July 2023 CMS Quarterly OASIS Q&As

Category 2

Question 1: **We understand that OASIS is not required to be collected when a patient receives only one visit in a quality episode. If a SOC OASIS is completed (to facilitate billing for the single visit), should we also complete a discharge OASIS?**

Answer 1: Based on CMS policy, OASIS data collection and submission is not required when only one visit is made in a single visit quality episode. In some single visit quality episodes, a SOC OASIS (RFA-1) may be required for billing. Whenever there is a single visit in a quality episode a discharge OASIS (RFA-9) **should not** be collected or submitted. This refined instruction supersedes previously published guidance in Chapter 3 of the OASIS-E Guidance Manual, eff. January 1st, 2023, and Q46 in Category 2 of the CMS OASIS Q&As last edited 05/22 that simply stated that the discharge OASIS is not required/mandated in the situation of a single visit quality episode.

Question 2: We have a situation where a clinician has left the agency and there are several OASIS assessments that our QA department had questions on, regarding the OASIS codes that were selected by the assessing clinician. Since the clinician is no longer available to provide their input how should the identified discrepancies be handled? Can the OASIS reviewer change the codes even if the assessing clinician cannot give their approval?

Answer 2: When a **potential inconsistency** is identified within the assessment timeframe and the assessing clinician is not available to approve the suggested edits then the original OASIS responses selected by the assessing clinician on the completed OASIS would be submitted.

If an error is discovered upon review by a supervisor or other auditing staff and it can be validated that it is a **true error** and not just a discrepancy (a difference between two data items without knowledge of which data item is correct), that error should be corrected following the agency's correction policy and established professional medical record documentation standards. When the original assessing clinician is not available to correct the true error, the clinical supervisor or quality staff may make the correction of the validated error following the agency's correction policy. The supervisor may document why the original assessing clinician is not available to make the correction and how the error was identified and validated as an error.

Please note that the comprehensive assessment, including OASIS, is a legal document and when signed by a clinician, the signature is an attestation that all information contained in the document is truthful and accurate.

Question 3: With the ending of the COVID-19 Public Health Emergency, what is being used to determine when the OASIS assessment completion and transmission waivers have ended? Is it based on the M0090 - Date Assessment Completed or the M0030 - Start of Care Date?

Answer 3: The temporary guidance waivers were effective through the end of the COVID-19 Public Health Emergency (PHE) declaration. As the end of the PHE was determined to be 11:59 pm May 11, 2023, these waivers expired with that date.

For the extension of the five-day completion requirement for the comprehensive assessment waiver at SOC, this would be based on the M0030 - Start of Care (SOC) Date. For example, if the M0030 - SOC Date is on or before 5/11/23, the five-day extension waiver is in effect. However, If the M0030 - SOC Date is on or after 5/12/23, the five-day extension waiver has expired.

Regarding the waiving of the 30-day OASIS submission requirement, this would be based on the M0090 - Date Assessment Completed. For example, if an assessment's M0090 date is on or before 5/11/23, the 30-day submission requirement for that assessment would be waived. If an assessment's M0090 date is on or after 5/12/23, the 30-day submission requirement is in effect.

Category 4b

C1310

Question 4: How should C1310 - Signs and Symptoms of Delirium (from CAM ©) be coded when a patient is comatose at baseline and at the time of assessment?

Answer 4: If the patient was comatose at baseline and at the time of assessment, code the items as follows:

C1310A - Acute Onset of Mental Status Changes as Code 0 - No
C1310B - Inattention as Code 1 - Behavior continuously present, does not fluctuate.
C1310C - Disorganized Thinking as Code 0 - Behavior not present.
C1310D - Altered level of consciousness as Code 1 - Behavior continuously present, does not fluctuate.

C1310 - Signs and Symptoms of Delirium (from CAM ©) identifies any signs or symptoms of acute mental status changes as compared to the patient's baseline status and if there are any signs or symptoms of delirium present at the time of assessment.

K0520

Question 5: If a patient has an order to be NPO in anticipation of a procedure/surgery is this considered either a mechanically altered diet or a therapeutic diet when coding K0520 - Nutritional Approaches?

Answer 5: No. The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge.

NPO related to a procedure/surgery is not considered a nutritional approach for the purposes of coding K0520C - Nutritional Approaches; Mechanically altered diet and/or K0520D - Nutritional Approaches; Therapeutic diet.

M1000

Question 6: If a patient has been receiving care in their home under a Hospital at Home program, and is then referred to Home Health within 14 days of discharge from the program, how should M1000 - Inpatient Facility be coded?

Answer 6: The intent of M1000 - Inpatient Facilities is to identify whether the patient has been discharged from an inpatient facility within the 14 days immediately preceding the Start of Care/Resumption of Care date.

In an instance where a patient is receiving care in their home under a Hospital at Home program, they are considered to be in an inpatient facility. This is because the services being provided are being delivered under the coordination of an acute care hospital.

If the patient's discharge from the Hospital at Home program is within the past 14 days, then for M1000, response 3 - Short-stay acute hospital (IPPS) should be checked.

M1600

Question 7: When coding M1600 - Has this patient been treated for a Urinary Tract Infection in the past 14 days? as 1 - Yes, does there also need to be a specific ICD-10 code added to the OASIS? The EMR that our agency uses provides a warning when we code 1 - Yes but there isn't a specific code identifying the UTI entered into the software system.

Answer 7: M1600 - Has this patient been treated for a Urinary Tract Infection in the past 14 days?, identifies treatment of a suspected or confirmed urinary tract infection during the past 14 days.

The OASIS guidance does not speak to requiring a specific, or any, ICD-10-CM diagnosis code(s) that would reflect the presence of or treatment for a UTI.

Questions related to vendor products or services should be addressed directly with your vendor.