April 2020 CMS Quarterly OASIS Q&As

Category 2

QUESTION 1: An in-person discharge visit is not always possible (e.g., patient moves out of the area or refuses a discharge visit). When is a "non-visit" discharge comprehensive assessment with OASIS allowed?

ANSWER 1: There is no OASIS guidance that allows for a "non-visit" discharge comprehensive assessment with OASIS. The OASIS Manual coding instructions for M0100 - Reason for Assessment, Response 9 - Discharge state: "This comprehensive assessment is conducted when a patient is discharged from the agency for any reason other than transfer to an inpatient facility or death at home. A patient visit is required to complete this assessment." The discharge comprehensive assessment with OASIS requires an in-person patient encounter and assessment from a qualified clinician per the Medicare Home Health Conditions of Participation (CoP §484.55).

For details on how to complete a discharge assessment in the case of an unplanned/unexpected discharge, see additional guidance in the Home Health July 2018 CMS Quarterly OASIS Q&As, Cat. 2, Q2 (https://qtso.cms.gov/providers/home-health-agency-hha-providers/reference-manuals).

Category 3

QUESTION 2: With PDGM, if a patient needs to have a recertification completed, but it is beyond the 60-day certification period, should we discharge the patient or complete a late recertification?

ANSWER 2: When an agency does not complete a recertification assessment within the required 5-day window at the end of the certification period, the agency should not discharge and readmit the patient. Rather, the agency should send a clinician to perform the recertification assessment as soon as the oversight is identified.

For the Medicare PDGM patient, payment implications may arise from this missed assessment. Any payment implications may be discussed with the agency's Medicare Administrative Coordinator (MAC).

Category 4b

M0100

Note: This Q&A supersedes October 2019 CMS Quarterly Q&A #6.

QUESTION 3: **Per the 2019 Home Health Final Rule and the proposed rule for 2020, it appears that CMS expects HHAs to discharge a patient if the patient requires post-acute care from a SNF, IRF, LTCH or care in an inpatient psychiatric facility (IPF). The HHA could then readmit the patient, if necessary, after discharge from such setting. This goes against the common current practice of completing a transfer and then ROC for patients transferred to any inpatient setting, unless they are not expected to need further home care.**

Should we still complete M0100 RFA 6 Transferred to an inpatient facility – patient not discharged from agency when a patient is transferred into any inpatient setting and we expect to receive this patient back after their inpatient stay and RFA 7 Transferred to an inpatient facility- patient discharged from agency when we do not expect to receive the patient back after the inpatient stay? Should we still complete a M0100 RFA 3 (ROC) when a patient is discharged from any inpatient facility while still under the services of the agency?

ANSWER 3: There is no change in the OASIS guidance in how agencies may use M0100 RFA 6 and 7 when a home health patient is admitted for an inpatient stay. In the event that a patient had a qualifying hospital admission and was expected to return to your agency, you would complete RFA 6 – Transferred to an inpatient facility – not discharged from agency. If the patient was not expected to return to your agency after this inpatient hospital stay, you would compete RFA 7- Transfer to an inpatient facility- patient discharged from agency.

However, if the patient requires post-acute care in a SNF, IRF, LTCH or IPF during the 30-day period of home health care, CMS expects and recommends (but does not require) the home health agency to discharge the patient by completing the RFA-7 (Transfer to an inpatient facility-patient discharged from agency) and then to readmit the patient with a new Start of Care upon return to home care. If the home health agency decides to complete an RFA-6 (Transfer to an inpatient facility- patient not discharged from agency), the home health agency will need to complete an RFA-3 (Resumption of Care) upon return to home care.

QUESTION 4: For PDGM, if a patient requires post-acute care, does inpatient rehabilitation facility (IRF) include an inpatient rehabilitation hospital or designated rehab unit? Does inpatient psychiatric facility (IPF) include a psychiatric hospital or unit?

ANSWER 4: An inpatient rehabilitation facility or unit (IRF) means a freestanding rehab hospital or a rehabilitation bed in a rehabilitation distinct part unit of a general acute care hospital. An inpatient psychiatric facility (IPF) means a psychiatric hospital or unit.

QUESTION 5: When a patient transfers to a short stay acute care hospital and we do a transfer without discharge (RFA 6), then we later discover that the patient has subsequently transferred to a SNF or IRF, etc., and we now discharge the patient, do we correct the transfer OASIS previously submitted to indicate it was a transfer with discharge (RFA 7)?

ANSWER 5: There is no need to update or change the RFA 6 transfer OASIS to an RFA 7 transfer OASIS to reflect this discharge.

GG0130E

QUESTION 6: A patient agreed to shower during an OT visit within the SOC assessment timeframe but would not let the OT provide any needed assistance during the bathing process. The only tasks the patient completed were wetting her body and washing her abdomen. She declined to have the therapist assist to complete the remaining bathing tasks. How would GG0130E – Shower/bathe self be coded?

ANSWER 6: The intent of GG0130E - Shower/bathe self, is to assess the patient's ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair) and does not include transferring in/out of tub/shower.

If the patient only performs a partial bath and does not have a complete bath during the entire assessment timeframe, use clinical judgment to determine if the situation allows the clinician to adequately assess the patient's ability to complete the activity of bathing self (GG0130E). If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires.

GG0130G

QUESTION 7: For GG0130G - Lower body dressing, if a patient is wearing a dressing gown and underwear during the first assessment, is this scenario acceptable to code lower body dressing? Or, at a visit the following day within the assessment timeframe, if the patient is wearing more items including underwear and shorts/pants, should we use this later scenario instead as a true baseline of their lower body dressing ability?

ANSWER 7: The intent of GG0130G - Lower body dressing is to assess the patient's ability to dress and undress below the waist, including fasteners, if applicable, in clothing routinely worn by the patient. At admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your agency staff.

Clinicians should use clinical judgment to determine if observing the patient dress and undress in the lower body clothing (i.e. underwear) worn during the first assessment allows the clinician to

adequately determine the patient's ability to complete the activity of lower body dressing (GG0130G) in clothing routinely worn by the patient. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires.

GG0130H

QUESTION 8: As the definition of "footwear" states that it "includes the ability to put on and take off socks and shoes", how should GG0130H - Putting on/taking off footwear be coded when only one of these items is present?

ANSWER 8: The intent of GG0130H - Putting on/taking off footwear is to assess a patient's ability to put on and take off socks and shoes or other footwear.

GG0130H - Putting on/taking off footwear is assessed with footwear that is appropriate for safe transfer and/or ambulation (mobility). If the patient wears footwear that is safe for mobility (e.g., grip socks), then GG0130H - Putting on/taking off footwear, may be coded. If the patient's socks are not considered safe for mobility, and the patient does not have shoes available, and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities, then code using the appropriate "activity not attempted" code.

If the patient wears shoes that are safe for mobility, but does not wear socks, then GG0130H - Putting on/taking off footwear, may be coded.

GG0130, GG0170

QUESTION 9: The OASIS Guidance Manual for section GG clarifies that Code 03- Partial/moderate assistance indicates the helper is providing less than half the effort and Code 02 – Substantial/maximal assistance indicates the helper is providing more than half the effort. If a helper provides exactly half the effort, how would the item be coded?

ANSWER 9: In the situation you describe, the helper and patient each are providing exactly half of the effort to complete a GG activity. If the patient performs exactly half of the effort, code the item 03 - Partial/moderate assistance.

QUESTION 10: For the GG functional items, I understand that verbal cueing during an activity would be coded a 04 – Supervision or touching assistance. Can a verbal cue provided prior to the initiation of the task be considered as 05 – Setup or clean-up assistance, as long as no further cues were provided during the actual activity? For example, prior to the "Picking up an item from the floor" activity, the therapist needed to cue the patient on where to place their hand for stability; then the patient completed all of the activity safely and without any assistance or additional cues. Would this be 05 - Setup or 04 - Supervision? Additionally, the OASIS Guidance Manual indicates via an example for bed to chair transfers, that "locking chair brakes" prior to the transfer is 05 – Setup, as long as no further assistance was required during the activity. Could a verbal cue reminding a patient to lock wheelchair brakes prior to the

initiation of the transfer be considered 05 - Setup as well, as long as no further cueing or touching was provided during the activity?

ANSWER 10: When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as he/she is safe. At admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity prior to benefit of services provided by your agency staff. This may be achieved by having the patient attempt the activity prior to providing any instruction that could result in a more independent code, and then coding based on the type and amount of assistance that was required prior to the benefit of services provided by your agency staff.

Communicating the activity request (e.g., "Can you stand up from the toilet?") would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity (e.g., "Push down on the grab bar", etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual

In the scenarios described, assuming the verbal cues were only required prior to the activity, were provided prior to the benefit of services, and no other assistance was needed in order for the patient to complete the activity safely, then the verbal cues fit the definition for 05 – Setup or clean-up assistance.

QUESTION 11: Can goals be changed for the GG Self-Care (GG0130) and Mobility (GG0170) items after the admission assessment timeframe?

ANSWER 11: The GG Self-Care and Mobility Discharge Goals are used in the calculation of the Process measure – *Percentage of Patients with an Admission and Discharge Function Assessment and a Care Plan that Addresses Function*. The measure reports, in part, that discharge goals were established, and does not take into consideration whether or not the goals were met.
Once a goal is established, there is no need to update it on OASIS if circumstances change or additional information becomes available either within or after the SOC/ROC assessment timeframe.

GG0170G

QUESTION 12: At discharge, if I assess my patient getting into their car to go to a doctor's appointment, can I code GG0170G - Car Transfer, OR do I have to observe the patient getting both into and out of a car to code this item?

ANSWER 12: The intent of GG0170G - Car Transfer is to assess the patient's ability to transfer in and out of a car seat on the passenger side.

Code the patient's functional status based on a functional assessment that occurs at discharge. At discharge, the self-care and mobility function scores are to reflect the patient's discharge

status, and are to be based on observation of activities, to the extent possible. The assessing clinician may combine general observation, assessment of similar activities, patient/caregiver(s) report, collaboration with other agency staff, and other relevant strategies to complete any and all GG items, as needed. Clinicians should use clinical judgment to determine if the situation (getting in the car) allows the clinician to adequately assess the patient's ability to complete the entire GG0170G – Car Transfer activity (transferring **in** and **out** of a car). If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires.

QUESTION 13: For GG0170G - Car Transfer, can the patient be assessed transferring in and out of a Sport Utility Vehicle (SUV)?

ANSWER 13: The intent of the GG0170G - Car Transfer is to assess the patient's ability to transfer in and out of a car or van seat on the passenger side.

Any vehicle model available may be used for the assessment. In the scenario presented, if in the clinician's professional judgment, the patient can transfer in/out of an SUV safely, code based on the type and amount of assistance required to complete the activity.

GG0170I

QUESTION 14: I have a question regarding the guidance in Q15 of the January 2020 OASIS Quarterly Q&As. In the answer, it states "The walking activities cannot be completed without some level of patient participation. A helper cannot entirely complete a walking activity for a patient". The example given was someone carrying a patient 10 feet. How would you code a situation where the patient walks part of the distance, possibly 4 feet, and then the helper carries them the remaining distance to get to the 10-feet needed for GG0170I - Walk 10 feet? Would this be coded "02 - Substantial / maximal assistance" because the helper is carrying the patient the majority of the distance? I know with the GG wheelchair items that a helper can complete the distance needed by pushing the patient in the wheelchair, but I am seeking clarification for the walking items.

ANSWER 14: The intent of the walking item GG0170I - Walk 10 feet is to assess the type and amount of assistance a patient requires to ambulate 10 feet once in a standing position. Since a helper cannot complete a walking activity for a patient, the walking activities cannot be considered completed without some level of patient participation that allows the patient to ambulate for the entire stated distance. In your scenario where the patient participates in walking 4 feet and then requires the helper to carry them for further distances, the activity GG0170I - Walk 10 feet is not considered completed. If the stated distance of 10 feet is not able to be walked by the patient, with or without some level of assistance, GG0170I would be coded with one of the "activity not attempted" codes. Each OASIS item should be considered individually and coded based on the guidance provided for that item.

GG0170Q

QUESTION 15: According to the guidance manual, the intent of GG0170Q – Does the patient use wheelchair and/or scooter is to assess the ability of patients who SELF-mobilize with a wheelchair/scooter or those who are learning to SELF-mobilize. The answer from the January 2020 Quarterly Q&As makes it sound like the item's intent is to code based on whether or not the patient is using a wheelchair or scooter at all, regardless if they self-mobilize. Please clarify.

ANSWER 15: At times, CMS provides new or refined instruction that supersedes previously published guidance. In such cases, use the most recent guidance. The January 2020 Quarterly OASIS Q&As represent more recent OASIS guidance than the OASIS Guidance Manual dated January 2, 2019, therefore, utilize the more recent guidance presented in January 2020, Question #20. Only code GG0170Q - Does the patient use a wheelchair and/or scooter? as "0 – No" if at the time of the assessment the patient does not use a wheelchair or scooter under any condition.