



July 2021 CMS Quarterly OASIS Q&As

Category 4b

All items

Question 1: In the latest Q&A release, there was a question that spoke to a decline with a patient within the assessment time frame with instructions not to update the assessment with such. The example given was related to dysphagia following an ER stay. I am questioning now if we can identify other “updates” within the 5-day assessment time frame such as new signs of infection with a surgical incision (M1342), development of a UTI (M1600), etc.? We have understood that at Start of Care (SOC), the 5-day assessment time frame allows us to update as we gather more data that would also update M0090 – Date Assessment Completed.

Are there situations in which we are able to update the OASIS items within the assessment time frame, and situations when this would not be allowed?

Answer 1: Each OASIS item should be considered individually, and coded based on the guidance provided for that item.

Unless otherwise specified in item guidance, information collected by the assessing clinician during the timeframe for the specified assessment type may be used to inform OASIS coding.

Note item guidance does specify special rules for coding pressure ulcer/injury and GG Function items at SOC/Resumption of Care (ROC). To support consistency of data collection related to pressure ulcers/injuries and GG function data across all post-acute care (PAC) providers cross-setting guidance directs coding for pressure ulcers/injuries to be based on the “first skin assessment” and coding for GG0130 - Self-Care and GG0170 - Mobility items should be based on a functional assessment that occurs at or soon after the patient’s SOC/ROC, and reflect the patient’s baseline ability to complete the activity, prior to the benefit of services provided by your agency staff.

M0104

Question 2: We received a general home care order to evaluate for home care needs for a patient after she experienced recent falls. At the time of the referral we don’t know what her care needs will be for home care. Would that general home care order constitute a valid referral for the purposes of determining M0104 - Date of Referral?

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Answer 2: M0104 - Date of Referral specifies the referral date, which is the most recent date that verbal, written, or electronic authorization to begin or resume home care was received by the home health agency.

A valid referral is considered to have been received when the agency has received adequate information about a patient (name, address/contact info, and diagnosis and/or general home care needs) **to initiate patient assessment** and the agency has ensured that the referring physician, or another physician or allowed non-physician practitioner will provide the plan of care and ongoing orders.

If a general order to “Evaluate for Home Care services” (no discipline(s) specified) is received from a physician who will be following the patient, this constitutes a valid order. Per the Conditions of Participation (CoPs) §484.55, the RN must conduct the initial assessment visit to determine immediate care and support needs and eligibility for the Home Health benefit for Medicare patients.

M1033

Question 3: For M1033 - Risk for Hospitalization does the time period under consideration or “look back” period include the day of assessment?

Answer 3: M1033 - Risk for Hospitalization identifies patient characteristics that may indicate the patient is at risk for hospitalization.

The time period under consideration or “look back” for responses 1-8 includes the day of assessment. Day of assessment is defined as the 24 hours immediately preceding the assessment and the time spent by the clinician conducting the assessment.

Question 4: If a patient is sent from one hospital Emergency Department (ED) to another does this count as one or two ED visits for M1033 - Risk for Hospitalizations, response 4 - Multiple Emergency Department Visits?

Answer 4: M1033 - Risk for Hospitalization, response 4 - Multiple Emergency Department Visits only includes hospital emergency department visits.

If a patient is transferred from one hospital emergency department to a second hospital emergency department, this is counted as two emergency department visits.

M1311

Question 5: I am looking for clarification in regard to coding of a wound. A patient is admitted with a Deep Tissue Injury (DTI) at SOC/ROC, during the stay the DTI opens, and at discharge presents as two distinct openings with each appearing as a stage 3 pressure ulcer. For the discharge OASIS, should the wound be coded as one DTI - “present at the most recent SOC/ROC” or as two stage 3 pressure ulcers - also “present at the most recent SOC/ROC”?

Answer 5: If at discharge you have two stage 3 pressure ulcers, then M1311B1 - Stage 3 = 2. Assuming no other pressure ulcers/injuries are present M1311F1 - Unstageable: Deep tissue injury = 0.

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If both stage 3 pressure ulcers present at discharge evolved from the DTI that was present at SOC/ROC, they would both be considered “present at the most recent SOC/ROC” and M1311B2 - Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC = 2. This is because they were both numerically staged as a stage 3 when first numerically stageable.

M2005

Question 6: Can the response for M2005 - Medication Intervention be determined at any time during the discharge window (day of discharge plus four preceding calendar days) or does this item need to be completed on the day of discharge?

Answer 6: The intent of M2005 - Medical Intervention is to identify if potential or actual clinically significant medication issues identified at the time of or any time since the SOC/ROC were communicated to the physician (or physician-designee) and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.

In order to report on all potential clinically significant medication issues, M2005 should be completed at the time of discharge.

GG0100

Question 7: For GG0100 - Prior Functioning: Everyday Activities, does Code 1 - Dependent have the same definition as the Code 01 - Dependent for GG0130 - Self-Care and GG0170 - Mobility activities? Specifically, for GG0100, would Code 1 - Dependent be used if a patient previously required the assistance of two helpers to complete an activity?

Answer 7: Yes, for GG0100 - Prior Functioning: Everyday Activities Code 1 - Dependent is indicated if the patient required one helper to complete all the activities for the patient or if two people were required to assist the patient complete the activities.

GG0100C

Question 8: How should GG0100C - Prior functioning: Everyday Activities Stairs be coded if a patient uses a ramp to enter their home and does not use any other stairs?

Answer 8: GG0100C - Prior functioning: Everyday Activities Stairs, identifies the patient’s need for assistance with internal or external stairs (with or without a device such as a cane, crutch, walker, railing or stair lift) prior to the current illness, exacerbation or injury.

The activity being assessed in GG0100C is going “up and down the stairs”. A ramp is not considered stairs for coding GG0100C.

If the patient was able to go up and down stairs prior to the current illness, exacerbation, or injury, code based on the amount assistance the patient required to complete the activity.

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If, even with assistance and/or devices, the patient was not able to go up and down stairs prior to the current illness, exacerbation, or injury, code 9 - Not applicable.

GG0130A

Question 9: A patient is admitted for home health services with quadriparesis from a previous spinal cord injury. Once an occupational therapist applied a universal cuff to the patient's hand, the patient was able to eat the entire meal without further assistance. What is the performance code for GG0130A - Eating?

Answer 9: 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.

In the scenario provided, if the patient only required assistance to apply a universal cuff, and no further assistance was required during the eating activity, code 05 - Setup or clean-up assistance. This is because assistance is required prior to or following the activity, but not during the activity.

GG0130C

Question 10: How should GG0130C - Toileting Hygiene be coded if a patient requires different types and amount of assistance after voiding versus after having a bowel movement?

Answer 10: The intent of GG0130C - Toileting Hygiene is to assess the patient's ability to maintain perineal hygiene and adjust clothing (including undergarments and incontinence briefs) before and after voiding or having a bowel movement.

When the patient requires different levels of assistance to perform toileting hygiene after voiding versus after a bowel movement, code based on the type and amount of assistance required to complete the ENTIRE activity. This is true even in scenarios where GG0130C - Toileting Hygiene is not completed entirely during one clinical observation.

GG0170I, GG0170J, GG0170K, GG0170L

Question 11: At SOC, if it is not recommended that a patient ambulate outside of home health visits, should the GG walking activities still be assessed and coded with a performance code or should an "activity not attempted" code be used?

Answer 11: Assessment of the GG self-care and mobility items is based on the patient's ability to complete the activity with or without assistance and/or a device. This is true regardless of whether or not the activity is being/will be routinely performed (e.g., walking may be assessed for a patient who did/does/will use a wheelchair as their primary mode of mobility).

If the patient is able to complete a walking activity with the assistance of one or two people, code based on the type and amount of assistance required even if walking is not being recommended or used as a functional mode of mobility outside of the home health visit.

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GG0170N, GG0170O

Question 12: For the GG stair activities, is a patient permitted to take a seated rest at the top of a staircase, prior to descending, and still have stair activity be considered as completed?

Answer 12: For GG0170N - 4 steps and GG0170O - 12 steps code based on the type and amount of assistance required for the patient to go up and down 4 steps and 12 steps by any safe means, with or without any assistive devices (for example, railing or stair lift).

Ascending and descending stairs does not have to occur sequentially or during one session. If the assessment of going up and down stairs occurs sequentially, the patient may take a rest break between ascending and descending the 4 steps or 12 steps.

GG0170S, GG0170SS

Question 13: If a patient utilizes a wheelchair for mobility and is able to wheel 50 feet with 2 turns but is unable to wheel 150 feet, how should we code items GG0170S/SS1? There is not a skip pattern if one of the "activity not attempted" codes are coded in GG0170S, and the directions on the OASIS states for GG0170SS1 to "Indicate the type of wheelchair or scooter used". Selecting one or the other (manual versus motorized) does not feel logical.

Answer 13: You are correct that there is no skip pattern for GG0170S - Wheel 150 feet and GG0170SS1 – Indicate the type of wheelchair or scooter used, unless GG0170Q - Does the patient use wheelchair and/or scooter is answered 0 - No. However, for the wheelchair items, a helper can assist the patient to complete the activity or make turns if required. Therefore, if the patient is unable to wheel the entire distance with or without assistance, the activity can still be completed and a performance code can be determined based on the type and amount of assistance required to complete the entire activity.

If, in your scenario, the patient was unable to complete the 150 feet themselves GG0170S - Wheel 150 feet could still be coded with a performance code based on the type and amount of assistance required to complete the entire activity. Then GG0170SS1 could indicate the type of wheelchair used.