



April 2021 CMS Quarterly OASIS Q&As

Category 2

(This serves as an updated reply to October 2020 CMS Quarterly OASIS Q&A Question 4)

Question 1: With the CARES Act, physician assistants, nurse practitioners, and clinical nurse specialists are now allowed to certify a patient’s need and eligibility for home health services. Is this update permanent? Even after the Public Health Emergency (PHE) ends will these practitioners be allowed to order home care services?

Answer 1: Yes, even after the COVID-19 PHE ends, per the Coronavirus Aid, Relief, and Economic Security Act or the CARES Act (Public Law 116-136), nurse practitioners, physician assistants and clinical nurse specialists are allowed, where not prohibited by State Law, to certify their patient’s need and eligibility and provide orders for home health services.

Category 4b

M1060

Question 2: If a patient’s height was not measured within the Start of Care (SOC) assessment timeframe for M1060a - Height is it okay to use a height that was measured on day 6?

Answer 2: To be compliant the SOC/ROC assessment must be completed by the end of the assessment timeframe. If a patient’s height cannot be measured during the assessment timeframe, and no agency-obtained height from a documented visit conducted within the previous 30-day window is available, enter a dash (-) to indicate “no information” for M1060a - Height. CMS expects dash use to be a rare occurrence.

M1600

Question 3: Is M1600 - Has this patient been treated for a Urinary Tract Infection in the past 14 days, only coded as “1-yes” when the patient is being treated for a confirmed Urinary Tract Infection (UTI)?

In the OASIS Guidance Manual, the Response Specific Instructions for M1600 state to “Enter Response 1 – Yes, when the patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed or suspected UTI.”

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However, CMS OASIS Q&A Category 4b, Q116.6 states: “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).”

Should we be coding M1600 as response “1-Yes” for a confirmed or suspected UTI as stated in the guidance in the OASIS Guidance Manual, or just when the UTI diagnosis is confirmed per Q116.6?

Answer 3: M1600 - Urinary Tract Infection reports if the patient has been treated for a urinary tract infection (UTI) in the past 14 days.

As instructed in the Guidance Manual, enter response “1 – Yes,” when the patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed or suspected UTI.

At times, CMS provides new or refined instruction that supersedes previously published guidance.

GG0130C

Question 4: If a patient does not need to void and/or have a bowel movement during the day of assessment, should an “activity not attempted” code be used for GG0130C - Toileting Hygiene?

Answer 4: The intent of GG0130C - Toileting Hygiene is to assess and code the level of assistance required to complete perineal hygiene and clothing management (including undergarments and incontinence briefs) before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening of the ostomy or colostomy bag but not managing equipment.

The toileting hygiene activity can be assessed and coded regardless of the patient’s need to void or have a bowel movement at the time of the assessment.

If the patient does not void or have a bowel movement on the day of assessment, assess the patient’s toileting hygiene performance based on direct observation of patient function, assessment of ability to complete similar activities, patient/caregiver report or collaboration with other agency staff.

Use clinical judgment to determine if the information gathered allows the clinician to adequately assess the patient’s ability to complete the activity of toileting hygiene. If the clinician determines that the information from observation and report is adequate, code based on the type and amount of assistance the patient required to complete the activity.

Use of an “activity not attempted” code should occur only after determining that the activity is not completed, and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities.

GG0170G

Question 5: Can you code GG0170G - Car Transfer with a performance code if the patient transfers into the back seat or into a long sitting position because of medical restrictions?

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Answer 5: The intent of GG0170G - Car Transfer is to assess the patient's ability to transfer in and out of a car or van on the passenger side.

Clinical judgment may be used to determine if a transfer in and out of the back seat is an acceptable alternative to meet the intention of this activity. The car transfer could still be completed while accommodating medical restrictions, such as long sitting.

GG0170I, GG0170J, GG0170K, GG0170L

Question 6: If we have a patient that requires a therapist to provide steadying assistance/contact guard assist and manage an oxygen tank while the patient is ambulating how would the GG0170 walking activities be coded?

Answer 6: The intent of the GG0170 walking items is to assess the patient's ability, once standing, to safely walk the stated distances and circumstances in each item.

If the helper is required to manage the oxygen tank and/or oxygen tubing and/or provide steadying assistance/contact guard, to allow the patient to complete an activity safely, code 04 - Supervision or touching assistance.

GG0170I

Question 7: During the SOC, the PT initiates treatment by providing a new walker, instructing in its use, and offering cues for proper technique. The patient then walked 10 feet with moderate assistance. How should GG0170I - Walking 10 feet be coded? Would it be with an "activity not attempted code" or would it be coded based on the patient's ability after the PT provided the walker and instruction?

Answer 7: At SOC/ROC, the GG0130 and GG0170 Self-Care and Mobility performance codes are to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your agency staff.

The patient may be assessed based on the first use of an assistive device or equipment that has not been previously used. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely, and code based on the type and amount of assistance required, prior to the benefit of services provided by your agency staff. "Prior to the benefit of services" means prior to provision of any care by your agency staff that would result in more independent coding.

Introducing a new device should not automatically be considered as "providing a service."

Whether a device used during the clinical assessment is new to the patient or not, code based on the type and amount of assistance that is required for the patient to complete the activity prior to the benefit of services provided by your agency staff.

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Communicating an activity request (“Can you walk to the door?”) would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity (“Stay closer to your walker,” etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/GG-Self-Care-and-Mobility-Activities-Decision-Tree.pdf>).

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