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

April 8, 2014

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

Dear Ms. Krulish:

Thank you for your letter of April 1, 2014 in which you requested review of a number of questions and scenarios related to data collection and accurate scoring of Outcome and Assessment Information Set (OASIS) items. The accompanying questions and answers have been reviewed by CMS staff, selected content experts and contractors, and consensus on the responses has been achieved.

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

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

Sincerely,

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

cc: Caroline D. Gallaher, JD, BSN, RN
Centers for Clinical Standards & Quality
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April 2014 CMS Quarterly Q&As

Category 2

Question 1. An initial assessment with skilled service Start of Care (SOC) was performed on 1/24/14 (the SOC comprehensive assessment with OASIS was begun, but not completed). Later in the day, the patient was admitted to the hospital and returned home on 1/26. The comprehensive assessment with OASIS data collection was completed on 1/26, within the 5 day window. Since the comprehensive assessment was completed after the hospital admission, we did not do a Transfer or ROC. Was this correct?

Answer 1. In order to bill for the 1/24 visit, the SOC assessment should be completed within 5 days after the SOC date, and the Transfer and Resumption of Care assessments (ROC) should be completed within 2 days after knowledge of a qualifying stay in the inpatient facility.

At SOC, you may take up to 5 days after the SOC date to complete the SOC comprehensive assessment, noting that it must be completed by one clinician. In your case, the initial assessment visit was made, a billable service was provided establishing the SOC and the SOC comprehensive assessment was begun but not completed before the qualifying stay in the inpatient facility. When the patient returned to your care on 1/26 which was within the allowed 5 day assessment time frame, the same assessing clinician could complete the SOC comprehensive assessment that was begun on the first visit, updating previously completed items as necessary and completing the rest of the items. M0030, Start of Care Date, remains the date of the first billable visit. M0090, Date Assessment Completed, is the actual date the single clinician completed the assessment. If the original assessing clinician could not complete the SOC comprehensive assessment that he/she began on the first visit, another qualified clinician would have to visit and complete a new SOC comprehensive assessment from beginning to end, within 5 days after the SOC date. Unless it had already been completed by someone else, the clinician who completes the SOC assessment on 1/26 may also complete the RFA 6-Transfer. The ROC assessment must be completed with 2 calendar days of the patient's inpatient facility discharge, and may also be completed on the 1/26 visit, by the same clinician who completes the SOC assessment and the OASIS Transfer data collection.

Question 2. In regards to gathering information through record review, the CMS Category 2 Q&A #15.3 states "Another individual with the qualifications necessary to gather the information may perform a record review and communicate the findings to the assessing clinician, who would be responsible for confirming and validating that non-assessment information is accurate." Does the "another individual" refer only to an RN, PT, OT or SLP or does an LPN qualify?

Answer 2. No, an LPN would not be qualified to collect the information. The individual must be qualified to complete a comprehensive assessment (RN, PT, OT, or SLP).

Category 3

Question 3. The patient had a qualifying stay in an inpatient facility, but the Transfer OASIS and the ROC assessments were not done when the RN made a routine visit following the patient's discharge home. The patient has since been recertified and continues as a current patient. How do we proceed?

Answer 3. When the agency becomes aware of a qualifying stay in an inpatient facility, a Transfer OASIS and Resumption of Care (ROC) assessment must be completed within 2 days of gaining the knowledge. In your situation, assuming the Recertification assessment had been performed during the last five days of the prior certification period, the agency would still need to complete a Transfer and send a qualified clinician to the home to perform the missing ROC assessment. You will receive a notice that the assessments have been submitted out of sequence.

Category 4a

Question 4. I am struggling to understand the precise intent of the January 2014 Q&A addressing the use of photographs and video streaming as part of the assessment. Why can't a less experienced nurse who is learning seek assistance from the WOCN in the office to confirm her/his assessment findings by viewing a photograph or video streaming? The nurse making the home visit conducted the assessment and just wanted confirmation of her/his findings before calling the physician. How does this violate the one clinician rule?

Answer 4. 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.

Category 4b

M0102; M0104

Question 5. 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?

Answer 5. The OASIS-C 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.

M1010; M1016

Question 6. Is it appropriate to code only a manifestation diagnosis in M1010, Inpatient Diagnoses and/or M1016, 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-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.

Answer 6. Follow ICD-CM coding rules and list both the etiology and manifestation diagnoses and codes.

M1040

Question 7. When completing M1040, 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?

Answer 7. 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 M1040, Influenza Vaccine, would be "NA" as the patient was transferred (M0906) on September 30th.

M1200

Question 8. 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".

Answer 8. 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.

M1306-M1322

Question 9. 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. There is no written history on the referral of a previous pressure ulcer. After contacting the physician, the RN still does not have a definitive answer on what stage the pressure ulcer was at its worst. How would this pressure ulcer be documented in M1308, Current Number of Unhealed Pressure Ulcers at Each Stage?

Answer 9. If the assessing clinician becomes aware that the patient had a full-thickness (Stage III or IV) pressure ulcer in the past that is now closed, but is unable to determine the stage at its worst, it should be reported in the OASIS pressure ulcer items as a Stage III. Although the assessing clinician can report the observed, closed ulcer on the OASIS without physician confirmation, collaboration with the physician would be required in order to receive related orders and/or provide physician-ordered care related to the pressure ulcer.

M2010

Question 10. 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.

Answer 10. The OASIS-C 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".

M2100

Question 11. Are vital signs, blood glucose or blood pressure considered a "procedure" when scoring M2100, Row d?

Answer 11. Measurement of vital signs and blood glucose are considered medical procedures.

M2250d and M2400c

Question 12. 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”?

Answer 12. 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 M2400, 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 M2400c.

M2400

Question 13. 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 M2400 be answered as "Yes" based off that teaching?

Answer 13. 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 M2400 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.