sufficient written information (for example: name and phone number) to enable them to make an appointment or obtain the service. Likewise, the HHA can make contact directly with the provider or organization to facilitate an appointment for the patient. There is no requirement that the referral be implemented (for example: the social work visit made, or the psychiatrist evaluation scheduled) for a response of “Yes” in M2250d, just that there is an order for a referral in the physician-ordered Plan of Care.

Note that in M2401, Intervention Synopsis, Row c, a referral for services for further evaluation or treatment meets the criteria for a response of “Yes” only if there is an order in the physician-ordered Plan of Care for the referral AND the referral was made by the agency. Once a referral has been made, it is not required that the patient has followed through or received the services related to the referral by the time of discharge for a response of “Yes” in M2401c.

Q.172.9.04.M2250d, M2401c. Please provide further clarification regarding when I can select “Yes” indicating the physician was notified of a positive depression screening for M2250, Plan of Care Synopsis, Row d and M2401, Intervention Synopsis, Row c. May I select “Yes” if I simply leave a voice mail for a physician regarding a positive depression screening or must I receive an acknowledgement of the message? [Q&A EDITED 10/16; Q&A ADDED 04/15; Previously CMS Qtrly 07/14 Q&A #9]

A.172.9.04. When completing M2250d, the assessing clinician may answer "Yes" in cases where the physician was notified of the positive depression screening by the end of the allowed assessment time period. Communication to the physician made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status is sufficient. There is no requirement that you receive acknowledgement of your message in order to select “Yes”.

M2401c does not offer the option of notifying the physician of a positive depression screening. When scoring M2401c, “No” must be reported if no orders for depression are received or no referral for other treatment made, unless the patient meets the criteria listed to mark “NA”.

Q172.9.08.M2250e. If the patient is taking a medication that could be used for pain control, e.g. aspirin 81 mg daily, does this automatically count as an intervention to mitigate pain when completing M2250e, even though the medication was prescribed for its cardiovascular effects? Do we need to clarify if the aspirin is being used for pain control? [Q&A ADDED 04/15; Previously CMS Qtrly 07/14 Q&A #8]

A172.9.08. In order to select "Yes" for a best practice intervention in M2250, there must be a physician order for an intervention(s) that specifically addresses the patient's needs as required in each best practice area (M2250 row). In order to select "Yes" for Row e, Pain, the physician-ordered plan of care must include both an order to assess pain and an order intended to

relieve/mitigate the individual patient's specific pain. An order for a medication at a dose intended as an antiplatelet would not be considered an intervention specifically intended to relieve the patient's pain.

Q172.9.09. M2250e. A patient is documented to have chronic arthritic joint pain that interferes with activity at least daily and is taking a pain medication daily as previously ordered. If the clinician only has orders to assess the effectiveness of the current pain medication treatment, is this order only an order to MONITOR pain (M2250e "No"), or would this be enough to answer "Yes", that we have an order to both monitor and mitigate pain? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/10 Q&A #15; Renumbered from Cat 4b 172.8.2 06/14]

A172.9.09. An ordered pain medication is considered an intervention to mitigate pain. Assessing for the effectiveness of the pain medication is considered an intervention to monitor pain. If both the pain medication and an order related to pain assessment are included in the physician-ordered Plan of Care, M2250e would be "Yes".

Q172.9.1. M2250g & M2401f. For M2250g – Plan of Care Synopsis and M2401 – Intervention Synopsis, may I answer "Yes" if either the physician ordered Plan of Care has orders for pressure ulcer treatments based on the principles of moist wound healing, OR if I requested these orders from the physician, but s/he refused to agree to them or have not been established yet? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #36]

A172.9.1. M2250, Plan of Care Synopsis, Row g. may be answered "Yes" if, by the end of the allowed assessment time period (5 days after SOC date/2 days after inpatient facility d/c for ROC) the physician-ordered Plan of Care includes orders for pressure ulcer treatment based on the principles of moist wound healing. The assessing clinician may also answer "Yes" in cases where the moist wound healing treatment was requested of the physician, by the end of the allowed assessment time period. It would not be required that the response from the physician be obtained in order to qualify as a "Yes". If the physician response is "No, moist wound healing is not appropriate for this patient, "NA" would be the correct response.

The parallel item in M2401 does not offer any option that an order for treatment using principles of moist wound healing was requested from the MD. So at M2401 if the MD does not order treatment based on principles of moist wound healing, "No" must be reported on Row f unless the patient meets the criteria listed to mark NA.

Q172.9.1.1. M2250g. M2250, Row g, states "Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician." Does the statement really mean "OR"? If it really means "OR" can I answer "Yes" if the patient does NOT have a pressure ulcer BUT we have orders for moist wound treatment (ointment and possible use of Unna boot) for psoriasis. Does this section only apply to pressure ulcers or for any moist wound treatment, like that "OR" statement says? [Q&A ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #21]

A172.9.1.1. M2250, Row g, is specific to pressure ulcer best practice and is answered "NA" if the patient has no pressure ulcers. An order for moist wound healing for other types of wounds is not reported in M2250, Row g.

Q172.9.1.2. M2250g & M2401f. Our home health agency has a physical therapy only patient with a Stage 2 pressure ulcer. Although we are assessing the patient's skin as part of the comprehensive assessment requirements, the wound care for the pressure ulcer is being provided by an outpatient wound center and family members in the home and includes moist wound healing interventions. Since the wound care is not part of the

home health plan of care, or being billed for by the agency, no orders for moist wound treatment were obtained from the physician by our agency. How should M2250 Plan of Care Synopsis Row g. (at SOC) and M2401 Intervention Synopsis Row f. (at discharge) be answered so that our agency's outcomes are not negatively affected, since the patient is getting appropriate care? [Q&A EDITED 10/16; Q&A ADDED 04/15; Previously CMS Qtrly 04/15 Q&A #7]

A172.9.1.2. M2250g & M2401f. Assuming the pressure ulcer in your scenario at discharge continues to be treated and managed as you describe at SOC, when determining the appropriate responses for M2250g – Physician orders for pressure ulcer treatment based on principles of moist wound healing, and M2401f – Pressure ulcer treatment based on principles of moist wound healing ordered and implemented, the assessing clinician would decide if the patient meets the criteria for a "Yes" or "NA" response, strictly based on CMS data collection guidance. If a "Yes" doesn't apply (because your agency's physician-ordered plan of care does not contain orders for pressure ulcer treatment based on moist wound healing), and the "NA" response does not apply (because the patient does have a pressure ulcer for which moist wound healing is indicated), then the assessing clinician must select "No."

Q172.9.2. M2250 & M2401. For M2250 - Plan of Care Synopsis. Item Intent states that this identifies if the physician-ordered home health Plan of Care incorporates specific best practices. The "physician ordered Plan of Care" means that the patient condition has been discussed and there is agreement as to the Plan of Care between the home health agency staff and the physician.

Response - Specific Instructions states that the question can be answered "Yes" prior to the receipt of signed ordered if the clinical record reflects evidence of communication with the physician to include specified best practice interventions in the Plan of Care.

In order to report on M2250 that physician orders exist, does that initial verbal/faxed communication need to include details of the specified best practice interventions (e.g. fall prevention interventions, pain monitoring, specific clinical parameters requiring physician notification, etc.)?

Could it be determined that all these specific best practice orders were present if the communication with the physician were more general (like the patient's clinical findings are discussed with the physician and there is an agreement as to the general POC between the admitting clinician and the physician. Then the formal detailed POC is sent to the physician for signature, outlining the specific parameters and interventions)?

[Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #25]

A172.9.2. The OASIS data set process measures are not changing the expectations and requirements for communicating with the physician to obtain verbal orders prior to providing services.

The Medicare Benefit Policy Manual defines clearly how orders can be obtained verbally if complete orders were not provided in the referral. Chapter 7, Section 30.2.5 states:

"Services which are provided from the beginning of the 60-day episode certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care."

All orders would be under the same instruction from CMS, including those which are reported in M2250 and M2401.

Q172.9.3. M2250 & M2401. Is it the clinician's clinical decision or the physician's that will determine the patient has no pressure ulcers with need for moist wound healing at M2250 and M2401? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #37]

A172.9.3. A physician ordered Plan of Care means that the patient condition has been discussed and there is agreement as to the Plan of Care between the home health agency staff and the physician. The clinician would discuss the patient's pressure ulcers with the physician and not make the decision regarding appropriate treatment alone. While clinicians caring for patient with pressure ulcers may be cognizant of wound care guidelines for pressure ulcer management and understand that certain pressure ulcers are not appropriate for moist wound healing, each patient status is to be discussed with the physician who ultimately makes all treatment plan decisions. When it is determined by the clinician/physician team or solely by the physician that moist wound healing is not appropriate for the patient, the Response "NA" would be chosen, and the clinician would then document the rationale behind not utilizing the moist wound healing techniques.

Q172.9.3.1. M2250 & M2401. A patient has two pressure ulcers for which wet-to-dry dressings are ordered. After the SOC assessment, the assessing clinician requests and receives an order for moist wound healing treatment for one of the pressure ulcers, without any discussion about appropriateness/inappropriateness of moist wound healing for the second ulcer. The moist wound healing treatment is provided and documented for the one pressure ulcer as ordered. How should 2401 be answered? [Q&A EDITED 10/16; Q&A ADDED 01/12; Previously CMS OCCB 10/11 Q&A #16]

A172.9.3.1. There is no requirement that every pressure ulcer be treated with moist wound healing in order to mark "Yes" for M2250 (g) or M2401 (f). If the agency has orders for and implements moist wound healing treatment for at least one pressure ulcer within the required time frames, then M2401 (f) should be "Yes".

Q172.9.4. M2250 & M2401. If I included an appropriate intervention in the Plan of Care and implemented it during the episode of care, can I mark "Yes", even though a formal assessment was not completed during the assessment time frame? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #41]

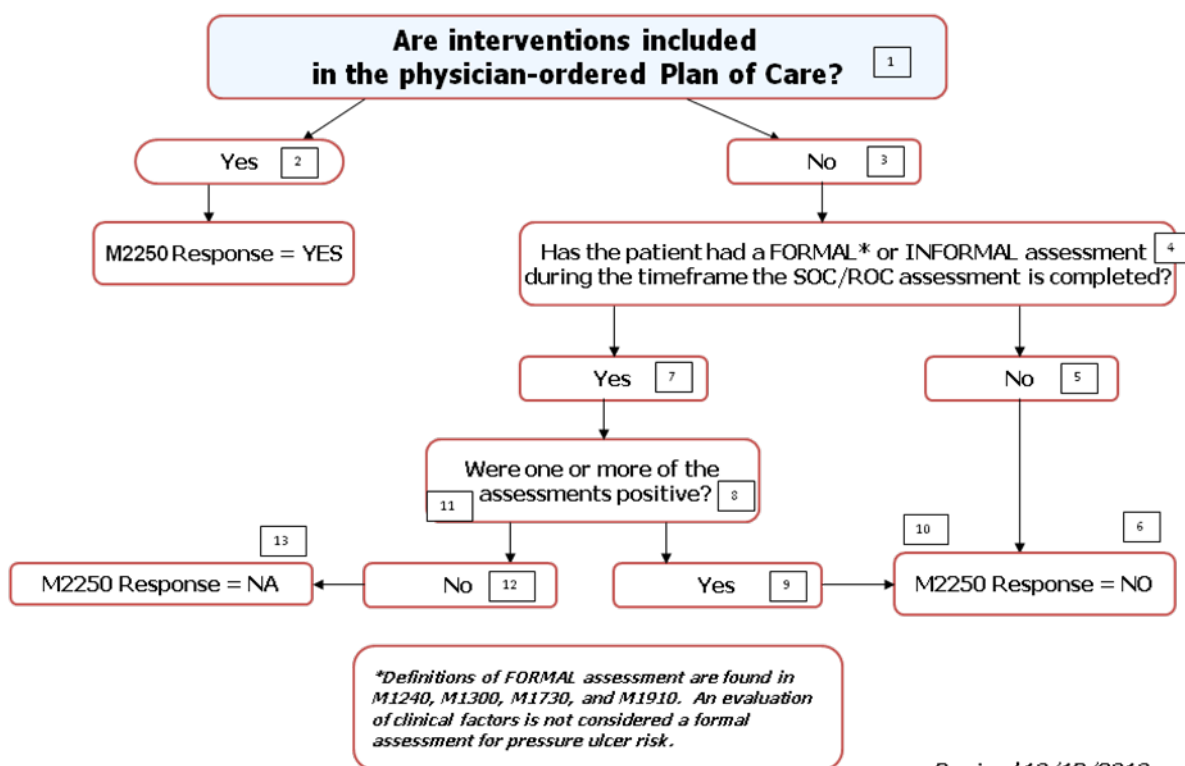
A172.9.4. Yes, M2250 reports if the physician-ordered Plan of Care includes specific interventions and should be marked "No" or "Yes", depending on the presence of the orders, whether or not a formal assessment for the related issue was conducted. M2401 reports if specific interventions were BOTH included in the physician-ordered Plan of Care AND implemented. M2401 should also be marked "No" or "Yes" based on the presence of the orders and documentation of their implementation, whether or not a formal assessment for the related issue was conducted. If no orders were present, "NA" may be appropriate to mark, if the situation meets the conditions stated in the specific NA statements (e.g., "NA, Patient has no diagnosis or symptoms of depression).

Q172.9.5. M2250 & M2401. Please clarify the use of the "NA" response option in M2250 rows c-f, and M2401 rows b-e, specifically when the previous assessment was a Recert assessment, where items related to pain, pressure ulcers, depression and fall risk assessment are not collected. The Chapter 3 guidance states this: 'For rows b-e, a formal assessment (as defined in the relevant OASIS item M1240, M1300, M1730, and M1910) must have been performed to select "NA." My question is then if the Recert assessment

did not contain these fields, am I correct to assume that the answers for each row would be “No”, and not “NA”. [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #38]

A172.9.5. When collecting OASIS data at Transfer or Discharge, M2401 should be answered based whether or not each specific intervention was both included in the physician-ordered plan of care AND implemented at the time of or at any time since the most recent SOC/ROC. Based on revised look back guidance for M2401 (OASIS-C2), the look back will always be to a SOC or ROC for M2401, and not to a Recert assessment. Where the last OASIS assessment was a Recertification, M2401 rows b-e do not necessarily need to be reported as “No” because the formal assessments for pain, pressure ulcers, depression and fall risk are not collected on the Recert assessment. The clinician may have conducted a formal assessment either at the time of or at any time since the most recent SOC/ROC time point, indicating that the patient was not at risk for falls (or did not have pain, etc.), in which case “NA” might be the appropriate response, depending on all other available information.

Determining response for M2250 c - f at SOC/ROC

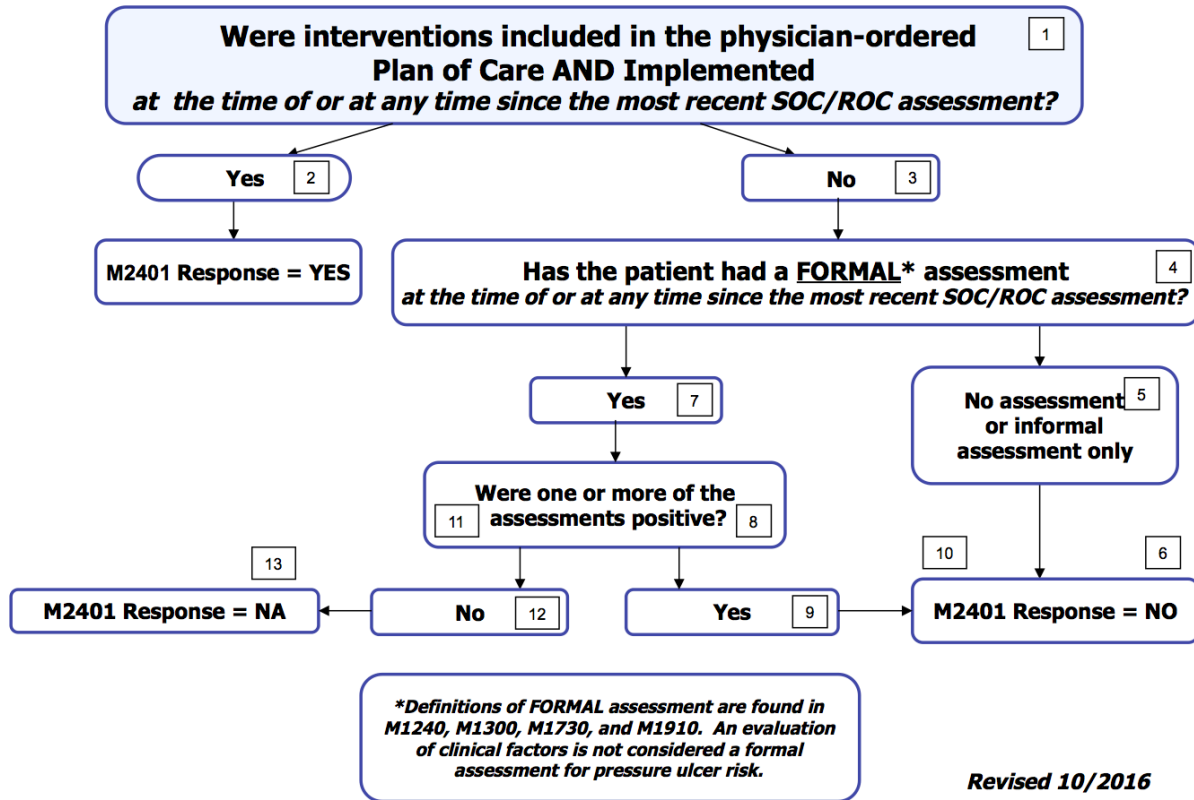


Determining Response for M2250 C – F at SOC/ROC

Definitions of FORMAL assessment are found in M1240, M1300, M1730, and M1910. An evaluation of clinical factors is not considered a formal assessment for pressure ulcer risk.

Step	Action
1	Determine if specified interventions are included on the physician-ordered Plan of Care within the allowed assessment timeframe at SOC/ROC.
2	If the answer is Yes, the M2250 Response is "Yes".
3 4	If the answer is No, determine if the patient has had a formal or informal assessment during the allowed timeframe at SOC/ROC.
5 6	If the answer is No, the M2250 Response is "No".
7 8	If the answer is Yes, determine if one or more of the assessments were positive for the specified risk or condition.
9 10	If the answer is Yes, the M2250 Response is "No".
11 12 13	If the answer was No, the M2250 Response is "NA".

Determining response for M2401 b – e at TRF/DC



Determining Response for M2401 B – E at TRF/DC

Definitions of FORMAL assessment are found in M1240, M1300, M1730, and M1910. An evaluation of clinical factors is not considered a formal assessment for pressure ulcer risk.

Step	Action
1	Determine if specified interventions were included on the physician-ordered Plan of Care AND implemented at the time of or at any time since the most recent SOC/ROC assessment.
2	If the answer is Yes, the M2401 Response is "Yes".
3	If the answer is No, determine if the patient has had a formal assessment at the time of or any time since the most recent SOC/ROC assessment. *Definitions of Formal assessment are found in M1240, M1300, M1730, and M1910 guidance. An evaluation of clinical factors is not considered a formal assessment for pressure ulcer risk.
4	
5	If the answer is No assessment or only informal assessment conducted, the M2401 Response is "No".
6	
7	If the answer is Yes, determine if one or more of the formal assessments were positive for the specified risk or condition.
8	
9	If the answer is Yes, the M2401 Response is "No".
10	
11	If the answer was No, the M2401 Response is "NA".
12	
13	

Q172.9.6. M2250 & M2401. I need clarification about the flowchart included in the April CMS OCCB Q&As Question 38. Can I answer "Yes" to M2250, Plan of Care Synopsis, and M2401, Intervention Synopsis, if the physician-ordered Plan of Care includes the specified intervention and they were implemented by Transfer/Discharge, even though the assessment revealed no risk? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 07/10 Q&A #25]

A172.9.6. You may answer M2250, Plan of Care Synopsis, "Yes" if the physician-ordered Plan of Care includes the specified best practice intervention by the end of the allowed assessment time frame. This is true even if the formal or informal assessment revealed no risk.

You may answer M2401 - Intervention Synopsis, "Yes" at Transfer/Discharge if the physician-ordered Plan of Care includes the specified best practice intervention and there is evidence in the clinical documentation that they were implemented. This is true even if the formal assessments were negative.

Q172.9.7. M2250 & M2401. If I complete my comprehensive assessment late (my M0090 date is 6 days post SOC) and I do a standardized pain assessment on that 6th day, would I report the pain assessment when completing M2250 (and when completing M2401 at Transfer/Discharge) because I did conduct the pain assessment? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #12]

A172.9.7. M2250 and M2401 don't directly report if the pain assessment was conducted. M2250 reports if the physician-ordered Plan of Care includes specific interventions (in this case, to monitor and mitigate pain) and should be marked "No" or "Yes", depending on the presence of

the orders, whether or not a formal pain assessment for the related issue was conducted within the assessment time frame, or conducted at all.

M2401 reports if specific interventions (in this case, to monitor and mitigate pain) were BOTH included in the physician-ordered Plan of Care AND implemented. M2401 should also be marked “No” or “Yes” based on the presence of the orders and documentation of their implementation, whether or not a formal pain assessment for the related issue was conducted within the assessment time frame, or conducted at all. “NA - Formal assessment did not indicate pain since the most recent SOC/ROC assessment” may not be selected in this case, since item guidance states that the formal assessment referred to for column d is M1240, Pain Assessment, and that since the pain assessment was conducted after completion of the comprehensive assessment (and outside the assessment time frame), M1240 should be reported as “0 – No standardized assessment conducted”, and therefore “NA” could not be reported for row d on M2401.

Q173. M2301. The patient was held in the ER suite for observation for 36 hours. Was this a hospital admission or emergent care? [Q&A EDITED 10/16; Q&A EDITED 08/07]

A173. If the patient were never admitted to the inpatient facility, this encounter would be considered emergent care. The time period that a patient can be ‘held’ without admission can vary from location to location, so the clinician will want to verify that the patient was never actually admitted to the hospital as an inpatient.

Q174. [Q&A RETIRED 09/09; Outdated]

Q175. [Q&A RECALLED 08/07]

Q176, 177, & 178. [Q&A RETIRED 09/09; Outdated]

Q178.1. [Q&A RETIRED 06/14; No longer relevant]

Q179. M2301. If a patient is admitted to an inpatient facility after initial access in the emergency room, can there be a situation in which that emergent care would NOT be reported on M2301, (i.e., patient is only briefly triaged in ER with immediate and direct admit to the hospital)? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 06/05; REVISED 01/11; Previously CMS OCCB 10/04 Q&A #11]

A179. The Item Intent in Chapter 3 of the current OASIS Guidance Manual states that responses to M2301 – Emergent Care, include the entire period at or since the most recent SOC/ROC data were collected, including current events. Any access of emergent care, regardless of how brief the encounter, should be reported on M2301 if it occurred at the time of or at any time since the most recent SOC/ROC assessment.

Q180. M2301. A patient whose Start of Care was January 9, had an emergent care visit on January 13 that did not result in hospitalization. The patient was subsequently recertified and discharged on March 17. Should the response to M2301 at Discharge be based on the last time any OASIS assessment was completed, or should it be based on the last assessment where M2301 appears? In this scenario, the item is being asked at the time of Discharge where the Recertification OASIS was the last time OASIS data was collected. Since the emergent care visit occurred before the Recertification, it would not have been identified at that time because it is not a required item. [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 06/05; REVISED 01/11; M numbers updated 09/09]

A180. The above scenario does not tell us when Recertification assessment was completed. According to the Conditions of Participation for HHA, the recertification visit should have occurred during a five-day period prior to the end of the episode, which should be March 5-9. The OASIS item M2301 Emergent Care, asks for responses to include the entire period at or since the most

recent SOC/ROC, including current events. Since the emergent care visit occurred since the SOC, and was not associated with a hospitalization the correct response to M2301 is “1- Yes, used hospital emergency department WITHOUT hospital admission”.

Q181, 181.1 & 181.2. [Q&A RETIRED 09/09; Outdated]

Q181.3. M2301. An RN completes a SOC assessment and establishes the Plan of Care. After the admission visit, subsequent care is provided by the LPN and home health aide for a period of 2 weeks, during which time the patient is seen in the ER. The physician contacts the agency to discontinue home care without an opportunity to complete a discharge assessment visit. Based on current guidance, in this case of an unexpected discharge, the discharge comprehensive assessment would be based on the last visit by a qualified clinician (which was the SOC assessment by the RN.) Since it should reflect the patient’s status on that SOC visit, should the emergent care use be captured, since it occurred after the SOC visit? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #47]

A181.3. No, in the situation described, the emergent care utilization would not be reported on the Discharge assessment.

In the case of an unexpected discharge, the agency may ask the last qualified clinician who visited the patient to complete the Discharge assessment if s/he actually assessed everything needed to complete the Discharge assessment. The OASIS responses would report the patient’s health status at that actual visit, and would not capture events or changes in patient status/function (improvements or declines) that occurred after the last visit conducted by a qualified clinician. Agencies should recognize that the practice of allowing long periods of time where the patient’s care is provided by those unable to conduct a comprehensive assessment may negatively impact the patient’s care and outcomes, and in fact, in a situation as the one described, may be the reason that the patient required emergent care.

The home health agency should carefully monitor all patients and their use of emergent care and hospital services. The home health agency may reassess patient teaching protocols to improve in this area, so that the patient advises the agency before seeking additional services.

See Category 2, Question 37 for guidance regarding other options.

Q181.3.1.M2301. In regard to CMS Q&A Cat 2 #17.1 and 17.1.1, both describe scenarios in which a SOC OASIS assessment was initiated but not completed prior to a patient being re-hospitalized. Please explain the sequence when an Initial Assessment is completed, establishing eligibility, but the patient goes to the Emergency Department with a hospital admission before the HH comprehensive assessment is completed. The patient returns home and the Comprehensive Assessment and SOC OASIS are completed within the 5-day window from the SOC date. Is a Transfer and ROC completed and if so, how is M2301 completed since it asks, “At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department”? An OASIS assessment had not been completed previously in this scenario, but the Initial Assessment did establish eligibility for a SOC date. [Q&A ADDED 10/16; Previously CMS Qtrly 07/16 Q&A #8]

A181.3.1. When within the assessment time frame, the start of care date has been established and the patient experiences a qualifying inpatient facility admission of 24 hours or longer for reasons more than diagnostic testing, the Transfer and Resumption of Care assessments would be required. In the situation where the SOC date was established, but the SOC comprehensive assessment had not been completed prior to the hospital admission, look back to the SOC date and report the use of the emergent care in M2301.

Q181.4. [Q&A RETIRED 09/09; Outdated]

Q181.5. M2310. We had a patient who attempted suicide using Coumadin. He was sent to the Emergency Room and then admitted to the hospital. When completing the Transfer OASIS data collection, we reported Response 1 - Improper medication administration, side effects, etc. as a reason for emergent care on M2310. Was Response 1 the correct answer, since it was a deliberate action chosen by the patient? [Q&A EDITED 06/14; ADDED 09/09; M number updated 09/09; Previously CMS OCCB 10/08 Q&A #11]

A181.5. The appropriate response for M2310 would be “1-Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis” whenever the patient sought emergent care as a result of improper medication administration, regardless of who (patient, caregiver, or medical staff) administered the medication improperly.

Q181.5.1. [Q&A RETIRED 06/14; Guidance in Ch. 3]

Q181.5.2. M2310. When answering M2310 (Reason for emergent care) how is the term “injury” defined in Response 2-Injury caused by fall? I understand a fractured bone is an injury, but what about ecchymosis, increased edema, neurological changes (no confirmed neurological diagnosis as far as a bleed, etc.), lacerations, abrasions, etc.? [Q&A ADDED 01/12; Previously CMS OCCB 07/11 Q&A #17]

A181.5.2. Injury means that hurt, damage or loss is sustained by the patient. The assessing clinician may use this definition and clinical judgment to determine whether or not the patient was "injured" when they fell.

Q.181.5.3.M2310. After the SOC assessment is completed, the patient fell and sustained a minor skin tear. No ER visit necessary or made, the skin tear was treated at home. A week later he was seen in the ER for an infection that developed in the wound. For M2310, Emergent Care Reason, should we select #2-Injury caused by fall, #19-Other than above reasons or #15-Wound infection or deterioration? [Q&A ADDED 04/15; Previously CMS Qtrly 07/14 Q&A #11]

A181.5.3. M2310 identifies the reasons for which the patient sought and/or received care in a hospital emergency department. Even if it is known that the skin tears that later became infected were originally caused by a fall, only report the direct reason(s) the patient sought and/or received care in the ER. If the patient was seen in the ER for the wound infection, Response #15-Wound infection or deterioration would be reported.

Q182. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

NOTE: For additional guidance related to M2401, Interventions Synopsis, see prior Q&As that combine M2250 and M2401.

Q182.1. M2401. The “NA” column of M2401 refers to use of a "formal" assessment tool". Does formal mean standardized? Is the clinician allowed to respond "Yes" (interventions on the POC and implemented) if a formal/standardized tool was not used in the assessment of b through e? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #29]

A182.1. Chapter 3 Item Intent states "The formal assessment that is referred to in the last column for rows b-e refers to the assessment defined in OASIS items for M1240 – Formal Pain Assessment, M1300 – Pressure Ulcer Assessment, M1730 – Depression Screening, and M1910 – Fall Risk Assessment." For M1240, M1730, and M1910 this means a standardized assessment. For M1300 – Pressure Ulcer Assessment, the use of a standardized, validated assessment tool is optional.

You may say "Yes" to M2401 b - e, if the specified clinical interventions were included in the physician ordered Plan of Care and implemented at the time of or at any time since the most recent SOC/ROC assessment whether or not a formal assessment was performed. However, the Response-Specific Instructions state that for Rows b-e, in order to select "NA-Not applicable", a formal assessment must have been performed as defined in the relevant OASIS items.

Q182.2. [Q&A RETIRED 06/14; Guidance in Ch. 3]

Q182.2.1. M2401. The assessing clinician completes a best practice, e.g. provides drug education, on the SOC date (M0030), but the assessment is not completed until 3 days after the SOC date (M0090 is 3 days after M0030). When the clinician completes the Discharge or Transfer, may they select "Yes"? [Q&A EDITED 10/16; Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 01/13 Q&A #15]

A182.2.1. Interventions provided on the SOC date are included when scoring M2401. This is true even if the comprehensive assessment was not completed on the SOC date. The quality episode begins on the SOC/ROC date (M0030/M0032), not the date the assessment was completed (M0090).

Q182.2.2. M2401. For situations where best practices are provided during an initial assessment visit that is conducted BEFORE the SOC date, would those clinical assessments/interventions be considered as being provided "at the time of or at any time since the most recent SOC/ROC assessment" or "within the outcome episode"? For example, in a situation of a Friday referral for a therapy only case, the RN makes a non-billable visit on a Saturday to meet the federal requirement that the initial assessment visit must occur within 48 hours of the referral. No nursing need existed and no billable service was provided, therefore Saturday was not the SOC date. The patient was a diabetic, but had no skilled nursing needs related to their diabetes, the nurse however, assessed the lower extremities for lesions, found no lesions, and verified the patient understood how to care for her feet. The PT did not assess the lower extremities for lesions and did not address the foot care education in any way before discharge. [Q&A EDITED 10/16; Q&A ADDED & EDITED 06/14; Previously CMS Qtrly 01/13 Q&A #16]

A182.2.2. None of the interventions that the nurse provided on the initial assessment visit would be considered when responding to M2401, Intervention Synopsis, even if orders existed, because the interventions were completed before the quality episode began on the SOC date.

Q182.3. M2401. Row c of M2401, Intervention Synopsis includes "referral for other treatment" as a "qualifying" intervention to report related to depression. If I obtain a referral, can I consider the intervention to be implemented when answering M2401, Intervention Synopsis, regardless of whether or not the ordered referral ever occurs? For example, I obtained an order for a psychiatric nursing evaluation for a patient who exhibited symptoms of depression, and then before the psych nurse could visit, the patient moved out of the service area. When completing the discharge assessment, how should M2401 row c be answered? [Q&A EDITED 10/16; Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #44]

A182.3. Since "referral for other treatment" is specifically listed as a qualifying intervention in item M2401, then "Yes" should be reported for the situation in which the referral is made for other treatment for depression, even if the treatment is never actually provided before the Transfer or Discharge time point. Obtaining the order for the referral is considered to be an implementation of the intervention, whether or not the order was carried out. This is only specifically stated and true for interventions related to depression (row c), not for other

treatment areas (e.g., falls prevention interventions, pressure ulcer prevention interventions, etc.)

Q182.4. M2401. If I included a physician-ordered intervention in my Plan of Care and attempted to implement it, but the patient either refused or did not need the intervention, can I report the education as being implemented in M2401 Intervention Synopsis? For example, my Plan of Care included diabetic foot care including monitoring and patient education on proper foot care. I provided the foot care, monitored the feet throughout the episode, but when evaluating the patient's knowledge base prior to educating, I discovered there was no identified need for education. [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 10/09 Q&A #45]

A182.4. If the education component of the intervention was ordered, attempted and not provided because of a documented lack of need for the education, the clinician can answer "Yes" to the Intervention Synopsis item. The intervention was implemented when the attempt to provide it was made, and the lack of need identified. This is distinctly different than stating an attempt was made to educate and the patient refused or otherwise declined to receive the needed instruction with no further attempt, in which case, the refused education should not be reported as being "implemented" on M2401.

Q182.5. M2401. If a clinician teaches Diabetic foot care, Prevention of falls, and/or pressure ulcers etc. on the discharge visit and then finds out that these were not included on the M2250 Plan of Care Synopsis, what would be the best way to answer M2401 - Intervention Synopsis? [Q&A EDITED 10/16; Q&A EDITED 04/15; ADDED 01/11; Previously CMS OCCB 07/10 Q&A #26]

A182.5. Selecting a response for M2401 Intervention Synopsis at Transfer or Discharge is not dependent on responses selected for best practice interventions at SOC/ROC for M2250 POC Synopsis. Whether or not best practice intervention(s) are included in M2250 POC Synopsis, the response for M2401 Intervention Synopsis is "No" if there are no physician orders present for these best practices during the "look back" time period at discharge. In order to answer M2401 – Intervention Synopsis "Yes", the current physician-ordered Plan of Care and other addendum orders present at the time of or at any time since the most recent SOC/ROC assessment must have included the specified best practice intervention, in addition to evidence that the intervention(s) were implemented.

Q182.6. M2401. At the time of a visit, the patient reports mild pain and the nurse observes that the patient's functioning is not limited by the mild pain. Pain management interventions on the POC are offered however the patient feels the pain is tolerable and elects no intervention at this time.

Can I select "Yes" for M2401d, Pain Interventions, because the intervention was implemented when the attempt to provide it was made and the lack of need was identified by the patient and the nurse? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 07/11 Q&A #18]

A182.6. In order to answer "Yes" for M2401d, the record review at Transfer/Discharge must reveal that at the time of or at any time since the most recent SOC/ROC assessment, there were orders to assess for pain and mitigate pain, as well as evidence that both interventions were implemented. If both interventions were not implemented, you may not answer M2401d "Yes".

If there were orders to relieve pain, e.g. prn analgesic, and record review revealed the clinician assessed pain, educated the patient regarding the pain mitigation intervention, but the patient

never had pain that required the ordered analgesic, M2401d may be answered "Yes". The education regarding the prn pain mitigation would be an implementation of the order.

Q182.7. M2401. We have orders on the Plan of Care to monitor pain and teach pain management, instruct on pharmacological and non-pharmacological approaches to pain management, types of pain, signs and symptoms of pain, and pain medications. The patient requests discharge before all the ordered pain mitigation interventions were completed. The clinical record does include documentation the pain monitoring and pain mitigation orders were implemented at or since the previous assessment.

Can we respond "Yes" to M2401 d if pain mitigation orders were implemented but not completed prior to discharge? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 10/11 Q&A #15]

A182.7. If there are multiple interventions to address a specific problem included in M2401, e.g. assess for pain each visit, instruct on non-pharmacological approaches to pain, educate regarding pain medication, etc., the assessing clinician may answer "Yes" at Transfer/Discharge if there is evidence that the required assessment component was implemented AND evidence that at least one of the pain mitigation orders were implemented.

Q182.8. M2401. If we have a foley cath patient for several cert periods, what type of orders would we need related to fall prevention, pressure ulcer prevention, etc. If we have assessed and taught the patient/caregiver in the past and they are knowledgeable then, this would not be a billable skill for nursing as there is no "knowledge deficit." Could we put a note on the 485 saying that the patient/caregiver has been assessed and is knowledgeable in the intervention whichever it is or do we have to have fall prevention/pressure ulcer prevention techniques, etc on our 485 and teach on it again? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 07/12 Q&A #9]

A182.8. M2401, Intervention Synopsis, reads "At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?" The time period under consideration is from the current Transfer or Discharge back to and including the most recent SOC/ROC assessment. If there are no orders for the applicable best practices during that time period, the answer to M2401 is "No". If there was an order but there is no evidence of implementation, the M2401 response is "No".

In order to select the M2401 Response "Yes" for long-term patients, orders for the applicable best practices must be present at the time of or at any time since the most recent SOC/ROC assessment, AND there must be evidence of implementation within the time period beginning with the most recent SOC/ROC and ending with the Transfer/Discharge. During that time period, if specific orders were present, and the clinician confirmed the patient/caregiver possessed the knowledge regarding the best practice that was taught in a prior payment episode, then upon confirmation that the patient/caregiver possessed the knowledge, the intervention may be considered implemented.

CMS does not expect an adherence rate of 100% for the process measures.

Q182.9. M2401. If an agency has an unplanned discharge and the only teaching on a process measure (such as PU prevention) is performed after the last qualified clinician's visit, can M2401 be answered as "Yes" based off that teaching? [Q&A EDITED 10/16; Q&A ADDED 06/14; Previously CMS Qtrly 04/14 Q&A #13]

A182.9. In situations of unplanned or unexpected discharges, when completing the discharge assessment, base the OASIS responses on the patient's status at the time of the visit by the last

qualified clinician. Do not include the reporting of any health status changes or service utilization that occurred after the date of the last qualified clinician's visit EXCEPT for completion of M2401 Intervention Synopsis, where the discharge OASIS can report any ordered interventions that were implemented up until the time of discharge (the M0906 date). This includes taking credit for education provided at a home visit by an LPN or therapy assistant.

Q183. M2410. A patient receiving skilled nursing care from an HHA under Medicare is periodically placed in a local hospital under a private pay arrangement for family respite. The hospital describes this bed as a purely private arrangement to house a person with no skilled services. This hospital has acute care, swing bed, and nursing care units. The unit where the patient stays is not Medicare certified. Should the agency do a transfer and resumption of care OASIS? How should the agency respond to M0100 and M2410?

[Q&A ADDED 06/05; M number updated 09/09]

A183. Yes, if the patient was admitted to an inpatient facility, the agency will need to contact the inpatient facility to verify the type of care that the patient is receiving at the inpatient facility and determine the appropriate response to M2410. If the patient is using a hospital bed, Response 1 applies; if the patient is using a nursing home bed, Response 3 applies. If the patient is using a swing-bed it is necessary to determine whether the patient was occupying a designated hospital bed (Response 1 would apply) or a nursing home bed (Response 3 would apply). The hospital utilization department should be able to advise the agency of the type of bed and services the patient utilized.

Q183.1. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q184. M2420. My patient was admitted to the hospital, and I completed the assessment information for Transfer to the Inpatient Facility. His family informed me that he will be going to a nursing home rather than returning home, so my agency will discharge him. How should I complete these items on the discharge assessment?

A184. Once the transfer information was completed for this patient, no additional OASIS data would be required. Your agency will complete a discharge summary that reports what happened to the patient for the agency clinical record; however, no discharge OASIS assessment is required in this case. The principle that applies to this situation is that the patient has not been under the care of your agency since the inpatient facility admission. Because the agency has not had responsibility for the patient, no additional assessments or OASIS data are necessary.

Q184.1. M2420. Is the dialysis center which maintains a patient's dialysis catheter considered formal assistive services? [Q&A ADDED 01/12; Previously CMS OCCB 04/11 Q&A #19]

A184.1. Formal assistive services are supportive community-based services provided through organizations or by paid helpers and do not include medical or rehabilitative services provided outside the home, e.g. outpatient therapy, physician office visits, dialysis, wound care clinic visits.

Q184.2 M2420. For M2420 Discharge Disposition, is personal care provided by the home health agency after discharge from skilled services considered Formal Assistance? [Q&A ADDED 10/16; Previously CMS Qtrly 10/15 Q&A #6]

A184.2 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.

Q185. [Q&A RETIRED 09/09; Outdated]

Q185.1. M2430. When answering M2430, Reason for Hospitalization, can I select Response 19 - Scheduled treatment or procedure, when my patient's health is deteriorating and the physician instructed us to monitor the patient's condition for 2 days and then call 911 if the patient does not improve? [Q&A ADDED 01/12; Previously CMS OCCB 04/11 Q&A #20]

A185.1. Response 19 - Scheduled treatment or procedure refers to a treatment or procedure that is scheduled in advance and is not related to an urgent or emergent condition or dependent upon an acute change in condition. Examples of a scheduled treatment or procedure include joint replacement surgery, non-emergency procedures to improve blood flow or heart function, such as angioplasty or pacemaker insertion, or cataract surgery.

The scenario you provided is not an example of a situation where the patient is being admitted for a scheduled treatment or procedure.

Q185.2.M2430. 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? [Q&A ADDED 04/15; Previously CMS Qtrly 10/14 Q&A #13]

A185.2. 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.

Q186 & 187. [Q&A RETIRED 09/09; Outdated]

Q188. M0903. Do the dates in M0903 and M0090 always need to be the same? What situations might cause them to differ? [Q&A EDITED 09/09]

A188. When a patient is discharged from the agency with goals met, the date of the assessment (M0090) and the date of the last home visit (M0903) are likely to be the same. Under three situations, however, these dates are likely to be different. These situations are: (1) transfer to an inpatient facility; (2) patient death at home; and (3) the situation of an "unexpected discharge." In these situations, the M0090 date is the date the agency learns of the event and completes the required assessment, which is not necessarily associated with a home visit. M0903 must be the date of an actual home visit. See M0100 Q&As for additional guidance on "unexpected discharges."

Q189. M0903. What constitutes a “home visit” when responding to OASIS Item M0903? Medicaid programs pay for some home health services provided outside of the home. If these patients receive all their skilled care outside the home, must OASIS data be collected and transmitted? If some of the visits are provided outside of the home should a visit provided outside the home be considered the last visit for M0903, or should M0903 be the last visit at the patient’s home? [Q&A EDITED 06/14; ADDED 06/05]

A189. The date of the last (most recent) home visit (for responding to M0903) is the last visit made to the home by agency staff, whether or not it was included on the Plan of Care. The HHA must conduct the comprehensive assessment and collect and transmit OASIS items for Medicaid patients receiving skilled care.

Q189.1. M0903. The agency had a therapy-only patient. The therapist discharged the patient on 9/15. The RN completed the discharge comprehensive assessment on 9/17 by making a non-billable visit that was not included on the POC. What is the correct response for M0903, Date of Last (Most Recent) Home Visit? [Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 01/11 Q&A #23]

A189.1. M0903 reports the last (most recent) home visit made to the patient by agency staff. In the situation above, report the last visit made by someone from your agency, 9/17, even though it was not included on the Plan of Care.

Q189.2. M0903. The patient died at home and we did the pronouncement. Is M0903, Date of Last (Most Recent) Home Visit, the date of the pronouncement or the date of the last visit by any discipline when the patient was alive? [Q&A ADDED & EDITED 01/12; Previously CMS OCCB 10/11 Q&A #17]

A189.2. M0903 reports the last (most recent) covered home visit made by agency staff. When state law allows the official pronouncement of death to be performed by a registered nurse, it is possible that the last covered home health visit would be a skilled nursing visit for purposes of pronouncing death. We also note that the need for a single skilled nursing visit would not meet the definition of intermittent skilled nursing, and therefore, if the patient’s only skilled need is for a single nursing visit to pronounce death, the patient would not be eligible for the home health benefit. However, if the patient otherwise is eligible for the home health benefit, a skilled nursing visit to pronounce death is covered under the home health benefit. If a registered nurse pronounced death for an eligible HH patient, that visit should be recorded in M0903.

This guidance represents a retraction of guidance provided in the October 2011 CMS OCCB QAs.

Q190. M0903 & M0906. When a speech therapist is the last service in a patient’s home, our agency has chosen to use an RN to complete the discharge assessment (with OASIS) as a non-billable visit. If the patient meets the speech therapist’s goals on day 50 of the episode, but we cannot schedule an RN until day 51 of the episode, how do we respond to M0903 and M0906? [Q&A ADDED 06/05]

A190. If the agency policy is to have an RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge assessment after the last visit by the SLP. This planned visit should be documented on the Plan of Care. The RN visit to conduct the discharge assessment is a non-billable visit. M0903 (Date of Last/Most Recent Home Visit) would be the date of the last visit by the agency; in this case it would be the date of the RN visit. The date for M0906 (Discharge/Transfer/Death Date) would be determined by agency policy. The date of the actual agency discharge date would be entered here. When the agency establishes its policy regarding the date of discharge, it should be noted that a date for M0906

(Discharge/Transfer/Death Date) that precedes the date in M0903 (Date of Last/Most Recent Home Visit) would result in a fatal error, preventing the assessment from being transmitted.

Q191. M0906. My patient died at home 12/01 after the last visit of 11/30. I did not learn of her death until 12/04. How do I complete M0903 and M0906? What about M0090? [Q&A EDITED 08/07]

A191. You will complete an agency discharge for the reason of death at home (RFA 8 for M0100). M0090 would be 12/04 -- the date you learned of her death and completed the assessment. M0903 (date of last home visit) would be 11/30, and M0906 (death date) would be 12/01.

Q191.1. M0906. 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? [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #36]

A191.1. 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.