# January 2022 CMS Quarterly OASIS Q&As

## Category 2

**Question 1: Will data collection for OASIS-E begin 1/1/2023? Or will it still begin on January 1st that is at least one full calendar year after the end of the COVID-19 Public Health Emergency?**

**Answer 1:** Based on the CY 2022 Home Health Final Rule, CMS finalized that OASIS-E data collection will begin with OASIS assessments with a M0090 date on or after January 1, 2023.

**Question 2: Now that the OASIS-E data collection will begin 1/1/23 will CMS release an updated OASIS-E All Item Set instrument, given the changes as a result of rulemaking?**

**If so, when can we expect it, and where will it be posted?**

**Answer 2:** As stated in the CY 2022 Home Health Final Rule, CMS will release a draft of the updated version of the OASIS instrument, OASIS-E, in early 2022. The updated draft dataset and the final OASIS-E dataset will be posted on the Home Health Quality Reporting Program OASIS Data Sets webpage (when available, date TBD) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-Data-Sets.

Please check the Home Health Quality Reporting Program Spotlight and Announcements webpage for updates (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Spotlight-and-Announcements).

**Question 3: On December 31st we recertified a patient, planning for a new 60-day certification period that started on January 3rd. Later in the day, on the 31st, the patient was admitted to the hospital and returned home on January 2nd. We completed a transfer (RFA 6) when they went to the hospital but now don't know if we should complete a resumption of care (ROC) or complete a new Start of Care (SOC), since the inpatient stay didn't extend into the new certification period. The patient's insurance is traditional Medicare.**

**Answer 3:** When completing the comprehensive assessment including OASIS upon the patient's return home from the qualifying inpatient stay, if the M0090 – Date Assessment Completed is between days 56-60, complete an RFA 3 (ROC). If the M0090 – Date Assessment Completed is after day 60 (M0090 date falls in the subsequent certification period) complete an RFA 1 (SOC).

## Category 4b

### M1242

**Question 4: The CY 2020 Home Health Final rule finalized the change to no longer require the submission of OASIS item M1242 - Frequency of Pain Interfering, yet the item remains on the OASIS-D instrument. How should M1242 be coded?**

**Answer 4:** Effective December 30, 2021, M1242 - Frequency of Pain Interfering became optional at all time points. HHAs may enter an equal sign (=) for M1242 at all time points (SOC/ROC, Follow-up, Discharge). 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. M1242 will not be included in the OASIS-E instrument that will be implemented January 1, 2023.

### M2020/M2030

**Question 5: In situations where a patient cannot demonstrate their ability to take oral or injectable medications, (ex: medications are not in the home) how are codes for M2020 - Management of Oral Medications, and M2030 - Management of Injectable Medications determined?**

**Answer 5**: In situations where one or more medications that the patient is currently taking and are listed on the Plan of Care are not available to the patient, preventing the patient from being able to demonstrate their ability to manage oral or injectable medications, the assessing clinician could code using assessment strategies other than direct observation. The assessing clinician would rely on their assessment of the complexity of the patient's overall drug regimen, as well as patient characteristics, including cognitive status, vision, strength, manual dexterity and general mobility, along with any other relevant barriers, and use clinical judgment to determine the patient's current ability. In selecting a code, the clinician may use information gathered by report and/or observation, including details about when and how the patient accesses and administers their medications.

**Question 6: Please provide guidance on how to code M2020 or M2030 when a medication is in a location in the home where the patient can't access it without assistance (ex: daughter has temporarily placed the meds out of reach for visiting children's safety, or a medication is locked up in the assisted living facility nursing office)?**

**Answer 6:**
In the situation where the medications are locked up in the assisted living facility nursing office, or in a home location that the patient would require assistance to get to, code based on the patient's physical and cognitive ability to access the medication from where it is routinely stored, and to take their medications at the right time and in the right dose.

**M2020**

**Question 7: A patient chooses not to fill a medication prescription, and therefore the ordered oral medication is not in the home and the patient is not taking it as prescribed. The assessing clinician determines the patient does not have a disorder that is contributing to their non-adherence. They are making a choice not to comply with physician's orders, cognizant of the implications of that choice. How would M2020 – Management of Oral Medications be coded?**

**Answer 7:** In situations where one or more medications that the patient is currently taking and are listed on the Plan of Care are not available to the patient, preventing the patient from being able to demonstrate their ability to manage oral or injectable medications, the assessing clinician could code using assessment strategies other than direct observation. The assessing clinician would rely on their assessment of the complexity of the patient's overall drug regimen, as well as patient characteristics, including cognitive status, vision, strength, manual dexterity and general mobility, along with any other relevant barriers, and use clinical judgment to determine the patient's current ability. In selecting a code, the clinician may use information gathered by report and/or observation, including details about when and how the patient accesses and administers their medications.

**Question 8: If the patient does not have their prescribed medications in the home because they cannot afford them and they do not plan on getting them, what is the most appropriate response for M2020 – Management of Oral Medications?**

**Answer 8:** When completing M2020 - Management of Oral Medications, you are reporting the patient's ability to take all oral medications reliably and safely at all times on the day of the assessment.

In situations where one or more medications that the patient is currently taking and are listed on the Plan of Care are not available to the patient, preventing the patient from being able to demonstrate their ability to manage oral or injectable medications, the assessing clinician could code using assessment strategies other than direct observation. The assessing clinician would rely on their assessment of the complexity of the patient's overall drug regimen, as well as patient characteristics, including cognitive status, vision, strength, manual dexterity and general mobility, along with any other relevant barriers, and use clinical judgment to determine the patient's current ability. In selecting a code, the clinician may use information gathered by report and/or observation, including details about when and how the patient accesses and administers their medications.

**M2030**

**Question 9: On my SOC visit, our diabetic patient did not have their insulin due to a problem at the pharmacy. How would I code M2030, Management of Injectable Medications, when I am unable to assess my patient's ability to prepare and take the SQ medication?**

**Answer 9**: When completing M2030, Management of Injectable Medications, report the patient's ability to administer all injectable medications reliably and safely at all times, including safe needle and syringe disposal.

In situations where one or more medications that the patient is currently taking and are listed on the Plan of Care are not available to the patient, preventing the patient from being able to demonstrate their ability to manage oral or injectable medications, the assessing clinician could code using assessment strategies other than direct observation. The assessing clinician would rely on their assessment of the complexity of the patient's overall drug regimen, as well as patient characteristics, including cognitive status, vision, strength, manual dexterity and general mobility, along with any other relevant barriers, and use clinical judgment to determine the patient's current ability. In selecting a code, the clinician may use information gathered by report and/or observation, including details about when and how the patient accesses and administers their medications.

**M2420**

**Question 10: With the change in guidance for M2420 – Discharge Disposition from Question 9 in the January 2020 CMS OASIS Quarterly Q&As, we wanted to clarify the following:**

**For M2420 - Discharge Disposition, what is the response if a discharge comprehensive assessment including OASIS is completed on a patient because their insurance is changing but they will continue to receive skilled home care services (e.g., discharged from a traditional Medicare plan to continue receiving skilled care under a Medicare Advantage plan)? The patient is not continuing with another home health agency but is continuing to receive services from the same home health agency.**

**Answer 10:** When completing a discharge OASIS on a patient because a new SOC OASIS is required due to an insurance change, for M2420 - Discharge Disposition code 2 - Patient discharged from agency (with formal assistive services).

Response 2 - Patient discharged from agency (with formal assistive services) is used when, upon discharge from your agency, the patient will receive skilled services from another Medicare certified home health agency. Response 2 is also used when an agency completes a discharge and a new SOC OASIS due to a pay source change.

**Question 11: Our agency is discharging a patient who will be admitted to a non-institutional hospice. After completing the discharge OASIS (M2420 - Discharge Disposition coded with response 3 - Patient transferred to a non-institutional hospice), the agency learns that the patient expired prior to being admitted to hospice. Does the clinician need to correct the M2420 code to response 1 - Patient remained in community (without formal assistive services)?**

**Answer 11:** Code M2420 - Discharge Disposition based on the information known at discharge regarding where the patient will reside, and the services the patient is expected to receive after discharge from the home health agency

**GG0170D**

**Question 12: When determining the appropriate performance code at Start of Care/Resumption of Care (SOC/ROC) for the GG self-care and mobility activities there are times when the patient's baseline status may differ from their usual status during the assessment timeframe. For example: At the SOC visit when attempting to perform a sit to stand transfer, even with assist from the nurse the patient is unable to complete the transfer due to pain. The nurse scored GG0170D - Sit to stand as Code 88 – Not attempted due to medical conditions or safety concerns. During the remaining days of the SOC assessment timeframe the patient was able to perform the sit to stand transfer with the assistance of two people following intervention from the nurse and therapist. Which code would I use? Code 88 - Not attempted due to medical conditions or safety concerns or Code 01 - Dependent?**

**Answer 12:** At SOC/ROC the self-care or mobility performance code is to 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.

"Prior to the benefit of services" means prior to provision of any care by your agency staff that would result in more independent coding.

When the baseline function code differs from the usual performance during the assessment period, report the baseline function code.

If in your scenario, the patient being unable to complete the sit to stand activity due to medical conditions or safety concerns represents their baseline ability, then code 88 - Not attempted due to medical conditions or safety concerns.

**GG0170N, GG0170O**

**Question 13: Question 12 of the July 2021 CMS Quarterly OASIS Q&As discusses how a patient is permitted to take a rest break between ascending and descending 4 or 12 steps. Can a patient take a seated rest break at any time while completing the activity? For example, they start ascending 12 steps but after 5 steps need to stop and rest before completing the remaining 7 steps.**

**Answer 13**: Ascending and descending stairs does not have to occur sequentially or during one session. If the assessment of going up and down stairs, by any safe means, occurs sequentially, the patient may take a rest break between ascending and descending the 4 steps or 12 steps.

While a patient may take a break between ascending or descending the 4 steps or 12 steps, once they start the activity, they must be able to ascend (or descend) all the steps, by any safe means without taking more than a brief rest break in order to consider the stair activity completed.

**GG0170Q, GG0170R, GG0170S**

**Question 14**: **According to Chapter 3 coding guidance in some instances (GG0170I - Walk 10 feet, GG0170M - 1 step, GGG0170N- 4 steps) we are instructed to Skip to another item if an "activity not attempted" code is used in the SOC/ROC performance column. When we skip coding performance for an activity, should we also skip (leave blank) the discharge goal for that activity? Or should we "dash" it? If we feel that we could set a reasonable discharge goal for an activity that isn't assessed at SOC, is it inaccurate to report a discharge goal for an activity that is skipped?**

**Answer 14:** Even in situations where activity performance is coded with an "activity not attempted" code or skipped, a discharge goal may still be reported. Use of a dash is permissible for any remaining self-care or mobility goals where a discharge goal was not established. Note an exception to this rule: When the performance of the GG0170R/GG0170S wheelchair activities is skipped due to a response of 0 - No on GG0170Q - Does the patient use wheelchair and/or scooter, the discharge goals for GG0170R and GG0170S are also skipped.