January 2020 CMS Quarterly OASIS Q&As

Category 4a

QUESTION 1: For PDGM, is a referral from a Swing Bed facility a referral from an acute care hospital? Or from a SNF?

ANSWER 1: A patient in a Swing Bed facility may be receiving acute care, or SNF care, or both.

Category 4b

M0090

QUESTION 2: In the answer for OASIS Q&A Cat. 4b, Q18, it states: "*The assessment completion date (to be recorded in M0090) should be the last date that data necessary to complete the assessment is collected.*" But in OASIS, Cat. 4b, Q17.1.1. it states *"M0090, Date Assessment Completed, is the actual date the assessing clinician completed the SOC assessment document."* If the last date data is collected is not the same date that the clinician completes the assessment document, what date is correct for coding M0090?

ANSWER 2: M0090 - Date Assessment Completed, is the last date that information used to complete the comprehensive assessment and determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed.

M0104

QUESTION 3: A complete referral is received from a physician at an inpatient facility on 01/01/2020 and has a diagnosis that does not fall into a PDGM clinical grouping; patient is discharged to home health on 01/01/2020. Intake staff calls physician requesting a more specific diagnosis. The more specific diagnosis is received on 01/04/2019 and care is started on 01/05/2020. Will M0104 be changed to 01/04/2020 based on the update to the specificity of the diagnosis?

ANSWER 3: M0104 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) and the agency has ensured that the referring physician, or another physician, will provide the plan of care and ongoing orders.

In the scenario described, if your agency received adequate information as outlined above (including a relevant diagnosis) a valid referral is present on 1/1/2020 to allow the home health admission to be initiated and the M0104 date would be based on the date the referral was received. The assessment process, along with collaboration with the physician, may lead to identification of additional diagnoses for care planning and/or reimbursement purposes.

M0110

QUESTION 4: For PDGM, should the response for M0110 be based upon the OASIS-D Guidance Manual instructions (PPS definition), or should the response be based upon what is considered Early or Late for episode timing under PDGM?

ANSWER 4: While CMS will no longer use M0110 to influence payment under PDGM, other payers, including Medicare Advantage, may be using this data in their PPS-like payment model. In such cases, agencies should follow instructions from individual payors directing data collection. Agencies may code M0110 Episode Timing with NA – Not Applicable for assessments where the data is not required for the patient's payer (including all Medicare FFS assessments). Otherwise, the coding instructions for M0110 are not changing from what is in the OASIS-D Guidance Manual.

M0110, M2200

QUESTION 5: I understand that for Medicare payment episodes that began before January 1, 2020, CMS would automatically adjust claims up or down to correct for episode timing (early or later, from M0110) and for therapy need (M2200) when submitted information was found to be incorrect. With PDGM, will CMS continue to make corrections if values submitted by HHA for M0110 and M2200 are not correct?

ANSWER 5: Starting with payment episodes with a M0090 date of 1/1/2020 or later, CMS will no longer use M0110 to influence payment under PDGM and agencies may code M0110 Episode Timing with NA – Not Applicable for assessments where the data is not required for the patient's

payer (including all Medicare FFS assessments). Because CMS is no longer using the data from M0110 for payment, this information will no longer be corrected by the Medicare Claims Processing System. This is effective for processing claims related to a payment period with a M0090 date on or after January 1, 2020.

CMS will no longer use M2200 to influence payment under PDGM and agencies may code M2200 Therapy Need with NA – Not Applicable for assessments where the data is not required for the patient's payer (including all Medicare FFS assessments). However, since M2200 is used for risk adjustment for OASIS-based functional outcomes, agencies may elect to enter the estimated number of therapy visits planned for the 60-day certification period, even for assessments where the data is not required to establish case-mix for payment. Only enter "000" if no therapy services are needed. A dash (–) is not a valid response for M2200. For assessments with a M0090 Date Assessment Completed of January 1, 2020 or later, agencies may enter an equal sign (=) for M2200 at the Follow-up time point only. Because CMS is no longer using the data from M2200 for payment, this information will not be on the Medicare FFS claims and therefore will no longer be corrected by the Medicare Claims Processing System. This is effective for processing claims related to a payment period with a M0090 date on or after January 1, 2020.

M1800s, GG0130, GG0170

QUESTION 6: Can you please provide clarification for the following situation? Many of my patients are identified by the MAHC-10 as "at risk for falls". An outsource coding company our agency uses has directed us that any patient that is scored as a fall risk on the MAHC-10 must be coded as requiring at least supervision for the function items (M1800s and GG). This instruction doesn't always seem to be consistent with general assessment observations, and if also used at discharge, limits the ability to show improvement my patients have made. Is there some specific instruction that has been provided that requires this directed coding?

ANSWER 6: Identifying that a patient is at risk for falls is only one criterion to consider when determining the type and amount of assistance needed for a patient to safely complete functional activities. There is no CMS guidance that requires that a patient scored as "at risk" for falls must be coded as needing supervision (or greater assistance) for any or all of the function OASIS items. Although a patient may meet the MAHC-10's "at risk for falls" threshold, (e.g., due to age, 3+ diagnoses, age-related vision impairment, and poly-pharmacy), additional assessment findings (like the patient wears glasses to correct vision impairment, and sits while completing dressing activities) may allow the patient to safely complete some activities without supervision or assistance.

Even if a patient is determined to be at risk for falls, each OASIS item should be considered individually and coded based on the item specific guidance and OASIS conventions that apply to each item.

M1845

QUESTION 7: If a female patient, who only uses a bed pan and does not use a urinal, can transfer on and off the bed pan independently should she be scored as a code 03 - unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently?

ANSWER 7: If the patient is unable to get to and from the toilet or bedside commode and uses only a bed pan (i.e. voiding and bowel movements for a female patient), then for M1840, response code 3 would apply if she/he is independent in safely getting on and off a bed pan.

M2001, M2003, M2005

QUESTION 8: The new CoPs indicate it is mandatory that an office nurse does the medication review. Our agency is letting the LPNs do this. Is this compliant with OASIS guidelines and the COPs?

ANSWER 8: While the new CoPs continue to allow an RN, PT, OT, or SLP to complete a comprehensive assessment and collect OASIS, the new Interpretive Guidelines §484.55(c)(5) do state that in rehabilitation therapy only cases, the therapist must submit a list of patient medications to an HHA nurse for review. According to the Home Health Survey Mailbox Team, in therapy only cases, an agency **RN** should review the medication list.
Further questions related to the Interpretive Guidelines may be directed to the home health regulations and compliance team via the Home Health Survey Mailbox at hhasurveyprotocols@cms.hhs.gov .

M2420

QUESTION 9: For the new quality measure, Transfer of Health Information to Provider, how are we to identify if the patient was discharged to the care of another home health agency? There is no OASIS item that identifies this information.

ANSWER 9: You are correct that currently, there is no way to determine if a patient was discharged to a home health agency, however, the guidance for M2420 Discharge Disposition is being revised to collect this information. Effective immediately, agencies should begin using the following guidance for M2420:

- Code 1, Patient remained in the community (without formal assistive services), if, after discharge from your agency the patient remained in a non-inpatient setting, either with no assistive services, or with any assistive services EXCEPT:
    1. Skilled services from another Medicare certified home health agency, and/or
    2. Hospice care from a non-institutional ("home") hospice provider.
- Code 2, Patient remained in the community (with formal assistive services), if, after discharge from your agency the patient remained a non-inpatient setting, receiving skilled services from another Medicare certified home health agency, (with or without other assistive services).

There are no changes in guidance to M2420 response options 3, 4, or UK.

GG0100C

QUESTION 10: Prior to injury, the patient was able to climb and descend 3 stairs to enter her home independently. She was unable to manage the full flight of stairs to the 2nd floor of her home, therefore stayed on the first floor. She reports that she did not use stairs in the community. Could you please advise as to the appropriate response for item GG0100C. Prior level of function on Stairs?

ANSWER 10: GG0100C identifies the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury. CMS guidance includes "internal or external stairs," and does not further define the number of steps for GG0100C Stairs.

In the scenario you describe, the patient does go and up down 3 stairs to get into and out of her home independently. Code GG0100C Prior Functioning - Stairs 3 – Independent.

GG0110C

QUESTION 11: Since GG0110C - Mechanical lift includes "any device a patient or caregiver requires for lifting or supporting the patient's body weight," does this mean a gait belt is included since it is a device that a caregiver could require for lifting or supporting a patient's body weight?

ANSWER 11: No – this item is intended to refer to mechanical devices or equipment such as a Hoyer lift/ stair lift that involve some type of machine required for lifting or supporting the patient's body weight.

GG0130A

QUESTION 12: Eating: A patient has had a stroke which has impacted their dominant hand. Upon admission to home health, the patient is noted to use their unaffected, non-dominant hand to feed themselves, and only requires setup/cleanup assistance. However, when asked by the OT to perform eating with the affected, dominant hand, the patient required substantial/maximal assist. These two attempts both occurred before therapeutic intervention was initiated. Which should be recorded as the patient's baseline status for admission?

ANSWER 12: The intent of GG0130A - Eating is to assess the patient's ability to use suitable utensils to bring food and/or liquids to the mouth and swallow food and/or liquid once the meal is placed before the patient. When assessing GG0130A - Eating, allow the patient to complete the activity of eating as independently as possible as long as they are safe.

GG0130F, GG0130G, GG0130H

QUESTION 13: Does the donning and doffing of devices and/or prosthetics have to occur at the same time of dressing to be counted as dressing items?

ANSWER 13: Coding of the dressing activities should consider relevant dressing items regardless of the timing of when each item is put on/taken off. For example, if a patient dresses himself except for donning an elastic support bandage because it is to be put on later in the day, or because the patient needed assistance to put on the support, code GG0130G – Lower body dressing based on the type and amount of assistance needed to put on/take off all items relevant to the patient, including the elastic support bandage**.**

QUESTION 14: If a patient is independent with dressing but requires supervision to gather her clothes from the closet and take them to the bed before she can get dressed, is she "independent" for dressing, "supervision" for dressing" or "set-up" for dressing?

ANSWER 14: The intent of the items GG0130F and GG0130G is the patient's ability to dress and undress above the waist (GG0130F) and below the waist (GG0130G); including fasteners, if applicable.

It is not the type of assistance that is provided that determines the 05 Setup/Clean-up code but rather when (related to the completion of the activity) the needed assistance is provided.

If the assistance provided is necessary only before or after the activity is completed, and no assistance is needed during the completion of the activity, select Code 05 Setup/Clean-up.

GG0170I, GG0170J, GG0170K, GG0170L

QUESTION 15: If the patient requires two helpers to carry him 10 feet from the bed to the chair, would this be coded 01- Dependent for GG0170I Walk 10 feet?

ANSWER 15: The walking activities cannot be completed without some level of patient participation. A helper cannot entirely complete a walking activity for a patient.

QUESTION 16: When the therapist must provide contact guard assist to the patient during ambulation and there is a second person helping to manage an Oxygen tank (or IV pump tubing), how are the GG walking items scored?

ANSWER 16: If two helpers are required to assist the patient to safely walk, (one to provide support to the patient and a second to manage necessary equipment to allow the safe walk), code 01 – Dependent, as two helpers are required for the patient to safely complete the activity.

QUESTION 17: Have some questions about coding GG0170K – walk 150 feet:
a) Patient ambulates 155 feet with the use of oxygen. The oxygen tank is needed to be pushed throughout the entire walking distance by a therapist. The therapist does not cue or physically assist the patient. Truly, only there to push the tank. What would the code be for this scenario? It is not only as set-up, but throughout the entire walking episode.
b) Patient ambulates 155 feet with the use of oxygen. The therapist obtains a longer nasal cannula tubing and only sets up/ removes the tank and tubing. The patient ambulates the distance without any assistance of others except for the tank set up/ "clean up". What is the code for such mobility?
c) Patient is educated on the ability for themselves to modify the tank to allow for longer tubing during ambulation. The patient ambulates the distance of 155 feet and is able to set up and "clean up" the tubing and tank independently. Would this allow for a code of 06 - Independent?

ANSWER 17: Intent of the GG0170 walking items is to collect information about the patient's ability to ambulate safely.

a) If the helper is only required to manage the oxygen tank, pushing it to allow the patient to safely walk without additional assistance from the helper, code 04 – Supervision/touching assistance.
b) If the patient can complete the walking activity safely only after a helper retrieves and/or sets up oxygen equipment necessary to perform the included tasks, code 05 – Setup or clean-up assistance.

c) If the patient is able to set-up the oxygen and is able to safely complete the walking activity without requiring the assistance of a helper, the activity would be coded 06-Independent.

GG0170M

QUESTION 18: For GG0170M, 1 step (curb), on admission a patient was not able to go up and down steps secondary to safety deficits. The PT completed their evaluation 2 days later and after providing education regarding the safety deficits and how to correctly ascend/descend the stairs the patient was then able to ascend and descend some steps.
Do we code 88 – not attempted due to medical conditions or safety concerns for GG0170M, 1 step (curb) since patient was unsafe on admission?
Or do we code based on how the patient performed on steps at the PT evaluation even though the patient had received interventions by agency staff in order to complete the activity?

ANSWER 18: The Intent of the GG0170 stair items is to determine the amount of assistance required by a patient to go up and down the stairs, by any safe means.
At Admission, the 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.
"Prior to the benefit of services" means prior to provision of any care by your agency staff that would result in more independent coding.

In your scenario if the patient was not able to go up and down the stairs prior to the benefit of services provided by the agency, and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities, use the appropriate activity not attempted code.

GG0170Q, GG0170R, GG0170S

QUESTION 19: On admission, my patient reported that he only uses a wheelchair when he visits his cardiologist because of the distance from the car to the office. He shared that because of hospital policies, they also had an aide push him in a wheelchair as he was being discharged from the hospital two days ago. Because GG0170Q reports if a patient uses a wheelchair or scooter at the time of the assessment, would the answer be 1- Yes? If so, then how do I answer GG0170R and GG0170S if he doesn't own a wheelchair?

ANSWER 19: The intent of the item GG0170Q Does the patient use a wheelchair/scooter? is to document whether a patient uses a wheelchair or scooter at the time of the assessment. The code 0 – No would only be used if at the time of the assessment, the patient does not use a

wheelchair or scooter under any condition. Although it is under infrequent conditions, in your scenario, the patient uses a wheelchair, therefore, GG0170Q would be coded 1 -Yes.

Regarding GG0170R and GG0170S, if a patient does not complete the wheelchair activities during home visit, determine the patient's abilities based on the patient's performance of similar activities during the assessment, or on patient and/or caregiver report. If you are unable to observe the activity, and usual status cannot be determined based on patient and/or caregiver report or on assessment of similar activities, then select the appropriate activity not attempted code.

QUESTION 20: For GG0170Q, the patient was coded at admission as yes for wheelchair use but was also ambulating. In the instances where a patient is both ambulating and using a wheelchair should both the walking activities and the wheelchair activities be coded? At discharge, if the same patient is ambulating and no longer using a wheelchair, can GG0170Q be coded "no"?

ANSWER 20: The intent of the item GG0170Q - Does the patient use a wheelchair/scooter? is to document whether a patient uses a wheelchair or scooter at the time of the assessment. The responses for the gateway wheelchair item (GG0170Q1 and GG0170Q3) do not have to be the same on SOC/ROC and discharge assessments.

If at the time of the SOC assessment, the patient is using a wheelchair, GG0170Q would be coded 1 – Yes.

If at SOC the patient is both walking and using a wheelchair, then code both the walking and the wheelchair activities based on the type and amount of assistance required for the patient to safely complete each activity.

If at discharge, the patient does not use a wheelchair, then GG0170Q would be coded 0 -No.

If at discharge, the patient is both walking and using a wheelchair, then code both the walking and the wheelchair activities based on the type and amount of assistance required for the patient to safely complete each activity.