



July 2019 CMS Quarterly OASIS Q&As

Category 2

QUESTION 1: We were billing a commercial pay source and then the business office discovered mid-episode that the patient qualified for Medicare eight months ago. The clinician providing the care no longer works at our agency and there are no other clinicians that saw the patient, with the exception of one clinician several months prior. How would we complete the OASIS in this situation? Would we need a SOC and Discharge OASIS?

ANSWER 1: The SOC and Discharge comprehensive assessments are based on an in-person patient encounter and assessment from a qualified clinician (which may include collaboration) per the Medicare CoP 484.55 Comprehensive assessment. If the qualified clinician that no longer works for the agency was the only qualified clinician to see the patient since the patient qualified for Medicare, it may not be possible to complete a SOC or Discharge comprehensive assessment.

In addition to OASIS completion, other regulatory and payer requirements may be affected by a payer source change.

- Questions related to home health regulations and compliance may be sent to the Home Health Survey Mailbox at hasurveyprotocols@cms.hhs.gov
- Questions regarding general information about the Home Health Prospective Payment System (HH PPS) may be sent to: HomeHealthPolicy@cms.hhs.gov

QUESTION 2: We had a patient who was readmitted back to the hospital. She was discharged back home on 5/12/19 and her certification period ended on 5/14/19. The patient refused to have the agency come into the home during this time to do a resumption/recertification. We plan to go out today 5/15 or tomorrow 5/16, depending on what the patient will allow. Should we do a resumption/recertification or a new SOC?

ANSWER 2: Regulations require a ROC visit within 48 hours of the discharge from the inpatient facility or on the physician-order ROC date. In the situation described, since the timeframe to complete the Resumption of Care overlaps with the timeframe to complete the Recertification, the ROC assessment should be completed, fulfilling both the ROC and Recert requirements. In the scenario provided, since a visit did not occur within the ROC/recert timeframe, the ROC/recert assessment should be completed as soon after this period as possible. Obviously, this situation should be avoided, as it does demonstrate non-compliance with the

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comprehensive assessment update standard (of the Conditions of Participation). For the Medicare PPS patient, payment implications may arise from this missed assessment. Any payment implications must be discussed with the agency's Medicare Administrative Coordinator (MAC).

QUESTION 3: Can you please guide on how the General OASIS Convention that “the time period under consideration includes the 24 hours immediately preceding the visit, plus the time in the home for the comprehensive assessment” works with using collaboration within the assessment timeframe?

ANSWER 3: When collaboration is used, other agency staff may provide information to the assessing clinician on what he/she assessed during a visit conducted during the **assessment timeframe**. Each person collaborating may provide information that was collected utilizing the existing conventions, including the “day of assessment.” For example, if desired, the PT who visited on Wednesday may provide information that was relevant to the PT’s “day of assessment” (the 24 hours that preceded the PT’s visit, and the time the PT was in the home) to the RN for consideration when coding the SOC/ROC assessment items.

Category 4a

QUESTION 4: In the OASIS-D1 Update Memorandum-(revised) found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-D1-Update-Memorandum_Revised_May-2019.pdf, it states “Data collection at certain time points for 23 existing OASIS items is optional. HHAs may enter an equal sign (=) for these items, at the specified time points only. This is a new valid response for these items, at these time points; the items themselves are unchanged”. Can you please clarify on two points?

- 1. What does the new valid response of an equal (=) sign mean? (definition/intent)**
- 2. Since there will be this new valid response to acknowledge data collection is optional for certain OASIS items at certain time points, does this mean leaving an optional OASIS item (at the certain time point the item is optional) blank is not a valid response?**

ANSWER 4: 1. The new valid response of an equal sign is optional for certain OASIS items at specified time points. By coding an item with an equal sign, HHAs are indicating that they are treating the allowed item as optional and have chosen not to report on the item.
2. When a clinician/agency chooses not to report on an optional item, the only valid response is an equal sign. An equal sign and a blank are not the same.

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QUESTION 5: In OASIS-D1, there are a number of items that are no longer required for RFA 4 and 5. The OASIS submission specifications state that these items can be answered with an equal sign for those RFAs once OASIS-D1 goes into effect. Can our software vendor remove these from these timepoints? Is there an expectation that these items will be required on RFAs 4 and 5 at some point in the future?

ANSWER 5: In the CY 2019 Home Health Prospective Payment System (HH PPS) final rule, CMS finalized proposals changing data collection from required to optional for 23 OASIS Items at certain collection time points. For these items, Home Health Agencies (HHAs) could instead enter an equal (=) sign for assessments with a M0090 date on or after January 1, 2020. Data collection was made optional for these Items as they were no longer needed for the purposes of payment or for the Home Health Quality Reporting Program (HH QRP). The rationale for the adoption of an “=” sign was to reduce burden on providers where possible. Due to the timelines associated with implementing changes to OASIS, CMS was unable to remove the optional items from the assessment instrument by CY 2020, which is why HHAs were instead permitted to enter an equal sign. Vendors must retain the optional items within the assessments at the required timepoints. However, CMS wishes to clarify that as the collection is optional, vendors are permitted to “hard code” these items at these timepoints with an equal sign, including having these optional items pre-filled with the equal sign for all client agencies. Vendors may want to discuss with the agencies that they service and decide based upon customer feedback whether to hard code the “=” sign or continue to report the data until January 1, 2021. As indicated above, CMS was unable to remove from the 2020 OASIS because of the timelines associated with implementing OASIS changes and have no plans to reinstate a requirement to submit this data in future version of OASIS. Additional information on the OASIS Update for CY 2020 including the optional items can be found in the OASIS-D1 Update Memorandum Revised May 2019 posted on the CMS OASIS User Manual web page at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-D1-Update-Memorandum_Revised_May-2019.pdf

Category 4b

M1306, M1311

QUESTION 6: A patient was admitted to services with a known pressure ulcer present on their coccyx, but they would not let us assess the pressure ulcer within the assessment timeframe. The referral documentation from the inpatient facility records the ulcer as a stage 2 on day of facility discharge, which was 2 days prior to the home health admission. Per the OASIS Guidance Manual for M1306 and M1311, the data sources/resources state the

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following sources can be used: patient/caregiver interview, observation, physical assessment, referral documentation, and physician.

Does this mean the information contained in the referral documentation from the inpatient facility may be used to record the stage of a pressure ulcer when a patient refuses to allow the assessing clinician to see it?

ANSWER 6: Responses to items documenting a patient's current status should be based on observation of the patient's condition and ability at the time of the assessment without referring back to prior assessments or documentation of status from a prior care setting.

In your scenario, the first skin assessment could not be completed within the assessment timeframe. The pressure ulcer items at SOC/ROC require a response and cannot be dashed, and no response code is available to indicate that the wound was not assessed. M0090 - Date Assessment Completed reports the date the last information is obtained to complete the comprehensive assessment, even if the agency completes the assessment late, after the required assessment time frame.

QUESTION 7: What if a patient allowed a partial skin assessment on Day 1 (e.g., didn't allow the admitting nurse to look at the buttocks) but then let a different nurse complete the remaining skin assessment on Day 4 and a pressure ulcer was found. How would this be coded? Would we report the presence of the pressure ulcer on the SOC OASIS?

ANSWER 7: Because a full skin assessment was not completed on the first visit, the original assessing clinician may collaborate with the second nurse (who is completing the first clinical skin assessment) regarding the presence/status of any pressure ulcers. At SOC, collaboration is expected to occur within 5 days of the SOC date. Providers are encouraged to complete the assessment as close to the SOC/ROC as possible.

M1340

QUESTION 8: Are burn wounds that have been surgically grafted considered a surgical wound even if the graft fails?

ANSWER 8: For OASIS coding purposes, when any type of ulcer or burn is treated with any kind of graft or flap, it is considered a surgical wound for M1340 until approximately 30 days after complete re-epithelialization.

QUESTION 9: If a patient has a fasciotomy to treat compartment syndrome is the fasciotomy incision considered a surgical wound when answering M1340?

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ANSWER 9: M1340 identifies the presence of a wound resulting from a surgical procedure. The fasciotomy incision would be considered a surgical wound.

M1800

QUESTION 10: OASIS guidance tells us that the ability to access the location and items needed to complete grooming tasks are considered in M1800, so if patient needs to be assisted to the bathroom for safety, or needed grooming items placed within reach, but then could complete the tasks with no further assistance, they would be scored a “1” for grooming. Some clinicians refer to M1800 “1” for grooming as “set up”. This has confused me because my concept of set up means doing things like opening the toothpaste tube and putting toothpaste on the toothbrush, not just placing an item within reach. For OASIS scoring, if a patient needs assistance to open and/or set up grooming items (i.e. put toothpaste on toothbrush, opening the top of the toothpaste tube or other items such as items to apply make-up), is this considered providing access to the items and scored as a “1”, or is it considered providing assistance and scored a “2” as long as the majority of the grooming tasks required this assistance?

ANSWER 10: Each OASIS item should be considered individually and coded based on the guidance provided for that item. Response 1 for M1800 relates to patient access of “utensils” needed for grooming (e.g., accessing grooming aids, mirror, sink). Response 1 for M1800 is placing grooming items within reach and is not to be considered the same as Response 05-Set-up or Clean-up assistance for GG0130 items which includes assistance a helper provides only prior to or following the activity, but not during the activity.

In your scenario, putting toothpaste on the toothbrush and opening the top of the toothpaste goes beyond placing the items within reach and would be considered providing assistance for M1800.

M2001

QUESTION 11: Would the use of essential oils be included in the Drug Regimen Review (DRR), whether taken orally, diffused, or used topically?

ANSWER 11: The DRR includes all medications, prescribed and over the counter, including nutritional supplements, vitamins, and herbals administered by any route (e.g., oral, topical, sublingual, and by infusion). The DRR also includes total parenteral nutrition (TPN) and oxygen. Following these guidelines, use clinical judgment to determine whether other substances would be considered when conducting the DRR.

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M2020

QUESTION 12: At SOC, patient was only prescribed two PO medications, Tamiflu 30 mg daily for 7 days and Ativan 0.5 mg, take 1/2 tab at bedtime as needed. Three weeks later, the patient is discharged. At DC, the Tamiflu had ended two weeks earlier, and the only medication patient was prescribed to take was the PRN Ativan. The patient had not taken or needed Ativan for the past week. How should M2020 - Management of Oral Medications be coded?

ANSWER 12: M2020 reports a patient's ability on the day of the assessment (24 hours preceding the visit and time spent in home for the visit), to take the correct oral medications at all the correct times. PRN oral medications that are not needed on day of assessment, are not included in M2020.

If the patient did not need any PRN medications on the day of the assessment, assess the patient's ability on all of the medications taken on the day of assessment.

In your scenario, we are assuming the two medications listed reflect all of the prescribed and/or over the counter oral medications relevant to the episode and the patient was no longer taking the Tamiflu. If the patient did not need/take the PRN Ativan within the time period under consideration for the discharge assessment, M2020 would be coded "NA -No oral medications prescribed."

GG0100C

QUESTION 13: How does CMS define stairs in GG0100C - Prior Functioning: Everyday Activities? Meaning would this include a curb that a patient would have to step up to go into an MD office or a curb a patient may encounter when getting to their vehicle?

ANSWER 13: The intent of GG0100C Stairs is to collect prior level of function. You are asking if a patient who went up or down a curb outside their home and/or in the community would have been considered to have completed "stairs" for this item.

CMS guidance for GG0100C includes "internal or external stairs," and does not further define the number of steps. In situations where a definitive answer to an assessing clinician's question is not contained in published CMS OASIS guidance (OASIS Guidance Manual, Q&As, etc.), the clinician may have to rely on clinical judgment to determine how to code the item, ensuring that the response coded does not conflict with current guidance.

QUESTION 14: January 2019 Q&A guidance for GG0170N and GG0170O indicates that scooting up and down stairs or via any other safe, non-traditional manner with a portable device is considered "going up and down stairs". Does this guidance also apply to GG0100C. Stairs in the same manner?

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ANSWER 14: Yes, when coding GG0100C. Prior functioning for stairs, if a patient had gone up and down stairs by scooting on their buttocks, code the patient's performance based on the amount of help needed to safely complete the activity.

GG0130A

QUESTION 15: What would the discharge goal be if rehab potential is not possible? For example, a patient has experienced a massive stroke, prior to the stroke he was independent in eating, but patient will never eat by mouth again.

ANSWER 15: In the situation described, the activity was not completed at SOC, is not expected to be completed at discharge, and WAS completed prior to the current illness, exacerbation, or injury. Code 88 – Not attempted due to medical condition or safety concern would be reported.

Question 16: My quadriplegic patient cannot raise his arms enough to get food into his mouth from the plate and a helper feeds him. He can chew and swallow safely while eating. How would GG0130A - Eating be coded?

ANSWER 16: The intent of GG0130A - Eating is to assess the patient's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.

- If the patient does not have a swallowing problem, coding is based only on the type and amount of assistance needed to bring food and/or liquid to the mouth. When a patient swallows safely without assistance, exclude swallowing from consideration when coding GG0130A - Eating.
- If the patient requires helper assistance (e.g., supervision or cueing) due to a swallowing problem, code based on the type and amount of assistance required for feeding and safe swallowing.

Because the patient described swallows safely without assistance, coding is based only on the type and amount of assistance needed to bring food and/or liquid to the mouth. GG0130A Eating would be coded 01 - Dependent, because the helper provides all of the effort to bring food/liquids to the mouth.

GG0130E

QUESTION 17: For GG0130E - Shower/bathe self, is the patient's ability to cover wounds or devices to protect them from getting wet considered?

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ANSWER 17: Assistance for covering wounds or devices for water protection during bathing **would be** considered part of the setup or clean-up process, assuming no assistance with the water protection device/strategy was needed during the bathing process.

GG0130, GG0170

QUESTION 18: OASIS guidance has been to score SOC/ROC before any teaching or intervention. Would this include scoring a patient’s ability before the physical therapist’s cues?

ANSWER 18: When coding GG0130 and GG0170 items, if the patient requires only verbal cueing to complete the activity, Code 04, Supervision or touching assistance would be the correct choice. Coding of the Section GG items should be based on the patient's actual performance prior to the benefit of therapy services to capture the patient's true baseline. The assessing clinician may need to use clinical judgement to differentiate between verbal cueing and therapeutic intervention.

GG0170M

QUESTION 19: A patient has one step with no railing to enter the home and his flight of 12 stairs to his bedroom has two railings. Using the railings, he can go up and down the flight of stairs independently. However, he requires assistance to go up and down the one step in and out of his home because there is no railing to use. How would GG0170M - 1 Step (curb) be coded?

ANSWER 19: If a patient's performance going up/down a curb is different than his performance going up/down one step with a railing, code GG0170M - 1 step (curb) based on the activity with which the patient needs the most assistance.

GG0170P

(This serves as an updated reply to April 2019 CMS Quarterly Q&A Question #7)

QUESTION 20: We have a patient who prior to her injury was able to pick an object up from the floor from standing but is currently no longer safe to do so. The assessing clinician determines that the patient will not be safe performing this activity ever again. Going forward, the safest option is for the patient to have their caregiver complete the activity by picking up objects for the patient. How would the discharge goal be coded?”

ANSWER 20: If helper assistance is required because patient’s performance is unsafe or of poor quality, score according to amount of assistance provided. For GG0170P, if a standing patient is unable to pick up a small object from the floor, therefore requiring a helper to assist in

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completing the activity of picking up the object, code 01, 02, or 03, depending on whether the helper is providing all of the effort, more than half of the effort, or less than half of the effort. Clinicians should use clinical judgment to apply guidance regarding patient's degree of participation in picking up an object.

If the patient is not able to stand, the activity did not occur, and an activity not attempted code (e.g. 09 or 88) would apply.

J1800, J1900

QUESTION 21: Does the fall and intercepted fall definition pertain to M items also or just the J items?

ANSWER 21: The definitions for fall and intercepted fall are for the Section J: Health Conditions Items J1800 and J1900.