CMS OASIS Q&As: CATEGORY 4 - OASIS DATA SET: FORMS and ITEMS

Category 4A - General OASIS forms questions.

Q1. [Q&A RETIRED 09/09; Outdated]

Q2. When integrating the OASIS data items into an HHA's assessment system, can the OASIS data items be inserted in an order that best suits the agency's needs, i.e., can they be added in any order, or must they remain in the order presented on the OASIS form? [Q&A EDITED 06/14]

A2. Integrating the OASIS items into the HHA's own assessment system in the order presented on the OASIS data set would facilitate data entry of the items into the data collection and reporting software. However, it is not mandatory that agencies do this. Agencies may integrate the items in such a way that best suits their assessment system. Some agencies may wish to electronically collect their OASIS data and upload it for transmission to the OASIS system. As long as the agency can format the required CMS data submission file for transmission to the OASIS system, it doesn't matter in what order the data are collected.

Q3. Are agencies allowed to modify skip patterns through alternative sequencing of OASIS data items? [Q&A EDITED 05/22; EDITED 10/16; EDITED 06/14]

A3. While we encourage HHAs to integrate the OASIS data items into their own assessment instrument in the sequence presented on the OASIS data set for efficiency in data entry, we are not precluding them from doing so in a sequence other than that presented on the OASIS data set. Agencies collecting data in hard copy or electronic form must incorporate the OASIS data items into their own assessment instrument using the exact language of the items from the current data set. Agencies must carefully consider any skip instructions contained within the questions in the assessment categories and may modify the skip language of the skip pattern as long as the resulting data collection complies with the original and intended skip logic. When agencies encode the OASIS data they have collected, data MUST be transmitted in the sequence presented on the OASIS data set. The software that CMS has developed for this function prompts the user to enter data in a format that will correctly sequence the item responses and ultimately be acceptable for transmission. This software includes certain editing functions that flag the user when there is missing information or a question as to the accuracy or validity of the response. Agencies may choose to use software other than that provided by CMS to report their data so as long as the data are ultimately transmitted to the OASIS system in the required CMS data submission format found on the CMS Website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/DataSpecifications.

Q4. Are any quality assurance tools available to help us verify that our staff is using the OASIS correctly? [Q&A EDITED 05/22; EDITED 06/14]

A4. We are not aware of any standardized quality assurance tool that exists to verify that clinical staff members are using OASIS correctly. A variety of audit approaches might be used by an agency to validate the appropriate responses to OASIS items. For example, case conferences can routinely incorporate OASIS items as part of the discussion. Multi-discipline cases with visits by two disciplines on adjacent days can contribute to discussion of specific items. (Note that only one assessment is reported as the 'OASIS assessment.') Supervisory (or peer) evaluation visits can include OASIS data collection by two clinicians, followed by comparison of

responses and discussion of any differences. Other approaches to data quality monitoring are included in Chapter 2 of the OASIS Guidance Manual.

Q5. [Q&A RETIRED 10/18]

Q6. Do you have anything available that would help us integrate the OASIS items into our own assessment? [Q&A EDITED 10/23; EDITED 05/22, EDITED10/18; EDITED 06/14]

A6. The most current version of OASIS will be found on the CMS Home Health Quality Reporting Program website. HHAs are required to incorporate the OASIS data items exactly as written into the agency's comprehensive assessment. For agencies using software that does not accommodate bolding or underlining for emphasis of words in the same manner as the current OASIS data set, capitalizing those words is acceptable. We also recommend including the OASIS item numbers when integrating to alert clinicians that the OASIS items MUST be assessed and completed. Ultimately this will minimize delays in encoding due to uncompleted OASIS data items. The OASIS data sets are available at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/homehealthqualityinits/oasis-data-sets

Q7. [Q&A RETIRED 10/18]

Q8. [Q&A RETIRED 09/09; Outdated]

Q9. Are the OASIS data sets (all time points) to become part of the patient's record? Do we keep them in the charts? Of course, our admission OASIS data set will be part of the chart because we have our admission assessment included in the OASIS questions. But with the ROC, Transfer, DC, do we make this part of the record? [Q&A EDITED 05/22; EDITED 10/18; EDITED 08/07]

A9. The Condition of Participation (CoP) §484.55 states that the current version of the OASIS data items are to be incorporated into the HHA's own assessments. Because all such documentation is part of the patient's clinical record, it follows that the OASIS items are also part of the clinical record, CoP §484.110. Verifying the accuracy of the transmitted OASIS data, CoP §484.45, requires that the OASIS data be retained as part of the clinical documentation.

Q10. [Q&A RETIRED 10/18]

Q11. [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat. 2 Q7]

Q12, 13, & 14. [Q&As RETIRED 09/09; Outdated]

Q15. [Q&A RETIRED 08/07; Outdated]

Q16. [Q&A RETIRED 01/08 due to changes in OASIS data set and skip patterns at follow-up (RFA 4, 5)]

Q17. Unless otherwise indicated, scoring of OASIS items is based on the patient's status on the "day of the assessment." Does the "day of the assessment" refer to the calendar day or the most recent 24-hour period? [Q&A EDITED 08/07; ADDED 06/05; Previously CMS OCCB Q&A 08/04 Q1]

A17. Since home care visits can occur at any time of the day, and to standardize the timeframe for assessment data, the "day of the assessment" refers to the 24-hour period directly preceding the assessment visit, plus the time the clinician is in the home conducting the assessment. This standard definition ensures that fluctuations in patient status that may occur at particular times during the day can be considered in determining the patient's ability and status, regardless of the time of day of the visit.

Q18. [Q&A RETIRED 09/09; Outdated]

Q19. Must the OASIS data items (on the screen and when printed) match the data set language and format exactly? [Q&A EDITED 10/18; EDITED 10/16; Previously CMS Qtrly Q&A 10/16 Q4; EDITED & Updated M numbers 04/15; ADDED 09/09; Previously CMS OCCB Q&A 01/08 Q4]

A19. The OASIS hard copy information for the chart printed out by a point of care system must use the exact language of the items from the current data set.

Due to the size and complexity of some of the items (e.g., M1021/1023/1311/2102/2401) the formatting may be modified to fit the computer screen as long as the data set language is not modified, and any format variances in no way impact the accuracy of the item scoring.

Q19.1. In the final version of the OASIS-E instrument, copyright information for specific items is being displayed as footers. Is it required to include the copyright reference when developing electronic or paper-based documentation? [Q&A ADDED AND EDITED 10/23; Previously CMS Qtrly Q&A 07/22 Q1]

A19.1. The copyright information is considered part of the OASIS item. The OASIS hard copy information for the chart printed out by a point of care system must use the exact language of the items from the current data set, including the copyright attribution. Due to the size and complexity of some of the items the formatting may be modified to fit the device monitor/screen as long as the data set language is not modified, and any format variances in no way impact the accuracy of the item scoring.

Q20. Our agency has been using a typical OASIS form that integrated the comprehensive assessment information with OASIS (as required by the Conditions of Participation) within one single form. We recently decided to use two separate forms. One form is the Comprehensive Assessment as stated above and the second is CMS OASIS data items. Someone told us that this was unacceptable and a single, physically integrated form is required. Is this true? [Q&A EDITED 05/22; EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 07/08 Q2]

A20. In order to be compliant with the Medicare Condition of Participation, §484.55, the OASIS Assessment Items must be incorporated into the agency's comprehensive assessment forms using the language of the OASIS items. The data items may not be kept on a separate form and attached as a separate document to the comprehensive assessment.

Q21. [Q&A RETIRED 10/18]

Q22. [Q&A RETIRED 10/18, Duplicative of Guidance Manual]

Q23. [Q&A RENUMBERED Cat. 4b Q160.6.3]

Q24. I am concerned that our software vendor has a new version coming out that answers the OASIS questions for you. I believe that it looks at how you answer comprehensive assessment items, and it then answers the OASIS items for the clinician. Does CMS consider this type of software feature compliant? [Q&A EDITED 10/18; EDITED 10/16; ADDED & EDITED 06/14; Previously CMS Qtrly Q&A 01/13 Q3]

A24. An agency's software may not "answer" or "generate" the OASIS response for the assessing clinician.

Q24.5. We have educated clinicians that it is a requirement that medication reconciliation be done. With this in mind, is it acceptable to electronically restrict clinicians from using

a dash (–) as a response to M2001 - Drug Regimen Review by eliminating it as a response option in the Electronic Medical Record (EMR), understanding that there still may be scenarios where the dash is the only correct response to this item? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/21 Q3; Also posted as Cat. 4b Q106.3.6]

Q24.5. A dash (–) is a valid response for M2001 - Drug Regimen Review. CMS expects dash use to be a rare occurrence. If elements of the drug regimen review were skipped, (for example drug-to-drug interactions were not completed), a dash should be reported, indicating the drug regimen review was not completed. A dash is also a valid response for this item and indicates no information is available.

Q25. When completing a comprehensive assessment, is it acceptable for providers to utilize separate paper-based standardized assessment tools or must all assessment tools be embedded into the agency's paper or electronic comprehensive assessment? [Q&A EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 04/13 Q1]

A25. There is no Medicare requirement that standardized assessment tools be embedded in the agency's comprehensive assessment, with the exception of tools that are embedded within the OASIS instrument (PHQ-2 to 9, BIMS, etc.). It is acceptable for a clinician to supplement the agency's comprehensive assessment with additional standardized assessment forms to meet the criteria for the OASIS best practice items.

Q26. [Q&A RETIRED 10/18]

Q27. I would like to better understand the rules on how to collect the OASIS as part of a comprehensive patient assessment. What are the best resources? [Q&A EDITED 05/22; EDITED 10/18; ADDED 10/16; Previously CMS Qtrly Q&A 04/16 Q1]

A27. CMS provides several key resources to support OASIS data accuracy. The OASIS Guidance Manual contains an item-by-item review with key instructions within Chapter 3 of the manual. Chapter 1 of the OASIS Guidance Manual contains the general and ADL/IADL specific conventions for completing OASIS items.

There are also OASIS Q&As available at https://qtso.cms.gov/tools/oasis/reference-manuals. Categories 1-4 are most relevant for OASIS data collection activities. At the same site, CMS posts quarterly Q&A updates with new and/or refined guidance related to OASIS items. The user may conduct a key word search in these .pdf documents to expedite the search for information.

Questions not otherwise answered in published CMS OASIS resources may be submitted to the CMS Home Health Quality Helpdesk at HomeHealthQualityQuestions@cms.hhs.gov

Q28. We utilize an electronic medical record. Do the formatting changes added to OASIS (for example the single box entry format introduced in 2017) need to be presented to the clinicians in the EMR? Is it acceptable if the response options are presented to the clinicians in a list with radio buttons to indicate response selection instead of single box entry, if the end result in the extract is the same? [Q&A EDITED 05/22; EDITED 10/18; ADDED 10/16; Previously CMS Qtrly Q&A 07/16 Q2]

A28. In the development and maintenance of the OASIS assessment user tools, vendors are advised to reference the Data Specifications (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/DataSpecifications). While the Data Specifications dictate the Assessment Instrument Items, their applicable time point(s) in the Assessment Instrument, the exact language of the Items, and each Item's allowable response

options, the Data Specifications do not dictate the format of the graphical user interface (GUI) software presentation of the Items in the Assessment Instrument. Per your example, presenting the allowable response options in the format of radio buttons in the GUI software is acceptable, and is left to the user's discretion, as long as such modification does not impact the accuracy of the item scoring.

Q29. [Q&A RETIRED 05/22]

Q30. While configuring the new OASIS-E items in our EMR system, would it be compliant if additional prompts were added to clarify the reason for coding a 0 response for one or more BIMS Interview Items (C0200 - C0400)? The 0 can have different meanings and the reason for coding the 0 may influence the scoring of C0500 - BIMS Summary Score.
[Q&A ADDED AND EDITED 10/23; Previously CMS Qtrly Q&A 01/23 Q2]

A30. HHAs are required to incorporate the OASIS data items exactly as written into the agency's comprehensive assessment.

In addition to any required OASIS items, an agency may determine what other assessment items will be included in the agency's comprehensive assessment(s) to meet regulatory, coverage and clinical needs.

In the development and maintenance of the OASIS assessment user tools, vendors are advised to reference the Data Specifications (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/DataSpecifications).

While the Data Specifications dictate the assessment instrument items, their applicable time point(s) in the assessment instrument, the exact language of the Items, and each Item's allowable response options, the Data Specifications do not dictate the format of the graphical user interface (GUI) software presentation of the Items in the assessment instrument. While the item language and response options may not be modified, reformatting of the presentation of the item is left to the user's discretion, as long as such modification does not impact the accuracy of the item scoring and is presented in a way that makes it clear which items (assessment questions and response options) are part of the OASIS, and which are not.

Category 4B - OASIS Data Items

Q1. [Q&A RETIRED 05/22]

Q2. PTS. Can other (agency-specific) items be added to the Patient Tracking Sheet? [Q&A EDITED 05/22; REVIEWED 09/09]

A2. If the agency typically collects other (non-OASIS) items at SOC and updates them only as necessary during the episode of care, the agency can incorporate those other items into the Patient Tracking Sheet (PTS) as needed for efficient care provision. Examples of such items that would "fit" nicely with the OASIS PTS items would be the patient's street address, telephone number, or directions to the patient's residence.

Q3. PTS. Must the clinician write down/mark every single piece of information recorded on the Patient Tracking Sheet (e.g., could clerical staff enter the address, ZIP code, etc.)? [Q&A REVIEWED 09/09]

A3. Consistent with professional and legal documentation principles, the clinician who signs the assessment documentation is verifying the accuracy of the information recorded. At the time of referral, it is possible for clerical staff to record preliminary responses to several OASIS items such as the address or ZIP code. The assessing clinician then is responsible to verify the accuracy of these data.

Q4. What do the "M0000" numbers stand for? [Q&A REVIEWED 09/09]

A4. The "M" signifies a Medicare assessment item. The following four characters are numbers that identify the specific OASIS item.

Q4.1. [Q&A RETIRED 09/09; Outdated]

Q5. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q5.1. M0018. When answering M0018 - National Provider Identifier (NPI) for the Attending Physician Who Has Signed the Plan of Care, what if the ordering physician is not the provider who ultimately signed the 485 (Plan of Care). Which attending physician's number should be entered? This happens when the ordering physician makes the referral and then goes on vacation for a month with another physician from their group signing the 485 on their behalf. [Q&A ADDED & EDITED 06/14; Previously CMS Qtrly Q&A 01/13 Q4]

A5.1. At SOC, when completing M0018, National Provider Identifier, the assessing clinician should enter the NPI number of the physician/allowed practitioner expected to oversee and sign the Plan of Care.

Q6. M0030. Is the Start of Care Date (M0030) the same as the original start of care when the patient was first admitted to the agency, or is it the start of care for the current certification period? [Q&A EDITED 10/23; EDITED 08/07]

A6. The Start of Care Date (M0030) is the date of the first reimbursable service and is maintained as the start of care date until the patient is discharged. It should correspond to the start of care date used for other documentation, including billing or physician orders.

Q7. M0030. What if a new service enters the case during the episode? Does it have a different Start of Care (SOC) Date? [Q&A EDITED 10/23; REVIEWED 09/09]

A7. There is only one Start of Care Date for the episode, which is the date of the first billable visit.

Q7.1. [Q&A RETIRED 05/22]

Q7.1.1. M0032, M0090, M0102. The HH CoPs state that the comprehensive assessment (including OASIS) must be updated within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician-ordered Resumption of Care Date. I understand that I must provide the ROC visit on the physician-ordered ROC Date, but do I need to also complete the entire ROC comprehensive assessment including OASIS on that date? Or do I have 48 hours from the physician-ordered ROC date to complete the assessment? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 7/18 Q4]

A7.1.1. When the physician specifies a date that home care services must resume (a physician-ordered Resumption of Care Date), the agency is expected to conduct the ROC visit on that date. The agency has up to 2 calendar days from the physician-ordered ROC Date (M0032) to complete the ROC assessment document (M0090). For example, if the patient is discharged from the hospital on September 1, and the physician orders home care to resume on September 4, the M0102 - Date of Physician-ordered Resumption of Care Date is 09-04-XXXX, the M0032 Resumption of Care Date is 09-04-XXXX, and the M0090 - Date Assessment Completed can be anytime on or between 09-04-XXXX and 09-06-XXXX.

Q7.2. M0040. Can/should an apostrophe be included in a patient's name in M0040? [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 04/16 Q3]

A7.2. The OASIS Guidance Manual, Chapter 3, M0040 - Patient Name Response-Specific Instructions state the patient's name should appear exactly as it does on the Medicare card or other insurance card. Per the data specifications for M0040, the item may contain a (') single quote/apostrophe. For additional information, please refer to the data specifications located at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/DataSpecifications

Q7.2.1. M0040. The Guidance Manual states that the patient's name for M0040 should match the Medicare or insurance card, but what should I do if the patient's last name has more letters than M0040 allows? [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 04/16 Q4]

A7.2.1. For M0040 - Patient Name, the OASIS Guidance Manual states the name should appear exactly as it does on the Medicare card or other insurance card. The OASIS item provides a maximum length of 12 characters for the first name, 1 character for the middle initial, and 18 characters for the last name. The length of the text submitted must not exceed the maximum length specified or it will result in a fatal Format Edit when submitted. In cases where a patient's name has more letters than the OASIS submission allows, enter the first 12 letters (for first name), the first letter (for middle initial), and the first 18 letters (for last name), and disregard any additional letters/characters for the purposes of M0040 - Patient Name. This approach should be used for all time points throughout the patient's episode of care. Note that this M0040 - Patient Name limitation should not be applied to other documentation (clinical records, claims, etc.) where the patient's full name should be used.

Q8 & Q9. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q10. M0063. If the patient has Medicare, but Medicare is not the primary pay source for a given episode, should the patient's Medicare number be entered? [Q&A EDITED 05/22; EDITED 08/07]

Q10. The patient's Medicare number, the Medicare Beneficiary Identifier (MBI) should be entered, whether or not Medicare is the pay source for the episode. Keep in mind that Medicare is often a secondary payer, even when another payer will be billed first. In order to bill Medicare as a Secondary Payer, the patient must be identified as a Medicare patient from the start of care. If the agency does not expect to bill Medicare for services provided by the agency during the episode, then Medicare would not be included as a pay source on M0150 – Current Payment Source for Home Care, even though the patient's Medicare number is reported in M0063 - Medicare Number.

Q10.1. M0065. Home Health Agencies in the state of Iowa are transitioning from Traditional Medicaid to three private companies for Medicaid Managed Care Organizations (MCOs). For M0065 - Medicaid Number, should agencies use the traditional Medicaid number, or the new patient ID number provided by the MCO? [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 07/16 Q3]

A10.1. M0065 - Medicaid Number specifies the patient's Medicaid number, if the patient has Medicaid. Answer this item whether or not Medicaid is the payer source for the home care episode. Do not enter the identification number provided by an HMO or MCO.

Q11. [Q&A RETIRED 08/07; Replaced by updated Q&A.]

Q12. & 12.1. [Q&A RETIRED 08/07; Outdated]

Q12.2. M0069. My question relates to a patient who self identifies as a gender different than that assigned at birth, but who has a disease that is inherent to the gender assigned at birth. Example: patient designated male at birth identifies as a female and has a diagnosis of benign prostatic hypertrophy (BPH). As the patient self-identifies as female, we report 2 - Female for M00069 - Gender. If we also list female as the gender on the claim, the claim is rejected because the diagnosis of BPH is not compatible with the female gender. How should we resolve this situation? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 01/23 Q9]

A12.2. Regarding the accurate coding of the OASIS item M0069 - Gender, refer to the OASIS Guidance Manual and published Q&As, then use clinical judgment to complete required OASIS assessment items. The Guidance Manual states to interview the patient and/or caregiver. If the patient does not self-identify, referral information (including hospital or physician office clinical data), or observation and physical assessment may be used. Based on these resources, enter a response for patient's gender in M0069.

CMS has no additional guidance on how to complete this OASIS item.

OASIS is not intended to represent a comprehensive assessment in and of itself. HHAs are expected to incorporate OASIS items into their comprehensive assessment documentation and follow their own assessment policies and procedures regarding other items to include in their comprehensive assessments. This may include adding non-OASIS assessment items.

At the CMS level, M0069 is not used in performing any gender specific procedure editing and is not used for OASIS and claims matching functions.

There are no instructions at the CMS level requiring the gender of the patient submitted on the claim to be populated from the gender response reported in M0069 of the OASIS. More specific questions related to reporting gender codes on claims may be sent to the Home Health Medicare Administrative Contractor (MAC). Information on MAC's can be found at https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html#ABandHH+H.

Q13. M0080. Why are Social Workers not included on OASIS item M0080 - Discipline of Per Completing Assessment? [Q&A EDITED 05/22; EDITED 10/18; EDITED 08/07]

A13. M0080 - Discipline of Person Completing Assessment, lists the clinicians (RN, PT, SLP/ST, OT) who can initiate a qualifying Medicare home health service and/or are able to complete the assessment. Social workers, although considered a skilled professional as noted in Condition of Participation (CoP) §484.75, are not a qualifying Medicare home health service. Social workers are not able to complete the comprehensive assessment but may support the assessing clinician through collaboration.

Q13.1. M0080. Which disciplines are allowed to perform the initial assessment and comprehensive assessment for a physical therapy only patient? For example, can a nurse or a speech therapist do a non-bill admission for a physical therapy only patient? [Q&A EDITED 05/22; ADDED & EDITED 09/09; Previously CMS OCCB Q&A 04/08 Q3]

A13.1. In a case where PT is the only ordered service, and assuming physical therapy services establish program eligibility for the payer, the PT could conduct the initial assessment visit and the SOC comprehensive assessment. Likewise, assuming skilled nursing services establish program eligibility for the payer, the RN could complete these tasks as well, even in the absence of a skilled nursing need and related orders. If speech pathology services were also a qualifying service for the payer, it would be acceptable, although not required, for the SLP to conduct the initial assessment visit and/or complete the comprehensive assessment for the PT only case, even in the absence of a skilled SLP need and related orders. Likewise, a PT could admit, and complete the initial assessment visit and comprehensive assessment for an SLP-only patient, where both PT and SLP were primary qualifying services (like the Medicare home health benefit).

It should be noted that under the Medicare home health benefit (and likely under other payers as well), the visit(s) made by the RN, (or SLP, or PT, etc.) to complete the initial assessment and comprehensive assessment tasks would not be reimbursable visits, therefore would not establish the start of care date for the home care episode.

Q13.2. M0080. Who can complete the OASIS data collection that occurs at the Transfer and Death at Home time points? Can someone in the office who has never seen the patient complete them? Does it have to be an RN, PT, OT or SLP? [Q&A EDITED 05/22; EDITED 06/14; ADDED 01/10; Previously CMS OCCB Q&A 01/09 Q4]

A13.2. Since the Transfer and Death at Home OASIS time points require data collection and not actual patient assessment findings, any RN, PT, OT or SLP may collect the data, as directed by agency policy. The current OASIS Guidance Manual explains that a home visit is not required at these time points. As these time points are not assessments and do not require the clinician to be in the physical presence of the patient, it is not required that the clinician completing the data collection must have previously visited the patient. The information can be obtained over the telephone and through record review by any RN, PT, OT or SLP familiar with OASIS data collection practices. This guidance applies only to the Transfer and Death time points, as a visit

is required to complete the comprehensive assessments and OASIS data collection at the Start of Care, Resumption of Care, Recertification, Other Follow-up and Discharge.

Q13.3. [Q&A RETIRED 05/22]

Q14. M0090. We have 5 calendar days to complete the admission/Start of Care assessment. What date do we list on OASIS for M0090 - Date Assessment Completed when information is gathered on day 1, 3 and 5? [Q&A EDITED 10/23; EDITED 05/22; EDITED 04/15]

A14. 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.

If the original assessing clinician gathers additional information during the SOC 5 day assessment timeframe that would change a data item response, the M0090 date would be changed to reflect the date the information was gathered and the change was made. If an error is identified at any time, it should be corrected following the agency's correction policy and M0090 would not necessarily be changed.

Q15. [Q&A RETIRED 05/22]

Q16. M0090. Is the date that an assessment is completed, in M0090, required to coincide with the date of a home visit? When must the date in M0090 coincide with the date of a home visit? [Q&A EDITED 10/23; EDITED 05/22; EDITED 08/07]

A16. M0090 - Date Assessment Completed may not coincide with the date of a home visit. M0090 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.

For example, in a situation where the clinician needs to follow up, off site, with the patient's family or physician in order to complete a specific clinical data item that the patient is unable to answer, M0090 should reflect that date, even if no visit is provided on that date.

Q17. M0090. If an HHA's policy requires personnel knowledgeable of ICD-10-CM coding to complete the diagnosis after the clinician has submitted the assessment, should M0090 be the date that the clinician completed gathering the assessment information or the date the ICD-10-CM code is assigned? [Q&A EDITED 05/22; EDITED 04/15; EDITED 08/07; ADDED 06/05]

A17. The HHA has the overall responsibility for providing services, assigning ICD-10-CM codes, and billing. CMS expects that each agency will develop their own policies and procedures and implement them throughout the agency in a manner that allows for correction or clarification of records to meet professional standards. It is appropriate for the clinician to enter the medical diagnosis on the comprehensive assessment. The HHA can assign a qualified coder to determine the correct numeric code based upon the written diagnosis provided by the assessing clinician. The 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. The M0090 date should not necessarily be delayed until coding staff verify the numeric codes.

Q18. M0090. Should the date in M0090 - Date Assessment Completed, reflect the date that a supervisor completed a review of the assessment? [Q&A EDITED 05/22; EDITED 08/07]

A18. While a thorough review by a clinical supervisor may improve assessment completeness and data accuracy, the process for such review is an internal agency decision and is not required. The 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.

Q19. M0090. A provider has decided to complete discharge assessments for all patients when payers change because they believe that, by doing so, their reports will better indicate their patients' outcomes. Before making this policy shift they need answers to the following questions: [Q&A EDITED 06/14; ADDED 06/05]

a. **Can the agency perform the RFA 09 and RFA 01 on the same visit?**
b. **If so, what is the discharge date for the RFA 09 at M0090?**
c. **If so, what is the admission date for RFA 01 at M0090?**
d. **Will recording of the same date for both of these assessments result in errors when transmitted to the OASIS system?**

A19. Under normal business practices, one home health visit should not include two types of assessments and be billed to two payer sources. The discharge date for the (RFA 09) Discharge from Agency should be the last date of service for the payer being terminated. The admission date for the new Start of Care (RFA 01) assessment should be the next scheduled visit, according to the Plan of Care. The agency may send a batch including both assessments to the OASIS system. An edit is in place at the OASIS system to sort for an assessment to close an open patient episode prior to opening a new episode.

Q19.1. [Q&A RETIRED 05/22]

Q19.2. M0090. I understand that M0090 - Date Assessment Completed, is the day the last information needed to complete the assessment is collected, and at discharge, it is generally the last visit. Due to the Notice of Provider Non-Coverage which must be given to Medicare recipients two days before discharge, there have been occasions when the notice was not signed at the discharge visit. In order to give the patient the 2 day notice, we hold discharging until after they have had the patient sign the notice, and call them back in two days to confirm the discharge plan, however, the OASIS is completed based on the last visit. When this happens, the system gives us an error when we put in the last visit date versus that last discharge date, even though the assessment is based on the last visit. [Q&A EDITED 05/22; EDITED 01/12; ADDED 09/09; Previously CMS OCCB Q&A 10/07 Q9]

A19.2. 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. In most cases, but not all, M0090 is the day of a visit. Sometimes the clinician may gather information off site, such as Therapy Need, or other items that are dependent on a call back from a caregiver or physician or other non-patient assessment data, like dates. M0906, Discharge Date, is defined by agency policy. For some agencies it is the date of the last visit, but other agencies may define it to be one or two days or more after the last visit. It is not prescribed by regulation, except that the discharge date cannot occur before the date of the last visit.

Regulation requires that the discharge assessment must be completed within two calendar days of the actual discharge date or within two calendar days of learning of the need to discharge in the case of an unplanned or unexpected discharge.

In the case you described, the discharge date (M0906) could be defined by the agency's policy as two days after the last visit to allow for the notice of non-coverage. The clinician would then have up to two calendar days after M0906 to complete the assessment (M0090).

The bulk of the assessment items could be completed on the visit and then M0906 - Discharge date and M0090 - Date Assessment Completed (the last items you needed to complete the assessment) could be 2 days after the date of the last visit, once the discharge was a certainty. Establishing a policy that defines the discharge date in this way prevents the problem with the timing of the data submission and is compliant with the regulation.

Q19.3. M0090. Should the M0090 - Date Assessment Completed date be changed when a correction is made after a clinician has completed the assessment but before the assessment is locked? For example, the nurse completes the assessment with a M2200 - Therapy Need response of 3 visits on February 1st and records that date at M0090. On Feb 2nd the nurse learns that the therapist assessed the patient and received physician orders for 10 therapy visits. Should the M0090 date be changed to February 2nd to reflect the date that M2200 is corrected? [Q&A EDITED 05/22; ADDED & M number updated 09/09; Previously CMS OCCB Q&A 04/08 Q4]

A19.3. If the original assessing clinician gathers additional information during the SOC 5 day assessment timeframe that would change a data item response, the M0090 - Date Assessment Completed would be changed to reflect 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. If an error is identified at any time, it should be corrected following the agency's correction policy and M0090 would not necessarily be changed.

Q19.4. M0090. I was reviewing CMS OASIS Q&A Cat. 4b Q19.3 and noted that the response states: "if the original assessing clinician gathers additional information during the SOC 5 day assessment timeframe", M0090 - Date Assessment Completed would need to reflect that more recent date. Our practice is to hold the OASIS SOC until all the therapy disciplines have submitted the add-on orders, complete with their frequencies. Then the OASIS document is submitted with the totaled number. This should be our best estimate of the actual number of visits planned for the patient by therapy.

My question is: In our situation, would "original assessing clinician" extend to the record review department? Would they need to change the M0090 answer once the totaled number of visits is added and put in M2200 - Therapy Need? [Q&A EDITED 05/22; ADDED & M number updated 09/09; EDITED 04/15; Previously CMS OCCB Q&A 01/09 Q4 & Q7]

A19.4. One clinician is responsible for completing the comprehensive assessment including the OASIS. If the assessing clinician gathers new information during the 5 day assessment timeframe, they may change the response to that item and change the M0090 date to reflect the 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. This would apply to M2200 - Therapy Need.

If the OASIS is completed by the assessing clinician and then, through an internal review process in the office, it is discovered that the OASIS data contains one or more errors, the identified data item(s) could be corrected by the qualified clinician responsible for performing the review following your agency's correction policy and in such cases of error correction, M0090 would not be changed.

Q19.4.1. [Q&A RETIRED 05/22]

Q19.5. M0090. I am not sure how to complete M0090 when it is a therapy only case and the RN in the office performs the final review and checking off of the medication sheet for interactions or issues? [Q&A EDITED 05/22; ADDED 09/09; Previously CMS OCCB Q&A 07/09 Q4]

A19.5. 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. The Condition of Participation, §484.55, requires that a drug regimen review be performed each time a comprehensive assessment is required. When the therapist has completed the SOC Comprehensive Assessment, and the agency has a nurse in the office review the med list, the M0090 date would reflect 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.

Q20. [Q&A RETIRED 05/22]

Q20.1. M0100. When we complete the RFA 6, Transfer to an inpatient facility - patient not discharged from agency; and the patient does not return to us, do we have to cancel the RFA 6 and resubmit the RFA 7, Transfer to an inpatient facility - patient discharged from agency? [Q&A EDITED 05/22; ADDED to Cat. 4b 06/14; ADDED 01/12 to Cat. 2 as Q41.1; Previously CMS OCCB Q&A 10/11 Q3]

A20.1. If you complete and transmit the RFA 6, Transfer to an inpatient facility - patient not discharged from agency, and the patient does not return to the care of the agency during the current 60 day certification period, no further OASIS is required. The quality episode ended with the Transfer (RFA 6) that was completed. You do not need to cancel the RFA 6 and resubmit the RFA 7, just complete your agency's internal discharge paperwork.

Q21. M0100. For a one-visit Medicare PPS (PDGM) patient, is Reason for Assessment (RFA) 1 the appropriate response for M0100? Is it transmitted? Is a discharge OASIS required? [Q&A EDITED 10/23; EDITED 05/22; EDITED 06/14]

A21. Based on CMS policy, OASIS data collection and submission is not required when only one visit is made in a quality episode (SOC/ROC date to TRF/DC). However, to bill Medicare PPS (PDGM) for a single visit quality episode, OASIS data must be collected and submitted, and used to calculate a HIPPS code for inclusion on the Medicare claim. If you choose NOT TO BILL Medicare for the single visit provided, there is no requirement to collect and transmit OASIS data for the single visit quality episode.

If OASIS is collected, RFA 1 - SOC is the appropriate response on M0100 for a one-visit Medicare PPS (PDGM) patient. When a patient is discharged after only one visit (a single visit quality episode), a Discharge OASIS should NOT be collected or submitted.

Q21.1. [Q&A RETIRED 05/22]

Q22. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q23. M0100. A patient receiving skilled nursing care from a HHA under Medicare is periodically placed in a local hospital for family respite. Does a patient receiving respite care in a hospital meet the requirements for an agency to complete a Transfer and Resumption of Care OASIS? [Q&A EDITED 10/23; EDITED 05/22; EDITED 12/12; ADDED 06/05; M number updated 09/09]

A23. Yes, if the patient was admitted to an inpatient facility bed for 24 hours or longer for reasons other than diagnostic testing, a Transfer OASIS is required. Respite care is more than diagnostic testing and the response to M0100 - Reason for Assessment (RFA) is RFA 6 or 7, Transfer to an inpatient facility. If the agency anticipates the patient will return to their care after the inpatient stay, RFA 6 – Transferred to an inpatient facility – patient not discharged from agency should be completed. RFA 7 – Transferred to an inpatient facility – patient discharged from agency will be selected if the agency does NOT anticipate the patient will return to their care.

Q23.01. M0100. If a patient was admitted to the hospital at 3 pm yesterday and then transfers directly to a hospice inpatient unit at 11 am today, are the inpatient hours additive? Should we do a Transfer at 3 pm today, after a full 24 hours of inpatient care, or does the clock start again at 11 am when the patient was admitted to the hospice inpatient? The same could happen with other inpatient settings- such as hospital and NF. [Q&A ADDED 06/14; Previously CMS Qtrly Q&A 07/13 Q3]

A23.01. A Transfer OASIS is required when the patient has been transferred to an inpatient bed for 24 hours or longer for reasons other than diagnostic testing. If the patient was admitted to one inpatient facility bed then transferred to another, the Transfer OASIS would be required once a total of 24 hours have been spent as an inpatient, under an inpatient billing status. In the situation described, a Transfer is required once the patient was inpatient for a total of 24 hours, in one or more inpatient facilities.

Q23.1. M0100. I understand that when calculating the days you have to complete the comprehensive assessment, the SOC is Day "0". At the other OASIS data collection time points, when you are calculating the number of days you have to complete an assessment, is the time point date, Day "0", e.g. for RFA 9, Discharge from Agency, the assessment must be completed within 2 calendar days of M0906, Discharge/transfer/death date. Is M0906 Day "0"? [Q&A EDITED 05/22; ADDED 08/07; Previously CMS OCCB Q&A 07/06 Q3]

A23.1. Yes, when calculating the days, you have to complete the comprehensive assessment, the SOC date is day "0". For the other time points the date of reference (e.g., transfer date, discharge date, death date) is day "0".

Note that for the purposes of calculating a 60-day certification period, the SOC day is day "1".

Q23.2. M0100. A patient is admitted to the hospital for knee replacement surgery. During the pre-surgical workup, a test result caused the surgery to be canceled. The patient only received diagnostic testing while in the hospital but the stay was longer than 24 hours. Does this situation meet the criteria for RFA 6 or 7, Transferred to inpatient facility? [Q&A ADDED 08/07; Previously CMS OCCB Q&A 07/06 Q4]

A 23.2. No, under the circumstances described, the patient did not meet the OASIS transfer criteria of admission to an inpatient facility for reasons other than diagnostic testing, if the

patient, indeed, did not have any other treatment other than diagnostic testing during their hospitalization. If the patient received treatment for the abnormal test result, then the situation, as described, would meet the criteria for RFA 6 or 7, Transfer to inpatient facility.

Q23.3. [Q&A RETIRED 05/22]

Q23.3.1. M0100. Our Home Health agency admitted a patient on July 1st. He was admitted to the hospital on July 28th; from there he went to a skilled nursing facility on August 6th where he stayed until he died on September 17th. When our Home Health agency audited the discharged record this week, it was discovered that a Transfer OASIS had never been done. My question is, should a Transfer OASIS be done and submitted this late after discharge from Home Health? [Q&A EDITED 10/23; EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 01/16 Q1]

A23.3.1. In the scenario described, the Transfer OASIS (M0100 - RFA 7 – Transferred to an inpatient facility – patient discharged from agency) would be completed to end the patient's quality episode. The M0906 date would be the date the patient transferred to the hospital (July 28th), and the M0090 - Date Assessment Completed would be the day that information used determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed. The Transfer OASIS is due within two calendar days of the qualifying transfer to an inpatient facility. OASIS not completed according to the required timeframes represents noncompliance with the data collection rules.

Q23.4. [Q&A RETIRED 10/18]

Q23.5. [Q&A RETIRED 05/22]

Q23.6. M0100. For the purposes of determining if a hospital admission was for reasons "other than diagnostic tests" how is "diagnostic testing" defined? I understand plain x-rays, UGI, CT scans, etc. would be diagnostic tests. What about cardiac catheterization, an EGD, or colonoscopy? (A patient does receive some type of anesthesia for these). Does the fact that the patient gets any anesthesia make it surgical verses diagnostic? [Q&A ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q9]

A23.6. Diagnostic testing refers to tests, scans and procedures utilized to yield a diagnosis. Cardiac catheterization is often used as a diagnostic test to determine the presence or status of coronary artery disease (CAD). However, a cardiac catheterization may also be used for treatment, once other testing has established a definitive CAD diagnosis. Each case must be considered individually by the clinician without making assumptions. The fact that the procedure requires anesthesia does not determine whether or not the procedure is purely diagnostic or not. Utilizing the definition of diagnostic testing, a clinician will be able to determine whether or not a certain procedure or test is a diagnostic test.

Q23.7. M0100 & M2410. HHAs are providing services for psychiatric/mental health patients. The physician admits the patient to the hospital for "observation & medication review" to determine the need to adjust medications. These admissions can occur as often as every 2-4 weeks. The patient(s) are admitted to the hospital floor under inpatient services (not in ER or under "observation status"). The patient(s) are observed and may receive some lab work. They are typically discharged back to home care services within 3-7 days. Most patients DO NOT receive any treatment protocol (i.e., no medications were added/stopped or adjusted, no counseling services provided) while they were in the hospital. Is this considered a qualifying inpatient admission? How do you answer M0100

– Reason for Assessment & M2410 – To which Inpatient Facility? [Q&A EDITED 05/22; EDITED 12/12; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q10]

A23.7. In order to qualify for the Transfer to Inpatient Facility OASIS assessment time point, the patient must meet 3 criteria:

1) Be admitted to the inpatient facility (not the ER, not an observation bed in the ER)
2) Reside as an inpatient for 24 hours or longer (does not include time spent in the ER)
3) Be admitted for reasons other than diagnostic testing only

In your scenario, you are describing a patient that is admitted to the inpatient facility and stays for 24 hours or longer for reasons other than diagnostic testing. An admission to an inpatient facility for observation is not an admission for diagnostic testing only. This is considered a qualifying inpatient hospitalization. The correct M0100 - Reason for Assessment (RFA) response would be either RFA 6 -Transfer to an inpatient facility - patient not discharged from agency or RFA 7 - Transfer to an inpatient facility - patient discharged from agency, depending on whether the agency anticipated the patient would return to their care (RFA 6) or not (RFA 7). M2410 - To which Inpatient Facility would be answered with Response 1 - Hospital as you state the patient was admitted to a hospital.

Q23.8. M0100 & M2301. Observation Status/Beds - A patient is held for several days in an observation bed (referred to as a "Patient Observation" or "PO" bed) in the emergency or other outpatient department of a hospital to determine if the patient will be admitted to the hospital or sent back home. While under observation, the hospital did not admit the patient as an inpatient, but billed as an outpatient under Medicare Part B. Should we complete a transfer, discharge the patient, or keep seeing the patient. [Q&A EDITED 05/22; EDITED 10/16; EDITED 06/14; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q11]

A23.8. For purposes of M2301 - Emergent Care, Response 1, Yes, used hospital emergency department WITHOUT hospital admission, is the appropriate response for a patient who was held in a hospital emergency department for outpatient observation services without a subsequent qualifying hospital admission. A qualifying hospital admission is an admission to a hospital inpatient bed for 24 hours or longer for reasons other than diagnostic testing. A Transfer OASIS is not required.

If, from observation status, the patient was eventually admitted to the hospital as an inpatient and the transfer criteria were met, the Transfer OASIS would be required. The agency would complete RFA 6 or RFA 7 data collection, depending on whether they anticipated the patient would return to their service (RFA 6) or not (RFA 7).

During the period the patient is receiving outpatient observation care, the patient is not admitted to a hospital. Regardless of how long the patient is cared for in outpatient observation, the home care provider may not provide Medicare billable visits to the patient at the ER/outpatient department site, as the home health benefit requires covered services be provided in the patient's place of residence.

If the patient is not admitted to the hospital, but returns home from the emergency department, based on physician orders and patient need, the home health agency may continue with the previous or a modified Plan of Care. An Other Follow-up OASIS assessment (RFA 5) may be required based on the agency's Other Follow-up policy criteria.

Q23.9. M0100. An HHA has a patient who has returned home from a hospital stay and they have scheduled the nurse to go in to do the resumption of care visit within 48 hours. However, this patient receives both nursing and physical therapy and the PT cannot go in on the 2nd day (tomorrow) and would like to go in today. I have found the standard for an initial assessment visit must be done by a registered nurse unless they receive therapy only. Is this the same case for resumption? Is it inappropriate for the PT to go in the day before and resume PT services and the nurse then to go in the next day and do the ROC assessment update? [Q&A EDITED 10/23; EDITED 10/18; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q12]

A23.9. The requirement for the RN to complete an initial assessment visit prior to therapy visits in multidisciplinary cases is limited to the SOC time point. At subsequent time points, including the ROC, either discipline (the RN or PT in the given scenario) could complete the ROC assessment. In the situation described, while the ROC visit and assessment must be completed within 48 hours of the patient's return home from the inpatient facility, there is no requirement that other services be delayed until the assessment is completed. Therefore, assuming compliance with your agency-specific policies and other regulatory requirements, there is no specific restriction preventing the PT from resuming services prior to the RN's completion of the ROC assessment.

Q23.10. M0100. If a patient goes into a hospital as a "planned admission", do we have to do a Transfer? We have a patient who is admitted routinely for chemotherapy treatments as planned admissions. Is this different than an admission for "planned" diagnostic testing? If it is a planned admission for testing only and "something goes wrong", does it become a Transfer? [Q&A EDITED 10/23; EDITED 05/22; ADDED 09/09; Previously CMS OCCB Q&A 04/09 Q6]

A23.10. An RFA 6 or 7, Transfer to an inpatient facility, is required any time the patient is admitted to an inpatient facility for 24 hours or longer for reasons other than diagnostic testing. The fact that it was a planned admission is not a factor in determining if the Transfer OASIS data collection and submission are required. The patient who goes routinely into an inpatient facility for chemotherapy would require an RFA 6 or 7, Transfer to an inpatient facility, if they are admitted to an inpatient for 24 hours or longer since they are receiving treatment and not just diagnostic testing.

If a patient is admitted for diagnostic testing only and does not receive treatment, they do not require an RFA 6 or 7, Transfer to an inpatient facility, no matter how long they stay in the inpatient facility. If it was a planned admission for diagnostic testing and the patient ends up receiving treatment, a Transfer would be required if the stay in the inpatient bed is for 24 hours or longer.

Q23.10.1. M0100. Does CMS expect an RFA 5 - Other follow-up OASIS assessment in order to support a change in primary and/or other diagnoses on the claim for the second 30-day payment period under PDGM? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/19 Q8]

A23.10.1. When diagnosis codes change between one 30-day claim and the next, there is no requirement for the HHA to complete an RFA 5 - Other follow-up assessment to ensure that diagnosis coding on the claim matches to the OASIS assessment. The CoP §484.55(d) does require an RFA 5 when there has been a major improvement or decline in a patient's condition that was not envisioned in the original Plan of Care. CMS expects agencies to have and follow

agency policies that determine the criteria for when the Other Follow-up assessment is to be completed.

Q23.10.2. Per the CY 2019 and CY 2020 Home Health Final Rules, it appears that CMS expects HHAs to discharge a patient if the patient requires post-acute care from a SNF, IRF, LTCH or care in an inpatient psychiatric facility (IPF). The HHA could then readmit the patient, if necessary, after discharge from such setting. This goes against the common current practice of completing a transfer and then Resumption of Care (ROC) for patients transferred to <u>any</u> inpatient setting, unless they are not expected to need further home care.

Should we still complete an RFA 6 - Transferred to an inpatient facility – patient not discharged from agency when a patient is transferred into <u>any</u> inpatient setting and we expect to receive the patient back after their inpatient stay, and complete an RFA 7 - Transferred to an inpatient facility- patient discharged from agency when we do not expect to receive the patient back after the inpatient stay? Should we still complete an RFA 3 - ROC when a patient is discharged from <u>any</u> inpatient facility while still under the services of the agency? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 04/20 Q3]

A23.10.2. There is no change in the OASIS guidance in how agencies may use RFA 6 and RFA 7 when a home health patient is admitted for an inpatient stay. In the event that a patient had a qualifying hospital admission and was expected to return to your agency, you would complete RFA 6 - Transferred to an inpatient facility – patient not discharged from agency. If the patient was not expected to return to your agency after this inpatient hospital stay, you would compete RFA 7 - Transferred to an inpatient facility - patient discharged from agency.

However, if the patient requires post-acute care in a SNF, IRF, LTCH or IPF during the 30-day period of home health care, CMS expects and recommends (but does not require) the home health agency to discharge the patient by completing the RFA 7 and then to readmit the patient with a new Start of Care upon return to home care. If the home health agency decides to complete an RFA 6 (Transferred to an inpatient facility - patient not discharged from agency), the home health agency will need to complete an RFA 3 (ROC) upon return to home care as long the ROC assessment is completed prior to the end of the current certification period.

Q23.11. [Q&A RETIRED 09/09]

Q23.11.1. M0102 & M0104. When determining the physician-ordered SOC(ROC) date (for M0102) or the date of referral (for M0104) should communication from the hospital/SNF DC planner be considered as representing physician referral? [Q&A EDITED 05/22; ADDED 01/11; Previously CMS OCCB Q&A 10/09 Q2]

A23.11.1. Yes, a referral received from a hospital or SNF discharge planner on behalf of the physician/allowed practitioner should be considered when determining the physician-ordered SOC(ROC) date or the date of referral.

Q23.11.2. M0102 & M0104. How should M0102 - Date of Physician-ordered SOC (ROC) and M0104 - Date of Referral, be answered when you discover that the patient's insurance changed months ago and the new payer requires a new SOC with OASIS data? We have orders for the care but not for a specific date and we do not have a paper

referral for that new episode. Do we just use the SOC date as the M0102 date? [Q&A ADDED 01/11; Previously CMS OCCB Q&A 07/10 Q1]

A23.11.2. In the situation you present, there is no need to obtain either a physician's ordered start of care date or a referral date as you are not initiating care, just changing payers. In the specific situation where a new SOC comprehensive assessment is completed for the sole purpose of changing payers, M0102 - Date of Physician-ordered SOC would be “NA”. For M0104 - Date of Referral, enter the day prior to the new Start of Care Date. If you know the date the insurance is changing, then actual dates can be used.

Q23.11.2.01. M0102 & M0104. When following the guidance in Cat. 2 Q61 for a late F2F situation, how should M0102 - Date of Physician ordered SOC/ROC and M0104 - Date of Referral be answered, as M0030 (Start of Care Date) will change based off of the first billable visit? This “workaround” for the late F2F has the potential to have a negative impact on the timely initiation of care process measure.

> **Category 2 Q61: If the F2F does not occur within 30 days after the start of care (SOC), but it does occur, for example, on the 35th day, how should OASIS data be collected and submitted?**
>
> **Answer (excerpt): Where a face-to-face encounter did not occur within the 90 days prior to the SOC or within 30 days after the SOC, a provider may use an existing OASIS assessment to generate another OASIS with a reported SOC date equal to the first visit date after all Medicare HH eligibility criteria are met. If multiple OASIS assessments exist, the data from the assessment conducted closest to the date of Medicare eligibility should be used.**

[Q&A ADDED 10/16; Previously CMS Qtrly Q&A 01/16 Q2]

A23.11.2.01. In the scenario cited, where a new Start of Care Date is established based on the completion of a late face-to-face encounter for Medicare eligibility, report M0102 - Date of Physician-ordered SOC as “NA” and report M0104 - Date of Referral, as the day prior to the new Start of Care Date.

Q23.11.2.1. [Q&A RETIRED 10/18]

Q23.11.2.2. M0102 & M0104. We received a referral for home care but were unable to reach the patient for several days. We notified the physician of the problem. When the patient did answer our phone call, the patient requested we start care a week after the original order date. We sent a fax to the MD 5 days after the original order was received requesting a delay in the SOC with a specific date 3 days from then. If we received the order back from the MD prior to that new date, how do we answer M0102 - Physician-ordered SOC date and M0104 - Date of Referral? [Q&A EDITED 10/23; EDITED 05/22; EDITED 04/15; ADDED 06/14; Previously CMS Qtrly Q&A 04/14 Q5]

A23.11.2.2. The OASIS Guidance Manual, Chapter 3, Response-Specific Instructions for M0102 state "If the originally ordered Start of Care (SOC)/Resumption of Care (ROC) is delayed due to the patient’s condition or physician/allowed practitioner request (e.g., extended hospitalization), then the date specified on the revised order to start home care services would be considered the date of physician-ordered SOC/ROC."

In order to report this new updated/revised physician's ordered start of care date in M0102 – Date of Physician-ordered SOC/ROC, it must have been received before the end of the 48 hour initial assessment timeframe (or before the date of the previous physician's ordered start of care

date, if one was provided). If the order to extend the physician's ordered start of care date is received after the 48 hour initial assessment timeframe (or after the date of the previous physician's ordered start of care date, if one was provided), report NA for M0102 and report the original referral date in M0104 - Date of Referral.

Q23.11.3. M0104. The home health agency received a referral on June 1st, and then on June 2nd received a faxed update with additional patient information that indicates a possible delay in the patient's hospital discharge date. What is the referral date for M0104? [Q&A EDITED 05/22; ADDED 01/11; Previously CMS OCCB Q&A 10/09 Q3]

A23.11.3. If start of care is delayed due to the patient's condition or physician/allowed practitioner request and no date was specified as the start of care date, then the date the agency received updated/revised referral information for home care services to begin would be considered the date of referral. In your scenario, June 2 is the correct response for M0104 - Date of Referral.

Q23.11.4. M0104. If a referral is faxed to the agency after business hours but does not get processed until the next day, what date would we use for the referral date? [Q&A ADDED 01/12; Previously CMS OCCB Q&A 10/11 Q4]

A23.11.4. M0104 - Date of Referral, is the date stamped by your fax machine indicating when the referral was received.

Q23.11.5. M0102. We have a very large referral base send referrals via fax. The physician ordered SOC date indicated on the referral is often 2-3 days before the date we even receive the fax (time stamp on fax is January 6th for a physician ordered SOC date of January 4th). We have been completing M0102 - Date of Physician Ordered SOC date with the date specified by the physician (January 4th), which has penalized our agency on the Timeliness of Care measure. We have attempted to obtain a verbal order to update the SOC date, however the physician group have become irritated with our calls. Please advise. [Q&A EDITED 05/22; ADDED 04/15; Previously CMS Qtrly Q&A 01/15 Q4]

A23.11.5. The agency should contact the physician/allowed practitioner to state that a patient referral was received after the physician ordered SOC date and to confirm that patient is still in need of home care services. If the need still exists, a valid SOC order, with updated referral or physician's ordered SOC date can be obtained.

Q23.11.6. M0104. As outlined in the Conditions of Participation, the initial assessment visit must be conducted "within 48 hours of referral", and the referral date should be reported in M0104 – Date of Referral. What constitutes a "valid referral" for the purposes of considering that we, in fact, have an actionable referral to initiate home care services? Sometimes we get a home care referral from a hospitalist who will NOT be giving orders or signing the plan of care. Sometimes we get a referral that contains only the patient's name without any contact information (no phone number or address). Sometimes we get a general order to "Evaluate for Home Health Services". If/when we try to follow up with the patient's primary care physician, or with the referral source to get patient contact information or clarify orders, we don't hear back the same day, and wonder how/if this impacts our M0104 - Date of Referral and initial assessment visit compliance? [Q&A EDITED 10/23; EDITED 05/22; ADDED 04/15; Previously CMS Qtrly Q&A 10/14 Q2]

A23.11.6. In order to be eligible for the Medicare Home Health benefit, a patient must be "Under the care of a physician". 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 practitioner will provide the plan of care and ongoing orders. In cases where the referring physician is not going to provide orders and follow the patient, this is not a valid "referral" for M0104 – Date of Referral. In the example of a hospitalist who will not be providing an ongoing plan of care for the patient, the HHA must contact an alternate, or attending physician, and upon agreement from this following physician, for referral and/or further orders, the HHA will note this as the Referral date in M0104 (unless referral details are later updated or revised). 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, and 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.

Q23.11.7. M0104. A complete referral is received from a physician at an inpatient facility on 01/01 and has a diagnosis that does not fall into a PDGM clinical grouping; patient is discharged to home health on 01/01. Intake staff calls physician requesting a more specific diagnosis. The more specific diagnosis is received on 01/04 and care is started on 01/05. Will M0104 - Date of Referral be changed to 01/04 based on the update to the specificityof the diagnosis? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/20 Q3]

A23.11.7. 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, 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 01/01 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.

Q23.12., **Q23.13**., **Q23.14.**, **Q23.15.**, **Q23.16.**, **Q23.17.**, **Q23.18.**, **Q23.19**. [Q&As RETIRED 05/22]

Q23.20. M0110. Is M0110 - Episode Timing going to continue to be used under PDGM to calculate early or late episodes? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/19 Q11]

A23.20. No. Medicare claims data, not OASIS Assessment data, will be used in order to determine if a 30-day period is considered ‘‘early’’ or ‘‘late’’ under PDGM.

Q24. M0150. For M0150 - Current Payment Sources for Home Care, what should be the response if the clinician knows that a patient has health insurance but that the insurance typically won't pay until attempts have been made to collect from the liability insurance (e.g., for injuries due to an auto accident or a fall in a public place)? [Q&A EDITED 05/22; EDITED 08/07]

A24. The purpose of this data item is to identify the current payer(s) that your agency will bill for services provided by your agency during this home care episode. Note that the text of M0150 -

Current Payment Sources for Home Care asks for the "current payment sources" (emphasis added) and contains the instruction, "Check all that Apply."

The clinician should indicate at admission all pay sources that the agency will bill for services by checking all of the appropriate responses. The item is NOT restricted to the primary payer source. When a Medicare patient has a private insurance pay source as the primary payer, Medicare may be considered a secondary payer. For example, when a Medicare patient is involved in a car accident and someone's car insurance is paying for their home care, Medicare is the secondary payer and the response to M0150 should include either Response 1 or 2 as appropriate for that patient. The only way an agency can bill Medicare as a secondary payer is to consider that patient a Medicare patient from day 1, so that all Medicare-required documentation, data entry and data submission exist. Although the agency may "intend" that the private pay source will pay the entire cost of the patient's home care that usually cannot be verified at start of care and may not be determined until the care is completed.

Q25. M0150. Please clarify what Title V and Title XX programs are? [Q&A EDITED 05/22; REVIEWED 09/09]

A25. Title V is a State-determined program that provides maternal and child health services, which can include home health care. Title XX of the Social Security Act is a social service block grant available to States that provide homemaking, chore services, home management, or home health aide services. (Title III, also mentioned in Response 6 to M0150 is part of the Older Americans Act of 1965 that gives grants to State Agencies on Aging to provide certain services including homemaker, home-delivered meals, congregate nutrition, and personal care aide services at the State's discretion.)

Q26. [Q&A RECALLED 08/07]

Q27. M0150. A patient with traditional Medicare is referred for skilled services, and upon evaluation, is determined to *not* be homebound, and therefore *not* eligible for the home health benefit. The patient agrees to pay privately for the skilled services. Should M0150 include reporting of response 1 - Medicare (traditional fee-for-service)? [Q&A EDITED 05/22; ADDED 06/05; Previously CMS OCCB Q&A 10/04 Q2]

A27. The purpose of M0150 - Current Payment Sources for Home Care is to identify any and all payers to which any services provided during this home care episode are being billed. Although the patient described is a Medicare beneficiary, Response 1 of M0150, Medicare (traditional fee-for-service), would not be marked, since the current situation described does not meet the home health benefit coverage criteria. In fact, since Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 temporarily suspended OASIS data collection for non-Medicare and non-Medicaid patients, if the services will not be billed to Medicare or Medicaid, then no OASIS collection would be required for this patient; although, if desired, the agency may voluntarily collect it as part of the still-required comprehensive assessment. If at some point during the care, a change in patient condition results in the patient becoming homebound, and otherwise meeting the home health benefit coverage criteria, then a new SOC assessment would be required, on which Response 1 - Medicare (traditional fee-for-service) would be indicated as a payer for the care.

Q28. M0150. The patient's payer source changes from Medicare to Medicaid or private pay. The initial SOC/OASIS data collection was completed. Does a new SOC need to be completed at the time of the change in payer source? [Q&A EDITED 05/22; EDITED 06/14]

A28. Different States, different payers, and different agencies have varying responses to these payer change situations, so we usually find it most effective to ask, "Does the new payer require a new SOC?" HHAs usually are able to work their way through what they need to do if they answer that question. If the new payer source requires a new SOC (Medicare is one that DOES require a new SOC), then it is recommended that the patient be discharged from the previous pay source and re-assessed under the new pay source, i.e., a new SOC comprehensive assessment. The agency does not have to re-admit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails a new admission). When transitioning from a skilled Medicare or Medicaid patient to a payer not requiring OASIS, CMS encourages HHAs to complete a discharge assessment at the last visit under the Medicare or Medicaid pay source. While this is not a requirement, conducting a discharge assessment at the point where the patient's skilled need has ended provides a clear endpoint to the patient's episode of care for purposes of the agency's quality initiatives.

Q29. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q29.1. M0150. Do I mark response 1 - Medicare (traditional fee-for-service) if the patient's payer is VA? [Q&A EDITED 05/22; Q&A ADDED 08/07; Previously CMS OCCB Q&A 07/06 Q8]

A29.1. If the patient has both VA and Medicare and both are expected payers, then you need to mark Response 1 - Medicare (traditional fee-for-service) and Response 7 - Other government (e.g., TriCare, VA). But if the patient does not have Medicare, or Medicare is not an expected payer for provided services, then Response 7 - Other government (e.g., TriCare, VA) would be the correct response.

Q29.2. [Q&A RETIRED 05/22]

Q29.3. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q29.4. M0150. It has come to our attention that we have been answering M0150 - Current Payment Source for Home Care incorrectly. How far do we need to go back when correcting our errors? [Q&A EDITED 05/22; EDITED 10/18; EDITED 01/12; ADDED 09/09; Previously CMS OCCB Q&A 10/07 Q11]

A29.4. Identified errors must be corrected whenever errors are discovered, recognizing that there may be payment or quality measure implications. Effective January 1, 2020 home health agencies have up to 24 months from the assessment's M0090 - Date Assessment Completed to correct an OASIS record.

Q29.5. M0150. CMS Q&A Cat 4b Q24 says that "when a Medicare patient has a private insurance pay source, Medicare may be considered a secondary payer", therefore whenever we have a private insurance patient who also has Medicare, for M0150 we routinely mark both "1 - Medicare" and "8 - Private Insurance" (for health) and/or "11 - Other" (for auto, etc.), just in case Medicare ends up getting billed for a portion of the home care services. Are we interpreting this guidance accurately? And, for those cases where Medicare never ends up getting billed for services, can we retroactively correct M0150, eliminating response "1" or inactivate the assessments altogether, since OASIS

data collection/submission is not required for Private Pay patients only? [Q&A EDITED 10/23; EDITED 05/22; EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 01/08 Q14]

A29.5. M0150 - Current Payment Sources for Home Care, is asking for identification and reporting of any payers the agency plans to bill for services during this episode of care. When a Medicare patient is admitted for home care services under a private insurer and the Medicare is considered to be a secondary payer then Medicare would be included in M0150. This action will ensure that OASIS data is collected in the event Medicare is a payer. If at the end of the episode, the agency did not bill Medicare for services, (and assuming there were no other Medicare or Medicaid payers for home health services), then the agency should take action to delete any and all assessments (e.g., SOC, Transfer, ROC, Discharge), clarifying in the clinical chart why the assessment is being deleted. Simply correcting M0150 and resubmitting to the OASIS system or inactivating affected assessments will not adequately remove the patient from the database. If the assessment is not deleted, the patient identifiable data will remain in the database and may inappropriately impact quality initiatives.

Q29.6. M0150. CMS Q&A Cat. 4b Q24 states that if a patient is involved in an auto accident the M0150 - Current Payment Sources for Home Care response should be 1 or 2 as appropriate for that patient. Would we also pick response 11 - Other and enter auto insurance or UK - Unknown? [Q&A EDITED 05/22; ADDED 09/09; Previously CMS OCCB Q&A 01/08 Q15]

A29.6. Response 8 - Private Insurance refers to private health insurance. Response 11 - Other (specify) would be selected for home care services expected to be covered by auto insurance.

Q30. M1000. If the patient has outpatient surgery within the 14-day timeframe described in M1000 - Inpatient Facilities, should NA be marked? [Q&A EDITED 10/23; EDITED 05/22; EDITED 09/09]

A30. The correct response would be NA - Patient was not discharged from an inpatient facility for M1000 - Inpatient Facilities because the patient's status would have been an outpatient for this situation.

Q31. M1000. For M1000 - Inpatient Facilities, what is the difference between response 1 (long-term nursing facility) and 2 (skilled nursing facility)? [Q&A EDITED 05/22; EDITED 01/10]

A31. Response 1, Long-term nursing facility, would be appropriate if the patient was discharged from a long-term nursing facility or a Medicare-certified skilled nursing facility, but did not receive care under the Medicare Part A benefit in the 14 days prior to home health care. Response 2, Skilled nursing facility, would be appropriate if the patient was discharged from a Medicare certified nursing facility where they received a skilled level of care under the Medicare Part A benefit or a transitional care unit within a Medicare-certified nursing facility during the last 14 days.

Q32. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q32.1. M1000. When a patient is discharged from an inpatient facility in the last 5 days of the certification period, should M1000 - Inpatient Facilities on the Resumption of Care (ROC) assessment report inpatient facilities that the patient was discharged from during the 14 days immediately preceding the ROC date or the 14 days immediately preceding

the first day of the new certification period? [Q&A EDITED 05/22; EDITED 01/12; ADDED 08/07; Previously CMS OCCB Q&A 07/06 Q11]

A32.1. When completing a Resumption of Care assessment which will also serve as a Recertification assessment, M1000 - Inpatient Facilities should reflect inpatient facility discharges that have occurred during the two-week period immediately preceding the first day of the new certification period.

Q32.2. M1000. We had a client who was admitted to an inpatient facility for less than 24 hours. We did not do a Transfer OASIS because the criteria for it were not met. Two days later the patient was discharged from our agency and we completed a discharge comprehensive assessment. Approximately 1 week later, the client developed a wound and was readmitted to our agency. When completing the new SOC comprehensive assessment, how do we mark M1000 regarding Inpatient Facility Discharge in the Past 14 Days? [Q&A EDITED 10/23; EDITED 05/22; ADDED & M number updated 09/09; Previously CMS OCCB Q&A 10/07 Q12]

A32.2. M1000 - Inpatient Facilities asks if the patient was discharged from an inpatient facility during the past 14 days. In your scenario, you describe a patient who was admitted and discharged from an inpatient facility during the 14 days prior to the completion of the new RFA 1 SOC comprehensive assessment. The inpatient stay would be reported in M1000.

M1000 does not ask you to only report inpatient facility stays that meet the criteria for the OASIS Transfer, i.e., it does not require that the stay in the inpatient facility is for 24 hours or longer for reasons other than diagnostic testing. It simply asks whether the patient was discharged from an inpatient facility during the past 14 days.

Q32.3. M1000. We are seeing more patients referred to our agency that have been in observation bed status while in the hospital (not admitted). What would be the correct response to M1000 - Inpatient Facilities in this case? [Q&A EDITED 05/22; ADDED & M number updated 09/09; Previously CMS OCCB Q&A 04/09 Q7]

A32.3. M1000 - Inpatient Facilities, is asking from which of the following inpatient facilities was the patient discharged during the past 14 days. If the patient had been admitted to the hospital as an inpatient for observation, it is considered a hospital discharge. If the patient was not admitted as an inpatient, but placed under observation utilizing one of the two G-codes for hospital outpatient department observation services, then it would not be an inpatient facility discharge and therefore not reportable in M1000.

Q32.4. M1000. For PDGM, is a referral from a Swing Bed facility a referral from an acute care hospital? Or from a SNF? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/20 Q1]

A32.4. A patient in a Swing Bed facility may be receiving acute care, or SNF care, or both.

Q32.5. M1000. If a patient has been receiving care in their home under a Hospital at Home program, and is then referred to Home Health within 14 days of discharge from the program, how should M1000 - Inpatient Facility be coded? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 07/23 Q6]

A32.5. The intent of M1000 - Inpatient Facilities is to identify whether the patient has been discharged from an inpatient facility within the 14 days immediately preceding the Start of Care/Resumption of Care Date.

In an instance where a patient is receiving care in their home under a Hospital at Home program, they are considered to be in an inpatient facility. This is because the services being provided are being delivered under the coordination of an acute care hospital.

If the patient's discharge from the Hospital at Home program is within the past 14 days, then for M1000, response 3 - Short-stay acute hospital (IPPS) should be checked.

Q32.8. M1000 & M1005. Is treatment in the hospital emergency department and discharge home considered an inpatient admission when scoring the OASIS items M1000 - Inpatient Facilities & M1005 - Inpatient Discharge Date? [Q&A EDITED 05/22; EDITED 10/18; EDITED & Number updated 04/15; ADDED 12/12; Previously CMS Qtrly Q&A 01/12 Q7]

A32.8. Treatment in the hospital's emergency department without admission to an inpatient bed is not considered an inpatient admission and would not be reported as such when answering the OASIS items.

Q33. M1005. In OASIS field M1005 - Inpatient Discharge Date, if there is no date, do you just fill in zeros? [Q&A EDITED 05/22; EDITED 10/18; EDITED & Number updated 04/15; M number updated 09/09]

A33. As noted in the "Skip" instructions for item M1000 - Inpatient Facilities, if the patient was not discharged from an inpatient facility within the past 14 days, (i.e., M1000 has a response of NA), M1005 - Inpatient Discharge Date would be skipped If the patient was discharged from an inpatient facility during the past 14 days, but the date is unknown, mark UK at M1005 and leave the date blank.

Q33.1. M1005. Our patient was confirmed as inpatient status on 11/27. However, on 11/28 his status was changed to outpatient observation. (We have documentation to confirm these dates and change in status.) The patient remained in the facility as "observation" until 12/1. We performed a ROC assessment on 12/2.

What date do we enter in M1005 - Inpatient Discharge Date? Is it 11/28, the day his status went from inpatient to observation or do we use the date he actually left the hospital (i.e., 12/1)?

If we are supposed to use the 11/28 date, will that impact our compliance with performing a ROC within 48 hours of hospital discharge? [Q&A EDITED 05/23; EDITED 05/22; ADDED & EDITED 06/14; Previously CMS Qtrly Q&A 01/13 Q5]

A33.1. The M1005 - Inpatient Discharge Date, identifies the date of the most recent discharge from an inpatient facility within the past 14 days. Assuming the patient, in the above scenario, was discharged from the inpatient status and admitted to an outpatient observation status, 11/28 would be the appropriate date to enter into M1005. Clinical documentation will explain the unusual events that led to the non-compliant Resumption of Care (ROC) date.

(Note that a Transfer and ROC would only be required if the patient's admission met the definition of a qualifying inpatient stay (admitted to an inpatient facility for 24 hours or longer for reasons other than diagnostic testing).

Q34, Q35 & Q36. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q37. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q38 & Q39. [Q&As RETIRED 09/09; Outdated]

Q39.1 & 39.2. [Q&As RETIRED 01/12; Outdated]

Q39.3 [Q&A RETIRED 12/12; Added to Ch.3]

Q39.4, Q40, Q41 & Q41.1. [Q&As RETIRED 10/18; Items deleted from OASIS]

Q42. [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat. 4b, Q40.]

Q42.1. [Q&A RETIRED 09/09; Outdated]

Q42.2 & Q43. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q43.1. [Q&A RETIRED 09/09; Outdated]

Q43.2 & Q43.3. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q44. [Q&A RETIRED 06/14; Outdated]

Q44.1. M1021 & M1023. During a supervisor's audit of a SOC assessment, the auditor finds a manifestation code listed as primary without the required etiology code reported. Can this be considered a "technical coding error", and can the agency follow their correction policy allowing the agency's coding expert to correct the non-adherence to multiple coding requirements mandated by the ICD-10-CM coding guidelines, without conferring with the assessing clinician? [Q& A EDITED 05/22; EDITED 10/18; EDITED & Number updated 04/15; EDITED 06/14; ADDED 08/07; M number updated 09/09; Previously CMS OCCB Q&A 07/06 Q14]

A44.1. The determination of the primary and secondary diagnoses must be completed by the assessing clinician in conjunction with the physician/allowed practitioner. If the assessing clinician identifies the diagnosis that is the focus of the care and reports it in M1021 – Primary Diagnosis, and ICD-10-CM coding guidelines required that the selected diagnosis is subject to mandatory multiple coding, the addition of the etiology code and related sequencing is not a technical correction because a diagnosis is being added. If any diagnosis is being added, in this case for etiology/manifestation coding requirements, the assessing clinician must be contacted and agree.

If, based on the review of the comprehensive assessment and plan of care, the auditor questions the accuracy of the primary diagnosis selected by the assessing clinician, this is not considered a "technical error" and the coding specialist may not automatically make the correction without consulting with the assessing clinician.

If after discussion of the etiology/manifestation coding requirement between the assessing clinician and the coding specialist, the assessing clinician agrees with the coding specialist or auditor that the sequence of the diagnosis codes should be modified to more accurately reflect the diagnosis that is most related to the current POC per ICD-10-CM coding guidelines, agency policy will determine how (e.g., by whom) this change is made.

Q44.1.5. M1021 & M1023. Can anyone other than the assessing clinician enter the ICD codes? [Q&A EDITED 10/23; EDITED 05/22; EDITED 10/18; EDITED & Number updated 04/15; EDITED 06/14]

A44.1.5. Coding may be done in accordance with agency policies and procedures, as long as the assessing clinician determines the primary and secondary diagnoses and records the symptom control ratings. The clinician should provide the medical diagnoses requested in M1021/1023 - Diagnoses and Symptom Control. A coding specialist in the agency may enter the actual alphanumeric ICD-10-CM codes once the assessment is completed. The HHA has the overall responsibility for providing services and assigning ICD-10-CM codes. It is expected that each agency will develop their own policies and procedures and implement them

throughout the agency that allows for correction or clarification of records to meet professional standards. It is prudent to allow for a policy and procedure that would include completion or correction of a clinical record in the absence of the original clinician due to vacation, sick time, or termination from the agency.

Q44.1.6. M1021 & M1023. Please clarify if M1021 - Primary Diagnosis and M1023 - Other Diagnoses should include all known diagnoses as stated in the Interpretive Guidelines for HHAs or continue to report only current diagnoses as it is currently defined in the OASIS Guidance Manual for M1021 and M1023? Specifically clarify if M1021 and M1023 should include known diagnoses that are resolved or diagnoses that do not have the potential to impact the skilled services ordered? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/19 Q20]

A44.1.6. OASIS guidance states that M1021 - Primary Diagnosis and M1023 - Other Diagnoses should include only current diagnoses actively addressed in the Plan of Care or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis even if not the focus of any home health treatment itself. M1021 and M1023 should exclude resolved diagnoses or those that do not have the potential to impact the skilled services provided by the HHA. This description is in accordance with assigning primary and other diagnoses from the ICD-10-CM Official Guidelines for Coding and Reporting.

The Interpretive Guideline for HH CoP §484.60(a)(2) state that the individualized plan of care must include the following: (i) All pertinent diagnoses; … further explaining that "All pertinent diagnoses" means all known diagnoses.

For M1021 and M1023, continue to report only current medical diagnoses actively addressed in the plan of care or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis even if not the focus of any home health treatment itself. Include comorbidities, a condition coexisting with the principal diagnosis that can affect the Home Health Plan of Care in terms of services provided and time spent with patients. Exclude other resolved diagnoses or those that do not have the potential to impact the skilled services provided by the HHA.

Q44.1.7. M1021 & M1023. With PDGM, diagnosis grouping will come from the diagnoses listed on the claim. I understand that that the OASIS and claim diagnoses codes may not always match. There are 6 spaces for diagnosis on OASIS and 25 spaces for diagnosis on the claim. Can I include additional diagnosis on the claim after matching the first 6 from my OASIS? What kindof diagnoses may I list on the claim? Must they meet the definition of a primary and other diagnosis found in Chapter 3 of the OASIS Guidance Manual, M1021 – Primary Diagnosis and M1023 – Other Diagnoses? Or may I include any pertinent diagnosis, which means any <u>known</u> diagnosis, per the HH CoP 484.60(a)(2) Interpretive Guidelines? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/19 Q21]

A44.1.7. Any additional diagnosis listed on the claim should follow the OASIS definitions for primary and secondary diagnosis found in the OASIS Guidance Manual. Include only current diagnoses actively addressed in the plan of care or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis even if not the focus of any home health treatment itself. Exclude resolved diagnoses or those that do not have the potential to impact the skilled services provided by the HHA, even if they are known/documented diagnoses. Adhere to the ICD-10-CM Official Guidelines for Coding and Reporting when assigning ICD-10-CM diagnosis codes. Note that the CY2019 Home Health Final Rule has stated that, "Because ICD–10 coding guidelines require reporting of all secondary diagnoses

that affect the plan of care, we would expect that more secondary diagnoses would be reported on the home health claim given the increased number of secondary diagnosis fields on the home health claim compared to the OASIS item set."

Q44.1.8. M1021 & M1023. I was recently instructed that with PDGM, the diagnoses used to determine payment will come from the claim and these diagnoses may not necessarily match the diagnoses listed in M1021 - Primary diagnosis and M1023 - Other diagnoses on OASIS. Please clarify. [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/19 Q22]

A44.1.8. For case-mix adjustment purposes, the principal diagnosis reported on the home health claim will determine the clinical group for each 30-day period of care. In Change Request 11272, CMS has updated billing instructions to clarify that there will be no need for the HHA to complete an ‘‘Other follow-up’’ assessment (RFA 05) just to make the diagnoses match. Therefore, for claim ‘‘From’’ dates on or after January 1, 2020, the ICD–10–CM code and principal diagnosis used for payment grouping will be from the claim rather than the OASIS. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases. Additional claims processing guidance, including the role of the OASIS item set will be included in the Medicare Claims Processing Manual, Chapter 10.

Q44.2. M1021 & M1023. Is it true that you can never change M1021 - Primary Diagnosis or M1023 – Other Diagnoses from the original POC (cert) until the next certification? [Q&A EDITED 05/22; EDITED 10/18; EDITED & Number updated 04/15; EDITED 06/14; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q13]

A44.2. Guidance in Chapter 3 of the current OASIS Guidance Manual for M1021/M1023 - Diagnoses and Symptom Control states the primary diagnosis is the chief reason the patient is receiving home care and the diagnosis most related to the current home health Plan of Care. Other diagnoses are defined as “comorbid conditions that exist at the time of the assessment that are actively addressed in the patient’s Plan of care OR that have the potential to affect the patient’s responsiveness to treatment and rehabilitation prognosis, even if the condition is not the focus of any home health treatment itself”.

M1021 - Primary Diagnosis and M1023 - Other Diagnoses are reported at Start of Care and Resumption of Care. After completing a comprehensive assessment of the patient and receiving input from the physician/allowed practitioner, the clinician will report the patient’s current primary and other diagnoses at the SOC (and ROC if applicable). Diagnoses may change following an inpatient facility stay for the Resumption of Care. The chief reason an agency is caring for a patient may change. The focus of the care may change. At each required time point the clinician will assess and report what is true at the time of the assessment.

Q44.2.1. [Q&A RETIRED 05/22]

Q44.3. [Q&A RECALLED 09/09]

Q44.4 & Q44.5. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q44.6. [Q&A RETIRED 04/15; Obsolete with ICD-10-CM]

Q45 & 46. [Q&As RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q46.1. M1028. For M1028 (Active Diagnosis) and other IMPACT ACT added items, what do I record on the paper instrument if I could not assess or did not have the information at the time of the assessment? I realize I would submit a dash (-) in the electronic submission. I understand the circumstances in which a dash is appropriate per the

Guidance Manual. So, I don't need any guidance of when to use the dash. However, there is NO dash on the paper instrument. I would feel uncomfortable submitting something electronically that does not appear on the paper instrument. So, which takes precedence? The paper instrument, which does NOT allow a dash, OR the electronic data specs which allow a dash? [Q&A ADDED 10/16; Previously CMS Qtrly Q&A 10/16 Q5]

A46.1. For OASIS items that allow the dash (–) as a valid option, the clinician should enter a dash in the applicable box on the agency's paper or electronic assessment. CMS expects dash use to be a rare occurrence.

Q46.2. [Q&A RETIRED 10/18]

Q46.3. M1028. Regarding M1028 - Active Diagnoses, according to the OASIS Guidance Manual, if information regarding active diagnoses is learned after the end of the assessment timeframe, the OASIS Data Set should not be revised to reflect this new information. The OASIS Data Set should reflect what was known and documented at the time of the assessment.

My patient's referral states that the patient is pre-diabetic. On the third day (still within the 5 days for the assessment) new information is received that the patient is being considered diabetic and orders are received. Can M1028 be changed based on this new information? Or should it not be changed because information was obtained after the admission? [Q&A EDITED 05/22; EDITED 10/18; ADDED 10/16; Previously CMS Qtrly Q&A 10/16 Q7]

A46.3. Each assessment type has a defined timeframe for completion as specified in the OASIS Guidance Manual. Information collected by the assessing clinician during the timeframe for the specified assessment type should be documented and 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.

In the scenario cited, if the clinician confirmed the diagnosis of diabetes during the assessment timeframe and before the assessment was completed, reporting M1028 - Active Diagnoses as Response 2 - Diabetes Mellitus (DM) would be appropriate.

Q46.4. M1028. In M1028, I need clarification on the term "active diagnoses." Specifically, when would a diagnosis of DM, PAD or PVD that is reported in M1021 - Primary Diagnosis or M1023 - Other Diagnoses not be reported in M1028 - Active Diagnoses as well? Are active interventions (treatments) on the POC required, or is it enough that the diagnosed condition justifies general monitoring/assessment? For example, a patient is admitted to home health for physical therapy s/p total hip arthroplasty. The patient is also a type 2 diabetic. The patient's diabetes is controlled by diet and they are independent with monitoring their blood sugars. The patient is knowledgeable about diabetic foot care & checks their own feet daily using a mirror. Because the change in activity could affect the patient's blood sugar levels and because the diabetes could affect their ability to heal from surgery, DM meets the selection criteria for a secondary diagnosis and would be reported in M1023. While the PT will be monitoring the patient holistically to identify problems and modify the plan of care as appropriate with physician collaboration, the PT orders do not list any active interventions related to the

DM. Should DM be reported in M1028 as an Active Diagnosis? [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 10/16 Q8]

A46.4. "Active diagnoses" are diagnoses that have a direct relationship to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment. Diseases or conditions that have been resolved are not included for M1028 - Active Diagnoses.

In the scenario cited, it is stated that the patient has a diagnosis of diabetes which could be affected by the patient's currently limited mobility, and/or could impact the healing of the patient's surgical incision(s). The home health provider's monitoring of the patient/wound healing with specific knowledge that the patient is a diabetic, would make diabetes an active diagnosis for this patient.

Q46.5. M1028, M1021, M1023. Is it possible that DM, PAD or PVD would be identified as an Active Diagnosis in M1028 but not be included as a primary or secondary diagnosis in M1021 or M1023? For example, a patient is referred to home health for speech language pathology interventions related to dysphagia. The patient also has PAD which is documented in the patient's medical history. However, the PAD, while identified in the physician's summary/notes, does not meet the selection criteria for inclusion as a primary or secondary diagnosis as the SLP has no interventions related to the patient's PAD nor is it felt to have an impact on the patient's prognosis related to the dysphagia. Should the PAD be reported in M1028 - Active Diagnoses? [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 10/16 Q9]

A46.5. In the scenario cited, you ask if it is possible for DM, PAD or PVD to be considered an Active Diagnosis in M1028, but not be reported as a primary (M1021) or other (M1023) diagnosis. In the scenario cited, while the patient has the diagnosis of PAD, the clinician is determining that the PAD is not the chief reason for home health services (not the primary diagnosis), and is not a comorbid condition that is addressed in the plan of care, and isn't felt to have the potential to affect the patient's responsiveness to treatment (not a secondary diagnosis). Therefore, for this patient, PAD does not appear to have a direct relationship to the patient's current functional, cognitive, mood or behavior status, medical treatment, nurse monitoring or risk of death at the time of assessment, and therefore would not be reported as an Active Diagnosis in M1028.

Note that OASIS item M1023 provides space for the listing of up to 5 Other (secondary) diagnoses. If DM, PAD or PVD were considered to be a comorbid condition that is addressed in the plan of care, with the potential to affect the patient's responsiveness to treatment, then it would be considered an active diagnosis in M1028, even if it ends up not being listed in M1023, due to the limited number of coding spaces available in the OASIS.

Q47., Q48. [Q&As RETIRED 05/22; Item deleted from OASIS]

Q49. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q50. [Q&A RETIRED 05/22; Item deleted from OASIS]

Q51. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q52. [Q&A RETIRED 01/11]

Q53. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q53.1., Q53.2. [Q&As RETIRED 05/22; Item deleted from OASIS]

Q53.3. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q53.4., Q53.4.1., Q53.5., Q53.6., Q53.6.1., Q53.7., Q53.8., Q53.8.1., Q53.8.2., Q53.8.3., and Q53.8.4. [Q&As RETIRED 05/22; Item deleted from OASIS]

Q53.9. [Q&A RETIRED 05/22]

Q53.10., Q53.11. [Q&As RETIRED 05/22; Item deleted from OASIS]

Q54 & 55. [Q&As RETIRED 09/09; Outdated]

Q55.0.1. M1033. When a clinician is responding to M1033 - Risk for Hospitalization, how should exhaustion be defined for response 8 - Currently reports exhaustion? Does this refer to mental or physical exhaustion, or both? [Q&A EDITED 10/23; EDITED 05/22; ADDED 04/15; Previously CMS Qtrly Q&A 04/15 Q1]

A55.0.1. The assessing clinician may consider both physical and/or mental exhaustion when responding to M1033 - Risk for Hospitalization. Note that the information can be gathered by report and refers to the patient's "current" (day of assessment) status.

Q55.1. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q55.2. M1033. For M1033 - Risk of Hospitalization, if my patient is discharged from the acute care hospital in the morning and readmitted to the acute care hospital that same day, is that counted as two acute care hospital admissions? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/19 Q15]

Q55.2. Yes, if the patient is discharged from an acute care hospital in the morning and readmitted to an acute care hospital that same day and both hospitalizations meet the definition for an acute care hospitalization, that is counted as two hospitalizations. Observation stays are excluded.

Q55.3. M1033. For M1033 - Risk for Hospitalization, Response 7 - Currently taking 5 or more medications, does this include medications that the patient is not taking due to non-compliance? For example, we have a patient that is prescribed 8 medications but is only actually taking 3 because of non-compliance with the other 5. Would we select Response 7 because the patient is prescribed more than 5 medications, even though the patient is not taking more than 5 medications? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 07/20 Q7]

Q55.3. For M1033 - Risk for Hospitalization, medications include prescribed and over the counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route and as noted on the reconciled medication profile. Medications may also include total parenteral nutrition (TPN) and oxygen (as defined in M2001 - Drug Regimen Review).

In your scenario, if your patient has 8 medications on their reconciled medication profile, M1033 – Risk for Hospitalization coding would include "Response 7 - Currently taking 5 or more medications," even if the patient is not consistently taking the medication as prescribed.

Q55.4. M1033. For M1033 - Risk for Hospitalization does the time period under consideration or "lookback" period include the day of assessment? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 07/21 Q3]

A55.4. 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 through 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.

Q55.5. M1033. 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 EmergencyDepartment Visits? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 07/21 Q4]

A55.5. 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.

Q56, 57, 57.1, 57.2, 58, 59, 60, & 61. [Q&As RETIRED 09/09; Outdated]

Q62. [Q&A RETIRED 08/07]

Q62.1, 62.2, 62.2.1. [Q&As RETIRED 06/14; No longer relevant]

Q62.2.2. M1041. When completing M1041, Influenza Vaccine, what response option is correct if we gave the flu vaccine on Sept. 15th and there was a Transfer date (M0906) of Sept. 30th, but the date the Transfer OASIS was completed (M0090 – Date Assessment was Completed) was Oct. 2nd? [Q&A EDITED 10/23; EDITED 05/22; EDITED; ADDED & Number Updated 06/14; Previously CMS Qtrly Q&A 04/14 Q7]

A62.2.2. Patients that did not receive care, (or have any days of their quality episode occur) between October 1 and March 31 are excluded from the computation of the Influenza process measures. The quality episode begins with M0030/M0032 SOC/ROC Date and ends with the Discharge/Transfer/Death at home Date, M0906. In your scenario, the appropriate response for M1041, Influenza Vaccine Data Collection Period, would be "0 – No [Skip to M2401 - Intervention Synopsis]" because the patient transferred to the inpatient facility (M0906) on September 30th.

Q62.3. M1046. What is the appropriate response for M1046 - Influenza Vaccine Received, in a case where the patient states his physician told him not to get the vaccine during the 6 week period post joint replacement surgery? Joint replacement surgery is not listed at the CDC website as a medical contraindication for administration of the influenza vaccine. [Q&A EDITED 05/22; EDITED & M number updated 06/14; ADDED 01/12; Previously CMS OCCB Q&A 01/11 Q5]

A62.3. If the assessing clinician confirmed the fact that the physician medically restricted the patient from receiving the vaccine for any reason, the appropriate response for M1046 - Influenza Vaccine Received would be response 5 - No; patient assessed and determined to have medical contraindication(s).

Q62.4. M1046. Does the March 31 date serve as an official "end date" when determining current flu season? When answering M1046 at Transfer/Discharge, is there a point in

time that we move from "this year's" flu season to the next year's flu season as we consider the period of time following SOC/ROC? How would we score M1046 – Influenza Vaccine Received in the following situations?

a. **Patient has a SOC date of September 1, 2021 and receives the influenza vaccine from the home health agency on April 15, 2022 and is discharged from the agency the June 15, 2022.**
b. **Patient has a SOC date September 1, 2021, the vaccine was given September 15, 2021, and the patient was discharged on October 1, 2022 (the following year), and the flu vaccine for the 2022/2023 flu season is already available.**

[Q&A EDITED 05/22; ADDED, EDITED & M number updated 06/14; Previously CMS Qtrly Q&A 01/13 Q6]

A62.4. The current flu season is established by the Centers for Disease Control (CDC). Each year, flu vaccine manufacturers only release the vaccine per CDC recommendations. Therefore, when the flu vaccine is available for administration in late summer or early fall, it signals the beginning of the current flu season. The end of the flu season is generally considered March 31st.

a. If the patient was on service during the October 1 through March 31 data collection timeframe and the flu vaccine was given by the agency after the typical end of flu season, March 31st, M1046 would be answered "1-Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)".

b. If a patient's quality episode overlaps more than one influenza season, M1046 should be answered based on whether or not the patient received the influenza vaccine for the current flu season.

    - If patient received the flu vaccine for the flu season that was current at the time of discharge, in this case, the one for the 2022/2023 flu season one of the "Yes" responses would be appropriate.
    - If the patient received the vaccine for the past flu season (2021/2022), but not for the current flu season (2022/2023), one of "No" responses would be appropriate.

Q62.4.1. [Q&A RETIRED 10/18; Duplicative of OASIS Guidance Manual]

Q62.5. M1046. Due to state law and/or agency policies, some home health staff may not be allowed to transport meds (including vaccines)? Patient and/or the family members might need to pick the vaccine up for the agency to administer. How would the agency get credit for this process measure? [Q&A EDITED AND outdated items removed 05/22; EDITED AND M number updated 06/14; ADDED 01/11; Previously CMS OCCB Q&A 01/10 Q5]

A62.5. The process measure describing the best practice gives credit not only when the agency provides the immunization (regardless of who transports the vaccine to the patient's home), but the agency also may get credit by facilitating the patient's receipt of the immunization through other health care providers. This facilitation will be represented in M1046 - Influenza Vaccine Received, and computation of this related process measure will rely on both M1041 - Influenza Vaccine Data Collection Period and M1046 - Influenza Vaccine Received.

Q62.5.1. M1046. When the patient and caregiver cannot remember if the flu vaccination had been received, what response should be selected for M1046 - Influenza Vaccine

Received? [Q&A EDITED AND outdated items removed 05/22; ADDED 04/15; Previously CMS Qtrly Q&A 01/15 Q5]

A62.5.1. OASIS data are collected using a variety of strategies, including observation, interview, review of pertinent documentation (for example, hospital discharge summaries), discussions with other care team members where relevant (for example, phone calls to the physician to verify diagnoses), and measurement (for example, presence of anxiety). In the scenario provided, the patient and caregiver do not remember if the patient received the vaccination, the assessing clinician should employ other assessment strategies to obtain the needed information, such as, review of the medical record for history and physical information and communication with the physician.

If the assessing clinician is unable to determine whether the patient received the influenza vaccination, report Response 8 - No, patient did not receive the vaccine due to reasons other than those listed in Responses 4-7 for M1046 Influenza Vaccine Received.

Q62.6. [Q&A RETIRED 10/18; Duplicative of OASIS Guidance Manual]

Q62.7. [Q&A RETIRED 05/22; Item deleted from OASIS]

Q62.8. M1046. If your agency does not immunize patients, how would you answer M1046 - Influenza Vaccine Received? What if another provider offered and the patient refused, could we select Response 4 - Patient offered and declined? [Q&A EDITED 05/22; ADDED, EDITED & M number updated 06/14; Previously CMS Qtrly Q&A 07/13 Q5]

A62.8. It is not required that the agency offer to administer the flu vaccine in order to select 4 - Patient offered and declined, only that the patient was offered the vaccine by any healthcare provider, and they refused.

Q62.9 & Q62.9.1. [Q&As RETIRED 10/18; Duplicative of OASIS Guidance Manual]

Q62.100. M1060. 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? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 04/21 Q2]

A62.100. 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.

Q63. [Q&A RETIRED 09/09; Duplicative of Q64.2]

Q63.1. M1100. My patient lives in an Assisted Living Facility with their spouse and it is the spouse who requires the facility's assistance, not my patient. The facility is not contracted to provide any level of assistance to my patient, only the spouse. How do I report the patient's living arrangement in M1100 - Patient Living Situation? [Q&A EDITED 10/23; EDITED 05/22; ADDED 01/11; Previously CMS OCCB Q&A 10/09 Q10]

A63.1. Report the patient's living arrangement as "c. Patient lives in congregate situation (e.g., assisted living)" because the patient is living in the ALF. The availability of assistance selected should be determined using instructions from the OASIS Item guidance.

Q63.2. M1100. To select a response for M1100 - Patient Living Situation, should an agency request to see the ALF contract to determine availability of assistance? [Q&A EDITED 05/22; ADDED 01/11; Previously CMS OCCB Q&A 10/09 Q11]

A63.2. For M1100 - Patient Living Situation, a response from row C should be selected for a patient living in an assisted living setting (ALF). This would be true regardless of the services provided to the patient. To determine the frequency of availability of assistance, the clinician may refer to the ALF service contract or may gather information from the patient or family.

Q63.3. M1100. Does the rule that the availability of a call bell equates to "around the clock care" apply only to the ALF setting, or if one is available in congregate housing would the availability of assistance in that situation also be reported as around the clock availability of assistance as well? [Q&A ADDED 01/11; Previously CMS OCCB Q&A 01/10 Q6]

A63.3. If, in a congregate housing situation, the patient has available in-person assistance in response to a call bell 24 hours a day, the correct answer would be "around the clock."

Q63.4. M1100. How do you answer M1100 - Patient Living Situation, when the patient lives with their family member and the family member is being paid to care for the patient, either by the patient or by a state funded program? [Q&A ADDED 01/11; Previously CMS OCCB Q&A 01/10 Q8]

A63.4. When answering M1100 - Patient Living Situation, if a patient lives with their family, Row b., Patient lives with other person(s) in the home, would appropriately depict their living arrangement, even if the patient pays their family member to provide care or the family member is being paid through another source, e.g., another family member or state funded program.

Q63.5. M1100. How do we answer M1100 - Patient Living Situation, when the patient lives with the daughter, but the patient stays in an adult day care center during the day while the daughter works? [Q&A EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 01/13 Q7]

A63.5. In M1100 - Patient Living Situation, "availability of assistance" refers to in-person assistance provided in the home of the patient. If the daughter leaves the home to work during the day, but plans to be there for all the nighttime hours for the entire upcoming episode of care (with infrequent exceptions), "8 - Patient lives with another person with Regular nighttime assistance" would be appropriate. If the daughter is gone some nights or not present all the hours of the nighttime, "9 - Occasional/short-term assistance" would be appropriate.

Assistance provided outside the home is not reported in M1100.

Q63.6. M1100. My patient lives in the independent apartments section of a large continuum of care complex. No personal care or nursing care is included in the rent, but the patient does receive housekeeping weekly, meals and someone onsite will go to their room if they pull the call cord. They cannot assist them off the floor if they have fallen, only call 911. What is my patient's living situation when scoring M1100 - Patient Living Situation? [Q&A EDITED 05/22; ADDED 04/15; Previously CMS Qtrly Q&A 07/14 Q4]

A63.6. M1100 - Patient Living Situation, Response-specific instructions state "Lives in congregate situation: The patient lives in a setting where assistance, supervision and/or oversight are provided as part of the living arrangement, such as an assisted living facility, residential care home or personal care home. The patient may live alone, or with a spouse or

significant other, in an apartment or room that is part of an assisted living facility, for example, and still be considered living in a congregate situation."

In the large care continuum complexes, the patient is living in a congregate setting when "assistance, supervision and/or oversight are provided as part of the living arrangement." This is true even if, as described above, they are in an independent cottage or an independent apartment and they are getting services, like meals, housekeeping, or laundry services, as part of the living arrangement. Since they have a call bell in their apartment, the assistance is considered “Around the Clock” if onsite care continuum staff is available to respond to the bell 24/7 for the entire upcoming episode of care.

Q63.7. M1100. My patient lives in a large continuum of care community. In this community, they live in a single-family home with their spouse and at this point, does not receive any support, assistance or oversight from the community. They phone 911 for an emergency and have access to shared recreational areas within the community. For the purposes of M1100 - Patient Living Situation, does the patient live with other persons in the home, or in a congregate living situation? [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 04/16 Q5]

A63.7. Assuming that the option for the patient to receive assistance, supervision or oversight is not a part of the living arrangement with the continuum of care community, a response from Row b - Patient lives with other person(s) in the home would be appropriate. If assistance, supervision, or oversight is provided to the patient as part of the living arrangement, (for example weekend brunches in the main dining hall, or a morning check-in call), but the patient doesn’t need and/or chooses not to utilize the available services, a response from Row c - Patient lives in congregate situation would be appropriate.

Q64., Q64.1., Q64.1.1., Q64.2., Q64.3., Q64.4., Q64.5. [Q&As RETIRED 05/22; Item deleted from OASIS]

Q65. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q66. [Q&A RETIRED 09/09; Outdated]

Q66.1 & Q66.2. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q67, 68, 69, & 70. [Q&As RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q70.1, Q70.2, Q70.3, Q70.4, Q70.5, Q70.6 & Q70.7. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q71., Q72., Q73., Q73.1., Q73.2., Q73.3. [Q&As RETIRED 05/22; Item deleted from OASIS]

Q74 & 75. [Q&As RETIRED 09/09; Outdated]

Q76, 77, 77.1 & 77.2. [Q&As RETIRED 08/07; Outdated]

Q78. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q79, 80, 81, 82 & 86. [Renumbered and moved to Q112.6-112.10]

Q83, 84, 85 & 87. [Q&As RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q87.1. M1300's. Do CMS OASIS instructions supersede a clinical wound nurse training program? [Q&A EDITED 05/22; EDITED 09/09; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q22]

A87.1**.** CMS references, not clinical training programs should be used to guide OASIS scoring decisions. While CMS utilizes the expert resources of organizations like the Wound Ostomy Continence Nurses Society and the National Pressure Injury Advisory Panel to help suggest assessment strategies to support scoring of the integumentary items, in some cases, the OASIS scoring instructions are unique to OASIS and may not always coincide or be supported by general clinical references or standards. While CMS provides specific instructions on how OASIS data should be classified and reported, OASIS scoring guidelines are not intended to direct or limit appropriate clinical care planning by the nurse or therapist. For instance, even though for OASIS data collection purposes a bowel ostomy is excluded as a surgical wound, such data collection exclusion does not suggest that the clinician should not assess, document and include in the care plan findings and interventions related to the ostomy.

Q87.1.1, Q87.2, Q87.3 & Q87.4. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q88. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q88.1. [Moved to Cat. 4b Q102.1]

Q88.5. M1306. If you have two Stage 4 pressure ulcers with intact skin in-between them and a tunnel that connects them underneath the wound surface, do you have one pressure ulcer or two? [Q&A EDITED 10/16; ADDED 01/12; Previously CMS OCCB Q&A 01/11 Q8]

A88.5. If a patient develops two pressure ulcers that are separated by intact skin but have a tunnel which connects the two, they remain two pressure ulcers.

Q88.6. M1306. We are seeking direction regarding serum filled blisters that are caused by shoes rubbing against the foot. Some of our clinicians consider these "trauma wounds" and others consider them "stage 2 pressure ulcers". Please advise. [Q&A EDITED 05/22; EDITED 10/18; ADDED 10/16; Previously CMS Qtrly Q&A 01/16 Q4]

A88.6. If the cause of a wound is solely a friction force which leads to visible skin impairment, such as the serum filled blister cited in the scenario, it would NOT be categorized as a pressure ulcer.

Q89. [Q&A RETIRED 10/18]

Q89.1 & Q89.1.1. [Q&As RETIRED 10/18; Duplicative of OASIS Guidance Manual]

Q89.2. [Q&A RETIRED 06/14; Redundant to 89.2]

Q89.3. [Q&A RETIRED 10/18]

Q89.4. M1306-M1324. If at the SOC visit, the assessing clinician observes an open ulcer over a bony prominence, with history of pressure and visible bone, can the clinician report this as a Stage 4 pressure ulcer, even if not able to get confirmation of the diagnosis from the physician prior to completing the assessment? [Q&A EDITED 10/18; EDITED 10/16; EDITED 4/15; ADDED 06/14; Previously CMS Qtrly Q&A 01/14 Q5]

A89.4. These items are a report of the clinician's integumentary status assessment findings. A pressure ulcer/injury may be reported on OASIS based on visualization of the wound, patient assessment and interview, review of relevant related historical documentation and clinical

judgment re: etiology. Although the assessing clinician can report the observed ulcer/injury on the OASIS integumentary status items without physician confirmation, collaboration with the physician is required in order to add a diagnosis and ICD-10-CM code to the OASIS diagnosis items and the patient's Plan of Care and to receive related orders and/or provide physician ordered care related to the pressure ulcer/injury.

Q89.5. [Q&A RETIRED 05/22]

Q89.6. M1306. & M1311. If a patient has an unstageable pressure ulcer due to black stable eschar at SOC and during the episode it peels off and leaves an area of newly epithelialized tissue, how should this be staged at Discharge on M1311 – Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage? [Q&A EDITED 05/22; EDITED 10/16; Previously CMS Qtrly Q&A 10/16 Q14; ADDED 04/15; Previously CMS Qtrly Q&A 10/14 Q6]

A89.6. Once the full thickness pressure ulcer is completely covered with new epithelial tissue, the wound is considered healed and no longer reportable as a pressure ulcer on the OASIS.

Q90, 90.1 & 93. [Q&As RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q91 & 92. [Q&As RETIRED 09/09; Outdated]

Q94. M1306 - M1324. If a Stage 3 pressure ulcer is closed with a muscle flap, what is recorded? What if the muscle flap begins to break down due to pressure? [Q&A EDITED 10/16; EDITED 06/14]

A94. If a pressure ulcer is closed with a muscle flap (defined as full thickness skin and subcutaneous tissue partially attached to the body by a narrow strip of tissue so that it retains its blood supply), the new tissue completely replaces the pressure ulcer. In this scenario, the pressure ulcer "goes away" and is replaced by a surgical wound. If the muscle flap healed completely, but then began to break down due to pressure, it would be considered a new pressure ulcer. If the flap had never healed completely, it would be considered a non-healing surgical wound.

Q94.0.1 M1306 - M1324. I have a question about the current guidance that states: "If a pressure ulcer/injury is surgically closed with a flap or graft, it should be considered a surgical wound and not a pressure ulcer/injury. If the flap or graft fails, it should still be considered a surgical wound until healed".

Is this in reference to ANY point in time that the flap/graft fails? For example, if the area of flap/graft heals and has been 100% re-epithelized for greater than 30 days and a patient subsequently develops a wound at the site of the original flap/graft, would it be considered failed surgical site or would it be considered a pressure ulcer/injury? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/21 Q4]

A94.0.1 If a pressure ulcer/injury was closed with a skin graft or flap, the surgical wound healed, and another pressure ulcer/injury forms in the same anatomical location due to pressure, then this would be considered a pressure ulcer/injury. Note it should be staged at the highest stage the pressure ulcer/injury was prior to closure, unless currently presenting at a higher stage or unstageable.

Q94.0.2. M1306 & M1340. Would a stage 3 pressure ulcer covered with a pig bladder (skin substitute) be considered a skin graft and therefore a surgical wound? Or would it be

considered a pressure ulcer that was unstageable? Or something else? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 07/18 Q6]

A94.0.2. For OASIS coding purposes, when a pressure ulcer is treated surgically with any kind of graft or flap, it is no longer considered a pressure ulcer and is considered a surgical wound until approximately 30 days after re-epithelialization. In your example, as this ulcer was closed with a skin substitute, the wound should be reported as a surgical wound until the graft is completely healed and no longer reportable. If the flap or graft fails, it should continue to be considered a surgical wound until approximately 30 days after re-epithelialization.

Q94.1. M1306 - M1324. If the patient had a pressure ulcer and the post-op surgical report states it was surgically excised and closed without placement of a muscle flap, do we still have a Stage 4 pressure ulcer-the original etiology or did this become a surgical incision? [Q&A EDITED 10/16; ADDED & EDITED 06/14; Previously CMS Qtrly Q&A 07/13 Q8]

A94.1. If all the tissue damaged by pressure is removed surgically, e.g., amputation or surgical excision, there is no longer a pressure ulcer. It becomes a surgical wound until healed.

Q95. [Q&A RETIRED 10/18; Duplicative of OASIS Guidance Manual]

Q96. M1306-M1324. If a single pressure ulcer has partially granulated to the surface, leaving the ulcer open in more than one area, how many pressure ulcers are present? [Q&A EDITED 09/09]

A96. Only one pressure ulcer is present.

Q97. [Q&A RETIRED 09/09; Outdated]

Q98. M1306-M1324. Can a previously observable Stage 4 pressure ulcer that is now covered with slough or eschar be categorized as Stage 4? [Q&A EDITED 10/18; EDITED 10/16; EDITED 06/14; ADDED 06/05]

A98. No. In order to stage the pressure ulcer as a Stage 4, bone, muscle, tendon, or joint capsule (Stage 4 structures) must be visible or directly palpable. A pressure ulcer that has some degree of necrotic tissue (eschar or slough) present that the clinician believes may be obscuring the visualization of the wound bed such that the level of tissue damage cannot be assessed, should be reported as unstageable due to slough and/or eschar, even if it was previously numerically stageable.

Q98.1. [Q&A RETIRED 10/18]

Q98.1.2 M1306-M1324. Guidance states that the response to M1311 - Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage cannot be updated when the pressure ulcer that is unstageable at SOC/ROC becomes stageable during the assessment timeframe. Does this guidance also apply to M1324 – Stage of Most Problematic Unhealed Ulcer/Injury that is Stageable? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 1/19 Q3]

A98.1.2 The first clinical skin assessment is the assessment used to complete the Outcome and Assessment Information Set (OASIS). This is to ensure consistency of data collection across all post-acute care (PAC) providers. The guidance to assess and report the pressure ulcer stage and status as close to SOC/ROC as possible applies to all OASIS pressure ulcer items.

Q98.1.1. [Q&A RETIRED 05/22]

Q98.2. [Q&A RETIRED 10/18]

Q98.2.1. [Q&A RETIRED 10/18; Duplicative of OASIS Guidance Manual]

Q98.2.2. M1306, M1311, M1322 & M1324. How are mucosal membrane pressure ulcers reported in the OASIS data set? [Q&A EDITED 05/22; EDITED 10/18; EDITED 10/16; EDITED 06/14; ADDED 12/12; Previously CMS Qtrly Q&A 04/12 Q14]

A98.2.2. OASIS data set integumentary items only include wounds and lesions to the integumentary system and do not include mucosal membrane wounds or lesions. Pressure ulcers occurring to mucosal membranes would be reported in the comprehensive assessment and clinical documentation but not in any of the OASIS integumentary items.

Q98.3. M1306 - M1332. Are diabetic foot ulcers classified as pressure ulcers or stasis ulcers? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/18 Q4]

A89.3. A patient with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when reporting whether a patient with DM has an ulcer/injury that is caused by pressure or other factors. Once etiology is determined, the ulcer would be reported in the appropriate OASIS item(s), if applicable. If, for example, a patient with DM has a heel ulcer/injury from pressure, the etiology of the ulcer would be considered pressure, not a diabetic or stasis ulcer, and would therefore be reported inthe OASIS pressure ulcer items. The key to coding pressure ulcers is to determine if the primary etiology of the ulcer is pressure. The OASIS includes specific items to capture pressure ulcers, stasis ulcers or surgical wounds. Not all types of wounds will be captured in these items.

Q98.4. [Q&A RETIRED 06/14; No longer applicable]

Q98.4.1. [DELETED 04/15; Replaced by 4b Q.98.4.3.1]

Q98.4.2. [Q&A RETIRED 05/22]

Q98.4.2.1. M1311. Is a pressure ulcer automatically a Stage 4 if osteomyelitis is present, despite what type of breakdown there might be (for example only superficial skin loss)? [Q&A EDITED 10/18; ADDED 10/16; Previously CMS Qtrly Q&A 01/16 Q5]

A98.4.2.1. The presence of osteomyelitis is not a characteristic used to stage a pressure ulcer/injury and does not automatically result in a Stage 4 ulcer. The pressure ulcer/injury stage should correspond to the clinician's visual assessment or ability to directly palpate on the day of assessment. The definitions for staging the pressure ulcer are available in Chapter 3 of the OASIS Guidance Manual.

Q98.4.2.2 & Q98.4.3. [Q&A RETIRED 10/18]

Q98.4.3.1. M1311. Upon admission, our patient had two distinct pressure ulcers (one Stage 2 and one Stage 3) in close proximity. Over the course of the episode the ulcers deteriorated and at discharge no longer had any separating tissue. How would this be reported on M1311 - Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage at SOC and at discharge? [Q&A EDITED 10/18; EDITED 10/16; ADDED 04/15; Previously CMS Qtrly Q&A 04/15 Q2]

A98.4.3.1. Assuming the patient had no other pressure ulcers, on the SOC assessment, M1311A1, Number of Stage 2 pressure ulcers, would be coded "1". M1311B1, Number of Stage 3 pressure ulcers, would be coded as "1".

In the scenario you describe, at discharge the surface areas of the pressure ulcers extended to the point that the assessing clinician could no longer differentiate one pressure ulcer from the other. In this case, the patient would be considered to have one pressure ulcer. If at discharge, the pressure ulcer was stageable and had not progressed in anatomic depth, the patient would have one Stage 3 pressure ulcer. On the discharge assessment, M1311B1, Number of Stage 3 pressure ulcers, would be coded “1”. M1311B2, Number of these Stage 3 pressure ulcers that were present at the most recent SOC/ROC would be coded “1”.

If there had been an increase in numerical stage and the pressure ulcer was a Stage 4 at discharge, M1311C1, Number of Stage 4 pressure ulcers, would be coded “1”. M1311C2, Number of these Stage 4 pressure ulcers that were present at the most recent SOC/ROC would be coded “0”.

If the pressure ulcer was unstageable due to slough or eschar at discharge, M1311E1, Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar, would be coded “1”. M1311E2, Number of these unstageable pressure ulcers that were present at the most recent SOC/ROC, would be coded “0”.

Q98.4.3.2. M1311. Our patient has a Stage 3 pressure ulcer that we have been treating during the episode. At the reassessment, it is covered with a scab. I know a pressure ulcer is unstageable if it has a non-removable dressing or is completely covered with eschar or slough, but I do not know how a scab would affect the staging for M1311 - Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/18 Q5]

A98.4.3.2. A pressure ulcer that was staged and now has a scab indicates it is healing therefore, staging does not change. In this scenario, it is a healing Stage 3. Scabs and eschar are different. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.).

Q98.4.3.3. M1311. We had a patient that was admitted with bilateral heel Deep Tissue Injuries (DTIs) coded at SOC as two unstageable - Deep Tissue Injuries. At discharge, the DTIs have some dark eschar tissue on both heels. Should these be considered as present at the most recent SOC/ROC? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/19 Q23]

A98.4.3.3. For each pressure ulcer/injury observed at discharge, consider current and historical levels of tissue involvement. We would like to clarify that discharge coding for the scenario described is dependent upon the clinical progression of the wound during the episode.

If the patient is admitted with two unstageable Deep Tissue Injuries that do not evolve during the home health episode to be numerically staged and are unstageable due to eschar at the timeof discharge, then on the discharge assessment M1311E1 - Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar = 2 and M1311E2, Number of these unstageable pressure ulcers that were present at most recent SOC/ROC = 2. M1311F1 - Number of unstageable pressure injuries presenting as deep tissue injuries = 0.

However, any pressure ulcer/injury that is observed to be unstageable due to slough and/or eschar at the time of discharge but was previously numerically stageable during the home health quality episode, is considered new, and not coded as present at the most recent SOC/ROC.

Q98.4.3.4. M1311. 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"? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 07/21 Q5]

A98.4.3.4. If at discharge you have two stage 3 pressure ulcers, then M1311B1 - Number of Stage 3 pressure ulcers = 2. Assuming no other pressure ulcers/injuries are present M1311F1 - Number of unstageable pressure injuries presenting as deep tissue injury = 0.

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.

Q98.4.4. [Q&A RETIRED 10/18]

Q98.5. [Q&A RETIRED 10/16; Redundant to revised Q 89.1]

Q98.6. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q99. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q99.1. [Q&A RETIRED 09/09; Outdated]

Q99.1.1. [Q&A RETIRED 06/14; Item deleted]

Q99.2, Q99.2.1 & Q99.2.2. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q99.3. M1324. My patient has a Stage 3 pressure ulcer that is closing. How do I report the stage when the opening has shrunk to a pinpoint size and does not present a viewable base due to the small opening? [Q&A EDITED 10/18; EDITED 10/16; EDITED 06/14; ADDED 01/12; Previously CMS OCCB Q&A 10/11 Q7]

A99.3. If you have a Stage 3 that is in the process of closing, it remains an observable Stage 3 unless the wound bed was covered with a dressing that could not be removed or the wound bed was obscured with slough/eschar. If the wound margins are open and have now closed to the point where the opening is a pinpoint, the pressure ulcer would remain a Stage 3 until completely re-epithelialized at which time it would no longer be reported as a pressure ulcer on OASIS.

Q99.15. [Q&A RETIRED 10/18]

Q100. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q100.01. M1330. Our patient's lower extremity wound originated as a trauma wound due to a fall. The patient also has diagnoses of venous insufficiency and stasis dermatitis. The physician stated the wound is not healing due to the venous insufficiency. Is there a point in time when the wound is no longer classified as a traumatic wound and considered a stasis ulcer for M1330 - Does this patient have a Stasis Ulcer? [Q&A EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 01/13 Q9]

A100.01. M1330 - Does this patient have a Stasis Ulcer, identifies patients with ulcers caused by inadequate venous circulation in the area affected. The healing process of other types of wounds, e.g., traumatic wounds, surgical wounds, burns, etc., may be impacted by the venous insufficiency, but it would not change the traumatic or surgical wound into a venous stasis ulcer.

Q100.1. M1330, M1332, M1334. How do we answer the OASIS stasis ulcer questions when the patient diagnoses include Peripheral Arterial Disease and Venous Stasis Insufficiency? The nurse spoke with the physician who stated the patient had "mixed arterial and venous disease." [Q&A EDITED 05/22; EDITED 10/18; EDITED 06/14; ADDED 01/12; Previously CMS OCCB Q&A 07/11 Q6]

A100.1. In a situation where the clinician visually assessed ulcers on the lower legs that the physician diagnosed as a mixture of venous stasis and arterial ulcers, the OASIS stasis ulcer items would be answered as follows:

M1330 - Does this patient have a Stasis Ulcer? = Yes.

M1332 - Current Number of Stasis Ulcer(s) that are Observable would be answered reflecting only those ulcers that were a result of venous insufficiency, not arterial.

M1334 - Status of Most Problematic Stasis Ulcer that is Observable would be based on the one observable ulcer resulting from venous insufficiency that is the most problematic.

Q100.1.1. [Q&A RETIRED 05/22]

Q100.2. M1332. My patient has a venous stasis wound of the lower extremity that covers the entire lower leg, but in the midst of the wound there are two dark areas. Do we count this as one ulcer or two? [Q&A EDITED 10/23; ADDED 01/12; Previously CMS OCCB Q&A 07/11 Q7]

A100.2. If areas of venous stasis ulceration are contiguous and developed at the same time, the entire area would be counted as one stasis ulcer. If the patient had a venous stasis ulcer and then later developed another venous stasis ulcer, and eventually the wound margins met, it would be counted as two ulcers, as long as it remains possible to differentiate one ulcer from another based on wound margins. Depending on the timing and progression, it may be difficult for the clinician to know that a current ulcer was once two ulcers, and/or where one ulcer ends and another begins for assessment/reporting purposes. It would be up to the assessing clinician to determine the number of stasis ulcers in situations where multiple ulcers may have merged together.

Q101. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q102. M1340 - M1342. Is a gastrostomy that is being allowed to close on its own considered a surgical wound? [Q&A EDITED 10/18; EDITED 09/09]

A102. A gastrostomy that is being allowed to close would be excluded from consideration as a surgical wound, because it is an ostomy.

Q102.1. M1340. Is a peritoneal dialysis catheter considered a surgical wound? Isn't the opening in the abdominal wall a type of ostomy? [Q&A EDITED 10/18; ADDED 08/07; M number updated 09/09; Previously CMS OCCB Q&A 07/06 Q22]

A102.1. The site of a peritoneal dialysis catheter is considered a surgical wound. The opening in the abdominal wall is referred to as the exit site and is not an ostomy.

Q103. M1340. If the patient had a port-a-cath, but the agency was not providing any services related to the cath and not accessing it, would this be scored as a surgical wound? [Q&A EDITED 09/09]

A103. Yes.

Q104. M1340. Are implanted infusion devices or venous access devices considered surgical wounds? Does it matter whether or not the device is accessed routinely? [Q&A EDITED 09/09]

A104. Yes, the surgical sites where such devices were implanted would be considered surgical wounds. It does not matter whether the device is accessed at a particular frequency or not.

Q104.1. M1340. Is the Vantas implanted device considered a surgical wound? [Q&A ADDED 06/14; Previously CMS Qtrly Q&A 07/13 Q12]

A104.1. The VANTAS® Implant is inserted just under the skin in the upper arm and provides a continuous 12-month administration of histrelin acetate for the palliative treatment of advanced prostate cancer. Once the surgical incision that was created to implant the device is made and until the implant device is removed, it is considered a surgical wound for M1340.

Q105. [Q&A RETIRED 05/22]

Q105.1. M1340. If a patient has a venous access device that no longer provides venous access, (e.g. no bruit, no thrill, unable to be utilized for dialysis), is it considered a venous access device that would be "counted" as a surgical wound for M1340, Surgical Wound and the subsequent surgical wound question? [Q&A ADDED 08/07; Previously CMS OCCB Q&A 07/06 Q26]

A105.1. Yes, as long as the venous access device is in place, it is considered to be a surgical wound whether or not it is functional or currently being accessed.

Q105.1.1. M1340. Is an arteriovenous (AV) fistula considered as a current surgical wound? Does it matter if it is still utilized for dialysis? [Q&A ADDED 06/14; Previously CMS Qtrly Q&A 07/13 Q11]

A105.1.1. While the surgical connection of a vein to an artery is not a synthetic access/device, an AV fistula is considered a current surgical wound once it is surgically created and as long as it is present in the patient's body. This is true even if the fistula never matures, and/or is not currently used for vascular access.

In addition to AV fistulas, the sites of implanted venous access devices or other implanted infusion devices such as medication pumps, catheters for peritoneal dialysis, AV shunts or AV grafts should all be considered surgical wounds for as long as they are present, whether functional or not.

Q105.2. M1340. Does the presence of sutures equate to a surgical wound? For example, IV access that is sutured in place, a pressure ulcer that is sutured closed or the sutured incision around a fresh bowel ostomy. [Q&A EDITED 10/18; EDITED 01/10; ADDED 08/07; Previously CMS OCCB Q&A 07/06 Q27]

A105.2. No, the presence of sutures does not automatically equate to a surgical wound. In the examples given, a peripheral IV, even if sutured in place, is not a surgical wound. A pressure ulcer does not become a surgical wound by being sutured closed, and the bowel ostomy would be excluded from M1340 - Does this patient have a Surgical Wound.

Q105.3. M1340. Since an implanted venous access device is considered a surgical wound for M1340, when it is initially implanted, is the surgical incision through which it was implanted a second surgical wound (separate from the venous access device)? [Q&A

EDITED 05/22; EDITED 06/14; ADDED 08/07; Previously CMS OCCB Q&A 07/06 Q28 and CMS OCCB Q&A 04/10 Q12]

A105.3. An implanted venous access device is considered a current surgical wound as long as it is implanted in the patient's body.

When first implanted, the incision is the surgical wound. The assessing clinician will follow the guidance in Ch. 3 of the current OASIS Guidance Manual and the CMS OASIS Q&As to determine the healing status of the incision. Once it is fully epithelialized, the site due to the implanted device will remain a current surgical wound with a status of "Newly epithelialized" for as long as it is present in the patient's body, unless it later develops complications.

Q105.4. [Q&A RETIRED 05/22]

Q105.4.1. M1340. If, when reading op reports I find that tissue and/or other structures (mesh, necrotic tissue etc.) were excised when the operation procedure only states I&D, is the resulting wound a surgical wound even though the surgery is labeled I&D? [Q&A EDITED 05/22; ADDED & EDITED 09/09; M number updated 09/09; Previously CMS OCCB Q&A 10/07 Q18]

A105.4.1. A simple incision and drainage (I&D) or simple debridement are not surgical wounds for OASIS reporting. A surgical procedure that involves excision of necrotic tissue beyond general debridement (such as excision of a necrotic mass), excision of mesh or other appliances or structures goes beyond a simple I&D/debridement and the resulting lesion would be reported as a surgical wound for M1340 until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

Q105.4.1.1 M1340. My patient has a diagnosed diabetic foot ulcer. Recently she had an I&D of the foot with a bone biopsy (needle or other technique) to rule out osteomyelitis. Would the ulcer be classified as a surgical wound after the biopsy? [Q&A ADDED 10/16; Previously CMS Qtrly Q&A 07/15 Q3]

A105.4.1.1 The wound in the example you cite would continue to be considered a diabetic foot ulcer, and not reported as a surgical wound.

Q105.4.2. M1340. If a patient had an intra-abdominal abscess that was drained percutaneously and then a JP drain was inserted via interventional radiology is this considered a surgical wound? [Q&A ADDED 06/14; Previously CMS Qtrly Q&A 01/14 Q8]

A105.4.2. Yes. Even though the opening was created percutaneously, it is considered a surgical wound because a drain was inserted.

Q105.5. M1340. I understand that a simple I&D of an abscess is not a surgical wound. Does it make a difference if a drain is inserted after the I&D? Is it a surgical wound if the abscess is removed? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q17]

A105.5. For purposes of scoring the OASIS integumentary items, a typical incision and drainage procedure does not result in a surgical wound. The procedure would be reported as a surgical wound if a drain was placed following the procedure.

Also, if the abscess was surgically excised, the abscess no longer exists and the patient would have a surgical wound. It is considered a surgical wound until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

Q105.5.1. M1340. An I&D is not considered a surgery - but a drain inserted during this procedure makes the wound a surgical wound. Dilemma: This makes the OASIS answer for surgical wound a yes but we cannot code aftercare because we don't code the I&D as a surgery - but we do have surgical wound care. This is quite confusing. [Q&A EDITED 10/23; EDITED 05/22; EDITED 10/18; ADDED 09/09; M numbers updated 09/09; Previously CMS OCCB Q&A 07/08 Q8]

A105.5.1. The OASIS item response will not always mirror diagnoses and ICD-10 codes found in M1021/M1023 - Primary Diagnosis/Other Diagnoses. Continue to score the OASIS following current CMS guidance and follow ICD-10-CM coding guidance for code selection for M1021 and M1023.

Q105.6. M1340. A patient, who has a paracentesis, has a stab wound to access the abdominal fluid. Is this a surgical wound? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q18]

A105.6. When a surgical procedure creates a wound in which a drain is placed (e.g., an incision or stab wound), the presence of the drain (or drain wound site until re-epithelialization has been present for approximately 30 days at which time it becomes a scar) should be reported as a surgical wound. If a needle was inserted to aspirate abdominal fluid and then removed (no drain left in place), it should not be reported as a surgical wound.

Q105.7. [Q&A RETIRED; Duplicative of Q105.11]

Q105.8. M1340. Does a patient have a surgical wound if they have a traumatic laceration and it requires plastic surgery to repair the laceration? [Q&A EDITED 05/22; EDITED 09/09; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q20]

A105.8. Simply suturing a traumatic laceration does not create a surgical wound. A traumatic wound that required surgery to repair the injury would be considered a surgical wound (e.g., repair of a torn tendon, repair of a ruptured abdominal organ, or repair of other internal damage), and the correct response to M1340 - Surgical Wound for this type of wound would be 1 - Yes, this patient has at least one observable surgical wound or 2 - Surgical wound known but not observable due to non-removable dressing/device depending on whether or not it was observable.

Q105.9. M1340. Is a PICC placed by a physician under fluoroscopy and sutured in place considered a surgical wound? It would seem that placement by this procedure is similar to other central lines and would be considered a surgical wound. [Q&A ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q21]

A105.9. Even though the physician utilized fluoroscopy to insert the peripherally inserted central catheter (PICC) and sutured it in place, it is not a surgical wound, as PICC lines are excluded as surgical wounds for OASIS data collection purposes.

Q105.9.1. M1340. A patient had a "PICC" catheter inserted centrally into the internal jugular. Is this considered a central line when scoring M1340 - Surgical Wounds? [Q&A ADDED 06/14; Previously CMS Qtrly Q&A 01/14 Q7]

A105.9.1. Central venous catheters or central lines are those with the catheter tip located in the superior vena cava. Central lines can be peripherally inserted (i.e., basilic or cephalic vein in upper arm, or femoral vein in the groin) or centrally inserted (i.e., internal jugular vein in the neck, or subclavian or axillary vein in the chest). Central lines that are centrally inserted (as in the internal jugular example) ARE considered surgical wounds for M1340 because of the central

insertion, even if the type of catheter inserted into the central vein was intended to be inserted peripherally. Central lines that are peripherally inserted are not considered surgical wounds.

Q105.10. DELETED 04/15; Replaced by 4b Q109.1

Q105.11. M1340. Is a heart cath site (femoral) considered a surgical wound? If not, what if a stent is placed? [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB Q&A 07/07 Q9]

A105.11. If a cardiac catheterization was performed via a puncture with a needle into the femoral artery, the catheter insertion site is not reported as a surgical wound for M1340. The fact that a stent was placed does not have an impact.

Q105.11.1. M1340. I know existing guidance states that a femoral stick site created to perform cardiac catheterization is not a surgical wound. Does the same apply for the femoral sheath site created with a cut down procedure to perform endovascular AAA repair? What if a cut down procedure is needed to create a larger "wound" than a typical femoral sheath stick….would this change its status? [Q&A ADDED 01/11; Previously CMS OCCB Q&A 10/10 Q7]

A105.11.1. If an incision or "cut down" was completed in order to perform a procedure per femoral sheath, this incision would be considered a surgical wound. A femoral puncture site created without "cut down" is not a surgical wound on M1340.

Q105.12. M1340. If a drain was placed post-op and removed prior to admission to home health is the drain site considered a surgical wound upon admission to home care? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB Q&A 10/07 Q17]

A105.12. A wound with a drain is reported as a surgical wound at M1340. It remains a surgical wound after the drain is pulled until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

Q105.13. M1340. A patient had a skin cancer lesion removed in a doctor's office with a few sutures to close the wound. Is this considered a surgical wound? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB Q&A 10/07 Q19]

A105.13. A shave, punch or excisional biopsy, utilized to remove and/or diagnose skin lesions, does result in a surgical wound. It is considered a surgical wound until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

Q105.13.01. M1340. Our patient had skin cancer treated with electrodessication and curettage, creating a lesion. Is this considered a surgical wound when completing M1340, Surgical Wounds? [Q&A ADDED 06/14; Previously CMS Qtrly Q&A 01/14 Q6]

A105.13.01. Yes.

Q105.13.02. M1340. The Q&As address wounds caused by electrodessication and curettage as being surgical wounds. Would lesions resulting from freezing with liquid nitrogen be considered surgical wounds for M1340? [Q&A EDITED 05/22; EDITED 10/18; ADDED 10/16; Previously CMS Qtrly Q&A 07/15 Q6]

A105.13.02. A lesion resultant from cryosurgery is not considered a surgical wound when scoring M1340 - Surgical Wound.

Q105.13.1. M1340. Is the removal of a callus considered to be a surgical wound? [Q&A EDITED 05/22; EDITED 10/18; ADDED 01/11; Previously CMS OCCB Q&A 10/10 Q8]

A105.13.1. A callus that was removed is NOT considered a surgical wound when scoring M1340 – Surgical Wound.

Q105.14. M1340. Are arthrocentesis sites considered surgical wounds? [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 04/08 Q10]

A105.14. When a surgical procedure creates a wound in which a drain is placed (e.g., an incision or stab wound), the presence of the drain (or drain wound site until re-epithelialization has been present for approximately 30 days at which time it becomes a scar) should be reported as a surgical wound. If a needle was inserted to aspirate fluid and then removed, (no drain left in place), it should not be reported as a surgical wound.

If a physician performs a surgical procedure via arthroscopy, the arthrocentesis site would be considered a surgical wound until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

Q105.14.1. M1340. Is a wound from an abdominal laparoscopy surgery considered a surgical wound? No drain was placed after the procedure. [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 07/15 Q5]

A105.14.1. Per existing guidance, for M1340 - Surgical Wound, an incision created for the purpose of laparoscopic surgery, arthroscopy, and other minimally invasive surgery/procedure would be considered a surgical wound. It remains a current surgical wound until the site is completely epithelialized and is without signs/symptoms of infection for approximately 30 days, at which time it becomes a scar.

Q105.15. M1340. Is an implanted mechanical left ventricle device (LVAD) that has an air vent exiting through lower right abdomen a surgical wound? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB Q&A 07/08 Q7]

A105.15. The Left Ventricular Assist Device's (LVAD/HeartMate) cannula exit site would be considered a surgical wound until the LVAD is discontinued and the wound is re-epithelialized for approximately 30 days at which time it becomes a scar.

Q105.16. M1340. Is a chest tube site a surgical wound? [Q&A EDITED 10/18; ADDED & EDITED 09/09; Previously CMS OCCB Q&A 07/08 Q10]

A105.16. A chest tube site is a thoracostomy. Ostomies are excluded as surgical wounds in the OASIS. A chest tube site is not a surgical wound even if a chest tube or drain is present.

Q105.16.1. M1340. A surgical incision was created to perform exploratory surgery. When closing the wound, the surgeon inserted a chest tube utilizing the opening created for the surgery. Can this closed incision with a chest tube be counted as a surgical wound when completing M1340? [Q&A EDITED 05/22; ADDED 01/11; Previously CMS OCCB Q&A 10/10 Q9]

A105.16.1. The wound described should be considered a thoracostomy and is not considered a surgical wound when completing M1340 – Surgical Wound.

Q105.17. M1340. Would an enterocutaneous fistula that developed as a result of a surgery be documented as a surgical wound? [Q&A EDITED 05/22; ADDED 09/09; M number updated 09/09; Previously CMS OCCB Q&A 10/08 Q5]

A105.17. A fistula is a complication of surgery but it is not a surgical wound. Though fistulas are sometimes located within surgical wounds, answering M1340 - Surgical Wound & M1342 - Status of Most problematic Surgical Wound that is Observable would be based on the condition of the surgical wound, not the fistula, using the healing status guidance outlined in the OASIS Guidance Manual. For example, if the only opening in a 3-month-old closed surgical wound healed by primary intention was an enterocutaneous fistula then the answer to M1340 - Surgical Wound would be "0-No".

Q105.18. M1340. Our patient has a complicated wound involving a mid-line abdominal incision and 6 buttons holding retention sutures running under the skin. Would each button be considered a surgical wound for OASIS data collection? [Q&A ADDED 09/09; Previously CMS OCCB Q&A 07/09 Q8]

A105.18. No, a retention suture that utilizes a button to prevent damage to the skin is not considered a surgical wound.

Q105.19. M1340. Is a Q ball used for pain management following a joint replacement considered a surgical wound if the Q ball remains in place? Is it considered a surgical wound after removal if the site is still observable? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB Q&A 07/09 Q9]

A105.19. The ON-Q pump was developed to continuously infuse local anesthetic through 2 small catheters inserted at the wound site. If the catheters are inserted into the surgical incision, they are not considered separate surgical wounds. If the surgeon implanted the catheters at locations other than the surgical incision, the insertion sites would be considered separate surgical wounds, as the ON-Q pump catheters are implanted infusion devices. After discontinuation of the infusion, the insertion sites would be considered current surgical wounds until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

Q105.20. M1340. Is a VP shunt for hydrocephalus a current surgical wound, no matter how old it is? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB Q&A 07/09 Q10]

A105.20. The incision created to implant the VP shunt is a surgical wound until re-epithelialization has been present for approximately 30 days at which time it becomes a scar. At this point it is no longer considered a current surgical wound, as the VP shunt is neither venous access device nor an infusion device.

Q105.21. M1340. Are toenail removals by a MD considered a surgical wound with or without sutures? [Q&A ADDED 01/12; Previously CMS OCCB Q&A 07/11 Q8]

A105.21. Removal or excision of a toenail is not considered a surgical wound. If a surgical procedure was performed that goes beyond simple excision, it would be considered a surgical wound.

Q105.22. M1340. Are insulin and morphine pumps captured in M1340, Surgical Wounds? [Q&A EDITED 04/15; ADDED 01/12; Previously CMS OCCB Q&A 07/11 Q9]

A105.22. If the infusion device is implanted, it would also qualify as a surgical wound under M1340. An external device infusing medication via a SQ needle is not counted as a surgical wound.

Q105.23 M1340. Are burr holes on the head following an evacuation of a subdural hematoma which still have tightly adhered scabs considered a surgical wound for M1340? [Q&A ADDED 10/16; Previously CMS Qtrly Q&A 07/15 Q4]

A105.23 For the purposes of the OASIS Integumentary Status items, a burr hole is a hole that is surgically placed in the skull, or cranium and is considered a surgical wound. It remains a current surgical wound until the site is completely epithelialized and is without signs/symptoms of infection for approximately 30 days, at which time it becomes a scar.

Q106. M1340. Is a peritoneal dialysis catheter considered a surgical wound? [Q&A EDITED 10/23; EDITED 05/22; EDITED 01/11]

A106. A peritoneal dialysis catheter (or an AV shunt) is considered a surgical wound in OASIS, as long as it is present in the patient's body. This is also true for central lines and implanted vascular access devices.

Q106.1. M1340 Our patient has a "Mammosite", a device implanted in her lumpectomy site. She receives radiation bead insertion through this catheter. It requires a sterile dressing change daily. Is this device a surgical wound for M1340 and M1342? [Q&A EDITED 05/22; ADDED 12/12; Previously CMS Qtrly Q&A 07/12 Q3]

A106.1. Based on the details provided in the question, the incision created to insert the balloon catheter is considered a surgical wound in OASIS. Utilize existing CMS guidance to determine the healing status.

Q106.2. M1340. Is the site resulting from a kyphoplasty procedure counted as a surgical wound when answering M1340 – Surgical Wounds? [Q&A EDITED 05/22; ADDED 12/12; Previously CMS Qtrly Q&A 07/12 Q4]

A106.2. If the kyphoplasty procedure was performed percutaneously and resulted in a pinpoint needle puncture site where the bone cement was injected, it would not be considered a surgical wound. If the kyphoplasty procedure involved an open approach, requiring a surgical incision, the resulting wound would be considered a surgical wound for M1340.

Q106.3. M1340. Is a Pleurx catheter considered a surgical wound? Is there a difference if the Pleurx catheter was in the abdomen vs chest cavity? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 07/18 Q7]

A106.3. The presence of a specific catheter type does not define a surgical wound. A Pleurx catheter inserted as a chest tube is considered a thoracostomy and would not be considered a surgical wound. All ostomies (including those with drains) are excluded as surgical wounds. A surgical procedure that creates a wound that is not an "ostomy", and that has a drain (for example a Pleurx catheter, a Jackson-Pratt, etc.)would be considered a surgical wound.

Q106.4. M1340. We are looking for some guidance on a diabetic ulcer that was covered with a skin graft and how to code it at SOC? Is it a diabetic ulcer or does it become a surgical wound, like pressure ulcers? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/19 Q5]

A106.4. For OASIS coding purposes, when any type of ulcer is treated surgically with any kind of graft or flap, it is considered a surgical wound for M1340 - Does this patient have a Surgical Wound until approximately 30 days after complete re-epithelialization.

Q106.4.1. M1340. Are burn wounds that have been surgically grafted considered a surgical wound even if the graft fails? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 07/19 Q8]

A106.4.1. 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 - Does this patient have a Surgical Wound until approximately 30 days after complete re-epithelialization.

Q106.5. M1340. If a patient has a fasciotomy to treat compartment syndrome is the fasciotomy incision considered a surgical wound when answering M1340 - Does this patient have a Surgical Wound? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 07/19 Q9]

A106.5. M1340 - Does this patient have a Surgical Wound identifies the presence of a wound resulting from a surgical procedure. The fasciotomy incision would be considered a surgical wound.

Q106.6. M1340. Would a pacemaker or an implantable loop recording device be considered a surgical wound once the initial insertion site has been fully epithelialized for at least 30 days? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/21 Q5]

A106.6. The incisions created to implant a pacemaker or loop recording device are surgical wounds until re-epithelialization has been present for approximately 30 days at which time, they become scars.

At that point they would no longer be considered current surgical wounds, as neither the pacemaker nor the loop recording device, are a venous access device nor an infusion device.

Q107. & 108. [Q&As RETIRED 09/09; Outdated]

Q108.01. & Q108.02. [Q&As RETIRED 05/22]

Q108.03. M1306-M1324, M1340. If a Pressure Ulcer is replaced with a muscle flap, and before the muscle flap suture line healed completely, pressure caused new break down within the flap area (not along the suture line). Is this considered a non-healing surgical wound? Or a new Pressure ulcer? [Q&A ADDED 04/15; Previously CMS Qtrly Q&A 10/14 Q5]

A108.03. If a pressure ulcer is closed with a muscle flap, and before the muscle flap suture line heals completely, pressure causes new breakdown within the flap area (not along the suture line), this would be considered a new pressure ulcer, and until the muscle flap suture site is completely epithelialized for approximately 30 days, the flap site would remain a surgical wound. In this scenario, the patient would have both a new pressure ulcer and a surgical wound simultaneously.

Q108.1. M1340 & M1342. Guidance states that a surgical wound becomes "healed" or no longer reportable as a surgical wound on M1340 once re-epithelialization has been present for approximately 30 days. Determining a specific timeframe in regards to complete epithelialization presents some issues. For instance, if we get a post-surgery patient who has been in the nursing home and then to home health, we may not know

when complete epithelialization occurs. Please provide further clarification. [Q&A EDITED 10/18; EDITED 01/12; ADDED 09/09; Previously CMS OCCB Q&A 10/08 Q6]

A108.1. If, at the SOC or other assessment time points, the clinician assesses the wound to be completely epithelialized (including no sign of infection or separation), and the date of complete epithelialization is unknown, the clinician will have to make a determination regarding the wound status based on the history of the date of surgery, any reported wound healing progress/complications and clinical assessment findings.

Since for the purposes of the OASIS, a surgical wound is considered healed and no longer counted as a current surgical wound once re-epithelialization has been present for approximately 30 days (assuming no sign of infection or separation), then if based on the surgery date, it is clear that the completely epithelialized wound could not possibly have been fully epithelialized for at least 30 days, Response 0-Newly epithelialized should be reported.

If the wound appears completely epithelialized (no sign of infection or separation) and the date of epithelialization is unknown, but based on the known wound history and date of surgery it is possible that the wound could have been fully epithelialized for at least 30 days, then the wound status is deemed “healed” and no longer reportable as a surgical wound.

Q109. M1340 & M1342. Is a mediport "not observable" because it is under the skin? [Q&A EDITED 06/14]

A109. Please refer to the definition of “not observable” used in the OASIS surgical wound items in the current OASIS Guidance Manual – “not observable” is an appropriate response ONLY when a non-removable dressing is present. This is not the case with a mediport. As long as the mediport is present, whether it is being accessed or not, the patient is considered as having a current surgical wound.

Q109.1. M1340 & M1342. How would M1340 – Surgical Wound and M1342 – Status of Most Problematic Surgical Wound be answered, if the clinician determines that the steri-strips completely obscure the incision preventing visual assessment of the wound? Would the clinician need to obtain an order from the physician stating the steri-strips are a “non-removable dressing“ for the wound to be considered not observable in M1340? [Q&A EDITED 05/22; ADDED 04/15; Previously CMS Qtrly Q&A 04/15 Q3]

A.109.1. M1340 & M1342. Steri-strips are skin closures (similar in intent to sutures or staples) and not a dressing or device. Steri-strips will remain in place until they fall off unless there is a specific clinical reason and/or direction from the physician/allowed practitioner to remove them sooner. While they are in place, if the placement of the steri-strips allows sufficient visualization of the wound, the assessing clinician can determine and report on M1342 – Status of Most Problematic Surgical Wound that is Observable the appropriate healing status response, based on the healing status guidance outlined in the OASIS Guidance Manual. If the steri-strips completely obscure the incision, or obscure the incision to the point that the assessing clinician is unable to visualize the incision well-enough to determine the healing status, then M1340 - Surgical Wound should be reported as Response 2 - Surgical wound known but not observable due to non-removable dressing/device, and M1342 would be skipped. Note that while steri-strips are clinically different than a dressing or a device, the limitations of the OASIS data responses make this the best response in the situation described**.**

Q110. [Q&A RETIRED 09/09; Outdated]

Q111. [Q&A RETIRED 08/07; Outdated due to revision of WOCN guidance]

Q.111.1. M1342. What standards are used to assess cemented surgical wounds when answering OASIS item M1342 - Status of Most Problematic Surgical Wound that is Observable [Q&A EDITED 05/22; EDITED 10/18; EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 10/08 Q4]

A111.1. When assessing a surgical incision that has been cemented rather than sutured, follow the same guidance found in Chapter 3 of the OASIS Guidance Manual, M1342 Status of most problematic surgical wound.

1. If the wound can be visualized, it is observable. Only surgical wounds that have a dressing that cannot be removed as directed by the physician/allowed practitioner and obscures visualization of the incision are considered non-observable.
2. For the purposes of determining the healing status, a surgical wound can be considered fully healed and not reportable as a current surgical wound approximately 30 days after complete epithelialization. The incision must be clean, dry and completely closed with no signs or symptoms of infection.
3. The Status of Most Problematic Surgical Wound that is Observable (M1342) is determined by assessment of the skilled clinician following the definitions outlined in Chapter 3 of the OASIS Guidance Manual, M1342 Status of most problematic surgical wound.

Q112. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q112.1, 112.2 & 112.3. [Q&As RETIRED 09/09; Outdated]

Q112.4. M1342. If staples remain in a surgical wound, would it be considered as not healing? [Q&A EDITED 05/22; ADDED 09/09; Previously CMS OCCB Q&A 07/08 Q9]

A112.4. A surgical wound with staples in place would only be considered not healing if it meets the definition of not healing as outlined in the OASIS Guidance Manual.

Q112.4.1. M1342. When sutures are removed from surgical wounds healing by primary intention, how does it affect the healing status of the wound? [Q&A EDITED 05/22; EDITED 06/14; Previously CMS OCCB Q&A 01/11 Q9]

A112.4.1. For the purposes of scoring M1342 - Status of Most Problematic Surgical Wound that is Observable, openings in the skin, adjacent to the incision line, caused by the removal of a staple or suture, are not to be considered part of the surgical wound when determining the status of the surgical wound. The status of these sites would be included in the comprehensive assessment clinical documentation.

When determining the healing status of the incision, follow the definitions outlined in the OASIS Guidance Manual, in addition to other relevant current CMS Q&As. The status of "Not healing" would only be selected if the wound, excluding the status of the staple/suture site(s), meets the healing status descriptors.

Q112.5. [Q&A RETIRED and replaced with Q112.5.1.]

Q112.5.1. [Q&A RETIRED 01/12; Guidance located in Ch.3]

Q112.5.2. M1342. In reference to M1342, Status of Most Problematic Surgical Wound that is Observable, for surgical incisions healing by primary intention is it true that the only

correct responses are "0-newly epithelialized" and "3-Not healing" as there are no open wound beds with granulation tissue? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB Q&A 04/10 Q13]

A112.5.2. Surgical incisions healing by primary intention do not granulate. Because of this the only response that could be appropriate for a surgical wound healing by primary intention would be 0-Newly epithelialized or 3-Not healing. "Newly epithelialized" should be chosen if the surgical incision has epidermal resurfacing across the entire wound surface, and no signs/symptoms of infection exist.

Q112.6. M1342. Once the needle is removed from an implanted venous access device, before a scab has formed, the wound bed may be clean but non-granulating. Is it true that based on the OASIS guidance, the wound would be reported as Response 3 - Not healing for M1342? [Q&A EDITED 05/22; Q&A ADDED & EDITED 09/09; Previously CMS OCCB Q&A 10/08 Q7]

A112.6. When a needle is inserted and removed from an implanted venous access device, it is possible that the skin that was pierced by the needle could have a resulting wound that would heal by secondary intention. Usually, with good access technique and current needle technology there will be no perceptible wound. Occasionally, if there was an extremely large bore needle or traumatic entry or removal, there may be a resulting wound that heals by secondary intention. In this situation, the accessing clinician would rely on guidance outlined in the OASIS Guidance Manual to determine the healing status. Note that a scab is a crust of dried blood and serum and should not be equated to either avascular or necrotic tissue when applying the guidance. Therefore, while the presence of a scab does indicate that full epithelialization has not occurred in the scabbed area, the presence of a scab does not meet the criteria for reporting the wound status as "Not healing".

Q112.6.1. M1342. How do I mark the healing status of a Q-port that has needle access always in place? Would it be "non-healing? [Q&A EDITED 05/22; EDITED 06/14; ADDED 01/11; Previously CMS OCCB Q&A 04/10 Q14]

A112.6.1. The assessing clinician must determine the healing status of a wound following guidance in Chapter 3 of the current OASIS Guidance Manual and related CMS OASIS Q&As. Some sites, because they are being held open by a line or needle, cannot fully granulate and may remain "non-healing" while the line or needle is in place.

Q112.6.1.1. M1342. I have a patient receiving peritoneal dialysis every night. I understand that the peritoneal dialysis catheter site is considered a surgical wound (Cat. 4b Q102.1). What would the site's healing status be for M1342? [Q&A EDITED 10/23; EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 07/16 Q5]

A112.6.1.1. Assuming the assessing clinician determines the peritoneal catheter site is the most problematic observable surgical wound, the clinician would determine the healing status of the wound following the definitions provided in the OASIS Guidance Manual, Chapter 3, M1342 Status of Most Problematic Surgical Wound that is Observable Coding Instructions. The peritoneal catheter exit site cannot fully granulate and/or epithelialize because of the presence of the catheter. In this scenario Response 3 - Not healing for M1342 would be appropriate.

Q112.6.10. [Q&A RETIRED 05/22]

Q112.6.11. M1342. If a patient is receiving antibiotics for a surgical site infection, but at the time of assessment, the patient no longer exhibits any signs or symptoms of

infection, would the surgical wound be considered "not healing"? In other words, is treatment for an infection, in the absence of current symptoms of infection, considered a sign/symptom of infection? [Q&A EDITED 05/22; ADDED 04/15; Previously CMS Qtrly Q&A 10/14 Q9]

A112.6.11. M1342 - Status of Most Problematic Surgical Wound that is Observable is reporting healing status based on the clinician's assessment of the patient and visualization of the wound. Since the patient could be at the point in the course of the antibiotic regimen where the infection has resolved, ongoing treatment for an infection should not be the sole basis for selecting 3 - Not healing, unless signs and symptoms of infection are currently present.

Q112.6.12. M1340 & M1342. If a surgical wound dehisces at opposite ends, with an area of intact/healed skin between, is this still addressed in OASIS as one surgical incision? Secondarily, if still considered a single surgical wound - if one of the dehisced areas is granulating, and the other covered in slough - would the overall percentage of wound bed be considered when determining healing status, rather than applying percentages to two separate wounds? [Q&A EDITED 05/22; Q&A ADDED 10/16; Previously CMS Qtrly Q&A 04/16 Q7]

A112.6.12. When a portion of the surgical wound is intact/healed, and a portion of the wound is open and healing by secondary intention, to determine the healing status consider the portion of the wound bed that is healing by secondary intention when applying the healing status coding criteria of “% of the wound bed covered with granulation tissue” or “% of wound bed covered with avascular tissue”. If the surgical wound has more than one area healing by secondary intention, separated by one or more areas of intact/healed tissue, all open areas healing by secondary intention would be included as the "wound bed”, when applying the percentages to determine healing status.

Q112.7, Q112.8, Q112.9, Q112.10, Q112.10.1 & Q112.11. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q112.12 & Q112.13. [Q&As RETIRED 06/14; No longer applicable]

Q113. [Q&A RETIRED 05/22]

Q113.1. M1400. What is the correct response for the patient who is only short of breath when supine and requires the use of oxygen only at night, due to this positional dyspnea? The patient is not short of breath when walking more than 20 feet or climbing stairs. [Q&A EDITED 05/22; ADDED 08/07; M number updated 09/09; Previously CMS OCCB Q&A 07/06 Q31]

A113.1. Since the patient’s supplemental oxygen use is not continuous, M1400 - Dyspnea should reflect the level of exertion that results in dyspnea without the use of the oxygen. The correct response would be 4 - At rest (during day or night). It would be important to include further clinical documentation to explain the patient’s specific condition.

Q113.2. M1400. What is the correct response to M1400 - Dyspnea, if a patient uses a CPAP or BiPAP machine during sleep as treatment for obstructive sleep apnea? [Q&A EDITED 05/22; ADDED 08/07; Previously CMS OCCB Q&A 07/07 Q12]

A113.2. Sleep apnea being treated by CPAP is not the same as dyspnea at rest (Response 4 for M1400). M1400 - Dyspnea asks about dyspnea (shortness of breath), not sleep apnea (absence of breath during sleep).

The two problems are not the same. Dyspnea refers to shortness of breath, a subjective difficulty or distress in breathing, often associated with heart or lung disease. Dyspnea at rest would be known and described as experienced by the patient. Sleep apnea refers to the absence of breath. People with untreated sleep apnea stop breathing repeatedly during their sleep, though this may not always be known by the individual. If the apnea does not result in dyspnea (or noticeable shortness of breath), then it would not be reported on M1400. If, however, the sleep apnea awakens the patient and results in or is associated with an episode of dyspnea (or noticeable shortness of breath), then Response 4 - At rest (during day or night) should be reported.

Q113.3. M1400. Patient currently sleeps in the recliner or currently sleeps with 2 pillows to keep from being short of breath (SOB). They are currently not SOB because they have already taken measures to abate it. Would you mark M1400 - Dyspnea, response 4 - At Rest or response 0 - Patient is not short of breath? [Q&A EDITED 05/22; EDITED 04/15; ADDED 08/07; Previously CMS OCCB Q&A 07/07 Q13]

A113.3. M1400 - Dyspnea reports what is true on the day of the assessment (the 24 hours immediately preceding the home visit and the time spent by the clinician in the assessment). If the patient has not demonstrated or reported shortness of breath during that timeframe, the correct response would be 0 - Not short of breath even though the environment or patient activities were modified in order to avoid shortness of breath.

Q113.4. M1400. In regards to M1400, Dyspnea, can you explain what is meant by the phrase "performing other ADLs" in Response 3 - With minimal exertion (e.g., while eating, talking or performing other ADL's)? If we had a client that had dyspnea when they bent over to tie shoes, or when they bent over to pick up something from the floor, would they be a response 3 - With minimal exertion? [Q&A EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 01/11 Q10]

A113.4. When completing M1400 - Dyspnea, the assessing clinician will assess and report what caused the patient to experience dyspnea on the day of the assessment. The responses represent increasing severity of shortness of breath and include examples that the clinician can use in order to make the determination regarding the amount of effort that caused the patient's dyspnea.

The examples included in Responses 2 - With moderate exertion and 3 - With minimal exertion are used to illustrate the degree of effort represented by the terms moderate and minimal. Response 3 - With minimal exertion or agitation includes the examples of eating, talking, or performing other ADLs. The reference to other ADLs means activities of daily living that only take minimal effort to perform like grooming. The assessing clinician can use the examples to make the determination regarding the amount of effort that caused the patient's dyspnea. The clinician is not limited to selecting Response 2 - moderate exertion, if the patient becomes short of breath while dressing if just minimal effort was exerted and resulted in dyspnea. For example, if a patient lifted their arm to insert it into the sleeve of the shirt and this minimal amount of effort caused the patient to become short of breath, the appropriate response would be Response 3 - minimal exertion, even though they became short of breath during the process of dressing. This patient would more than likely also have become short of breath while eating or performing other activities requiring only minimal exertion. The assessing clinician will consider the examples as a guide when determining whether it was moderate or minimal exertion that caused the patient's dyspnea.

A patient who became short of breath after just bending over to pick something up or tie a shoe could be considered a Response 3 - With minimal exertion, if in the clinician's judgment, the patient became dyspneic after exerting just minimal effort.

Q114. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q114.1. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q114.2. [Q&A RETIRED 06/14; No longer applicable]

Q114.5. M1400, O0110. Is there a definition for continuous oxygen use for M1400 - Dyspnea? Does the definition for intermittent and continuous oxygen, used in O0110 - Special Treatments, Procedures, and Programs, apply to M1400 as well? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 04/23 Q10]

A114.5. Each OASIS item should be considered individually and coded based on guidance specific to that item.

The definitions for intermittent and continuous oxygen use provided in the guidance for O0110 - Special Treatments, Procedures, and Programs are intended to be specifically used to support coding for O0110C1 - Oxygen Therapy, O0110C2 - Continuous, and O0110C3 - Intermittent.

M1400 - When is the patient dyspneic or noticeably Short of Breath? identifies the level of exertion/activity that results in a patient's dyspnea or shortness of breath, regardless of any underlying condition.

For M1400, if the patient uses oxygen continuously (at all times during the day of assessment, with only brief interruptions), enter the response based on assessment of the patient's shortness of breath while using oxygen. If the patient uses oxygen intermittently, enter the response based on the patient's shortness of breath WITHOUT the use of oxygen. Responses are based on the patient's actual use of oxygen in the home, not on the physician's oxygen order.

Q115. [Q&A RETIRED 08/07; Duplicative of Archived Chapter 8 guidance]

Q116. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q116.1, Q116.1.5, Q116.1.6, Q116.2, Q116.2.1, Q116.2.2, Q116.2.3 & Q116.2.4. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q116.5. [Q&A RETIRED 10/18]

Q116.6. [Q&A RETIRED 05/22]

Q116.7. M1600. When coding M1600 - Has this patient been treated for a Urinary Tract Infection in the past 14 days? as 1 - Yes, does there also need to be a specific ICD-10 code added to the OASIS? The EMR that our agency uses provides a warning when we code 1 - Yes but there isn't a specific code identifying the UTI entered into the software system. [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 07/23 Q7]

A116.7. M1600 - Has this patient been treated for a Urinary Tract Infection in the past 14 days?, identifies treatment of a suspected or confirmed urinary tract infection during the past 14 days.

The OASIS guidance does not speak to requiring a specific, or any, ICD-10-CM diagnosis code(s) that would reflect the presence of or treatment for a UTI.

Questions related to vendor products or services should be addressed directly with your vendor.

Q117. M1610. Is the patient incontinent if she only has stress incontinence when coughing? [Q&A REVIEWED 05/22]

A117. Yes, the patient is incontinent if incontinence occurs under any situation(s).

Q118. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q119. [Q&A RETIRED 10/18]

Q119.1. M1610. How long would a patient need to be continent of urine in order to qualify as being continent? [Q&A ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q23]

A119.1**.** Utilize clinical judgment and current clinical guidelines and assessment findings to determine if the cause of the incontinence has been resolved, resulting in a patient no longer being incontinent of urine. There are no specific timeframes that apply to all patients in all situations.

Q119.2. [Q&A RETIRED 05/22]

Q119.2.01. M1610. How would M1610 – Urinary Incontinence be answered on ROC for a patient that has a nephrostomy tube that is now capped off? The tube is still present but is not attached to a bag. Is it still considered a urinary catheter? [Q&A EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 01/13 Q10]

A119.2.01. M1610, Response 2 - Requires a urinary catheter, may be selected if the patient has a catheter or tube that is utilized for urinary drainage, even if drainage is intermittent. If, however, there is a catheter or tube inserted in a urinary diversion and it is capped, with no plan to drain urine, even intermittently, Response 2 should not be selected.

Q119.2.1. M1610. Urinary Incontinence or Urinary Catheter Presence guidance indicates that if a catheter was inserted and discontinued during the comprehensive assessment we should mark either 0, No incontinence or catheter or 1, Patient is incontinent. Does this mean that intermittent catheterization is no longer considered under Response 2, as essentially this is what you do, insert and d/c during the visit? [Q&A EDITED 10/23; EDITED 05/22; Edited 06/14; ADDED 01/12; Previously CMS OCCB Q&A 04/11 Q7]

A119.2.1. No. M1610 – Urinary Incontinence Response 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) remains the appropriate response if a patient requires intermittent catheterization. The current OASIS Guidance Manual Chapter 3 M1610 Coding Tips statement "If a catheter was discontinued during the comprehensive assessment or if a catheter is both inserted and discontinued during the comprehensive assessment, Response 0 or 1 would be appropriate, depending on whether or not the patient is continent" is referring to an indwelling catheter.

Q119.2.2. M1610. My patient has an order for a nurse to perform a straight catheterization to obtain a urine specimen for C&S because my patient has symptoms of a UTI. There are no other orders for urinary catheterization. Would this be considered a "condition" requiring catheterization as noted in the item intent for M1610 – Urinary Incontinence? Or does catheterization in M1610 relate to catheterization for urinary drainage only? [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 07/15 Q8]

A119.2.2. A patient requiring a one-time catheterization for the sole purpose of obtaining urine for laboratory testing or other diagnostic procedure would not be considered having a "catheter for urinary drainage" when responding to M1610 Urinary Incontinence or Urinary Catheter

Presence. Response 0 or 1 would be appropriate depending on whether or not the patient is continent.

Q119.3. M1610. Do I mark response 1 - Patient is incontinent if my patient voluntarily urinates into a diaper at night only for convenience? She ambulates to the toilet during the day, but states she is tired at night and doesn't like getting up. [Q&A EDITED 05/22; EDITED 10/18; ADDED 01/11; Previously CMS OCCB Q&A 10/09 Q24]

A119.3**.** M1610 – Urinary Incontinence reports the presence of urinary incontinence for any reason. Urinary incontinence is defined as involuntary leakage of urine. If the nightly urination is voluntary, meaning the patient has the cognitive and physical ability to urinate in a toilet, etc. but chooses to use a diaper, the patient would not be reported as incontinent in M1610.

Q119.4. [Q&A RETIRED 05/22]

Q120. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q121. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q121.1 & Q121.2. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q122. M1620. How should you respond to this item if the patient is on a bowel-training program? How would that be documented in the clinical record? [Q&A EDITED 05/22; REVIEWED 09/09]

A122. There is no assumed presence of bowel incontinence simply because a patient is on a regular bowel program. The patient's elimination status must be completely evaluated as part of the comprehensive assessment, and the OASIS items answered with the specific findings for the patient.

Q122.1. M1620. Please clarify what timeframe we are looking at when assessing bowel incontinence in M1620 - Bowel Incontinence Frequency. Our agency has been told the start of care (SOC) is day 0 and we look back 7 days to answer this question. Is that correct?

What about this scenario? At the SOC assessment no bowel incontinence is reported for the past 7 days, at a repeat visit within the 5 day window, the patient has experienced bowel incontinence since the SOC. Can we amend M1620 to response 1 or response 2 and also update the M0090 - Date Assessment Completed date to reflect this additional assessment information? [Q&A EDITED 10/23; EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 07/13 Q13]

A122.1. The time period under consideration is the day of assessment and relevant past. This lookback is directed by Response options "0-Very rarely or never has bowel incontinence" and "1-Less than once weekly." Considering these two options, the assessing clinician would need to consider bowel incontinence that was experienced beyond the past 7 days. The assessing clinician must use clinical judgment to determine how far into the past would be relevant to this home care admission.

The SOC comprehensive assessment must be completed on or within 5 days after the SOC date, M0030. In the scenario above, the assessing clinician may elect to re-assess bowel incontinence within the allowed timeframe and change their original response as well as M0090 - Date Assessment Completed.

Q123. M1630. If a patient with a bowel ostomy was hospitalized with diarrhea in the past 14 days, does one mark Response 2 to M1630 - Ostomy for Bowel Elimination? [Q&A EDITED; 05/22; EDITED & M number updated 09/09]

A123. Response 2 is the appropriate response to mark for M1630 - Ostomy for Bowel Elimination in this situation. By description of the purpose of the hospitalization, the ostomy was related to the inpatient stay.

Q123.1. [Q&A RETIRED 05/22]

Q123.9. M1700 & M1710. What is the difference in what is measured in M1700 - Cognitive Functioning and M1710 - When Confused? [Q&A ADDED 12/12; Previously CMS Qtrly Q&A 07/12 Q6]

A123.9. M1700 - Cognitive Functioning, is intended to report the patient's cognitive functioning, as evidenced by their level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands on the day of assessment (at the time of the assessment and in the preceding 24 hours).

M1710 - When Confused, is intended to identify the time of day or situations when the patient experienced confusion, if at all, during the past 14 days (Day of assessment and prior 14 days). M1710 - Confusion, may not directly relate to M1700 - Cognitive Functioning. Confusion is defined in Mosby's Medical Dictionary as "a mental state characterized by disorientation regarding time, place, person, or situation. It causes bewilderment, perplexity, lack of orderly thought, and inability to choose or act decisively and perform the activities of daily living. It is usually symptomatic of an organic mental disorder, but it may accompany severe emotional stress and various psychological disorders."

If a patient is demonstrating confusion on the day of the assessment, it would be reported both in M1700 and M1710. If a patient was NOT confused on the day of assessment, but had experienced confusion during the prior 14 days, it would only be reported in M1710.

If a patient has a cognitive impairment on the day of the assessment, that does NOT result in confusion, e.g., forgetfulness, learning disabilities, concentration difficulties, decreased intelligence, it would only be reported in M1700.

Q124. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q124.01. M1710. My patient was confused both when encountering a new situation and on awakening in the morning. Since M1710, When Confused, is not a "Check All That Apply" item, please clarify when the response options should be selected. [Q&A ADDED 12/12; Previously CMS Qtrly Q&A 10/12 Q5]

A124.01. The response options for M1710 - When Confused, identify the time of day or situations when the patient experienced confusion, if at all, within the last 14 days. Response 0 is selected if the patient had no confusion in the last 14 days. Responses 1 - 4 are selected if the patient has experienced confusion and each response represents a worsening of confusion. Response 1 is selected when the patient's confusion is isolated to a new or a complex situation, e.g. the patient became confused when a new caregiver was introduced or when a complicated procedure was taught for the first time. Response 2, 3, & 4 are selected when confusion occurs without the stimulus of a new or complex situation, or when confusion which initially presented with a new or complex situation persists days after the new or complex situation become more routine. Responses 2, 3 & 4 differ from each other based on the time when the confusion occurred. Response 2 is selected if the confusion only occurred when the patient was

awakening from a sleep or during the night. Response 3 is selected if the confusion occurs during the day and evening, but is not constant. If confusion was not constant, but occurred more often than just upon awakening or at night, select Response 3.

Q124.1. M1710 & M1720. What does nonresponsive mean? [Q&A EDITED 05/22; EDITED 09/09; ADDED 08/07; Previously CMS OCCB Q&A 07/06 Q33]

A124.1. It means the patient is unable to respond or the patient responds in a way that you can't make a clinical judgment about the patient's level of orientation. A patient who only demonstrates reflexive or otherwise involuntary responses may be considered nonresponsive. A patient with language or cognitive deficits is not automatically considered "nonresponsive". A patient who is unable to verbally communicate may respond by blinking eyes or raising a finger. A patient with dementia may respond by turning toward a pleasant, familiar voice, or by turning away from bright lights, or by attempting to remove an uncomfortable clothing item or bandage. A patient who simply refuses to answer questions should not automatically be considered "nonresponsive". In these situations, the clinician should complete the comprehensive assessment and select the correct response based on observation and caregiver interview.

Q124.2. M1710 & M1720. May the clinician use clinical judgment to determine if the confusion or anxiety is relevant to this home health episode or should they report all confusion during the past 14 days, (e.g., my patient was anxious 14 days ago and was started on an anti-anxiety drug and has not experienced anxiety for the last 12 days)? [Q&A ADDED 01/11; Previously CMS OCCB Q&A 10/09 Q26]

A124.2. When completing M1710 - When Confused and M1720 - When Anxious, the clinician should report any episodes of confusion or anxiety that meet the descriptors contained in the item that occurred during the last 14 days, without regard to the cause or potential relevance of the confusion/anxiety to this episode of care.

Q124.4., Q124.5., Q124.5.1. [Q&As RETIRED 05/22; Item deleted from OASIS]

Q124.5.2. [Q&A RETIRED 10/18]

Q124.5.3. [Q&A RETIRED 05/22; Item deleted from OASIS]

Q124.5.5. M1740. If a patient is alert and oriented, but decides not to use their cane because they think they don't need it (they are unsafe without it) or they decide they aren't going to take their diuretic because they are going to the doctor and don't want to have any accident, would you select Response 2 - Impaired decision-making? [Q&A EDITED 10/23; EDITED 05/22; EDITED 06/14; ADDED 01/12; Previously CMS OCCB Q&A 01/11 Q13]

A124.5.5. The intent of M1740, Cognitive, Behavioral, and Psychiatric Symptoms, is to capture specific behaviors that are a result of significant neurological, cognitive, behavioral, developmental or psychiatric limitations or conditions. It is not the intent of M1740 to report non-adherence or risky choices made by cognitively intact patients who are free of the aforementioned conditions. The assessing clinician will have to determine if the patient has a disorder that is causing their non-adherence or is the patient making a choice not to comply completely with physician's orders, cognizant of the implications of that choice.

Q124.5.5.1. M1740. Would "hoarding" be considered disruptive behavior triggering a "yes" response on M1740 - Cognitive, Behavioral, and Psychiatric Symptoms? [Q&A EDITED 10/23; EDITED 05/22; ADDED 04/15; Previously CMS Qtrly Q&A 01/15 Q7]

A124.5.5.1. M1740 - Cognitive, Behavioral, and Psychiatric Symptoms identifies specific behaviors associated with significant neurological, developmental, behavioral, or psychiatric disorders that are demonstrated at least once a week. If a patient had a diagnosis, such as hoarding disorder, and the clinician determined the associated behaviors resulted in concern for the patient and/or caregiver's safety or wellbeing, then it would meet the intent of M1740. In such a case, the assessing clinician may determine that the hoarding behaviors meet the intent of Response 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions and/or Response 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions).

Q124.5.6. M1740. When reporting on the behaviors to be considered for M1740 - Cognitive, Behavioral, and Psychiatric Symptoms, what time period should we consider? Does it include the recent past, if so, please define what is officially considered "recent" past. [Q&A EDITED 10/23; ADDED 01/12; Previously CMS OCCB Q&A 04/11 Q8]

A124.5.6. The time period under consideration for M1740 - Cognitive, Behavioral, and Psychiatric Symptoms that are demonstrated at least once a week, is defined in the wording of the item - "at least once a week". The phrase "at least once a week" means that a behavior was demonstrated multiple times in the recent, relevant past and the frequency of the occurrence was at least one time a week prior to and including the day of assessment. The assessing clinician will determine "recent, relevant past" based on the patient/caregiver interview, referral information, assessment findings, diagnoses and recent history of medical treatment and its effectiveness.

Q124.6. M1740 & M1745. Is M1745 - Frequency of Disruptive Behavior Symptoms, only based on disruptive behavior: physical, verbal or other disruptive/dangerous symptoms? Or is this item based on what we answer with M1740 - Cognitive, Behavioral, and Psychiatric Symptoms? [Q&A EDITED 10/23; EDITED 05/22; ADDED 01/11; Previously CMS OCCB Q&A 07/10 Q11]

A124.6. M1740 - Cognitive, Behavioral, and Psychiatric Symptoms, and M1745 - Frequency of Disruptive Behavior Symptoms are not directly linked to one another. There may be behaviors reported in M1740 that are not reported in M1745 and vice versa. For example, a patient may express excessive profanity or sexual references that cause considerable stress to the caregivers and be reported in M1740, but in the clinician's judgment, the behavior does not jeopardize the safety and well-being of the patient or caregiver, therefore is not reported in M1745. Answer each question individually. M1740 contains a list of specific behaviors associated with significant neurological, developmental, behavioral or psychiatric disorders and asks if they are demonstrated by the patient at least once a week. M1745 is not reporting on a specific list of behaviors, but rather any behaviors that are disruptive or dangerous to the patient or the caregivers.

Q124.7. M1740 & M1745. When completing M1740 - Cognitive, Behavioral, and Psychiatric Symptoms and M1745 - Frequency of Disruptive Behavior Symptoms, do we have to take into consideration if the patient has a fulltime caregiver to watch over them, or do we

address it without including the caregiver's presence? [Q&A EDITED 10/23; ADDED 01/11; Previously CMS OCCB Q&A 07/10 Q12]

A124.7. The environment in which the patient lives and the skills of the caregiver may impact the scoring of M1740 - Cognitive, Behavioral, and Psychiatric Symptoms, and M1745 - Frequency of Disruptive Behavior Symptoms. For example, if a patient has dementia, they may exhibit a number of behaviors listed in M1740 but may not be reported in the OASIS item if they live in a setting specifically designed to care for patients with dementia. The same would be true for M1745. Look to the descriptors for the behaviors that are reportable for both M1740 and M1745 to determine if the behavior would be reportable.

Q124.8. M1740 & M1745. A question continues to be raised when discussing the two behavioral M items: M1740 - Cognitive, Behavioral and Psychiatric Symptoms, and M1745 - Frequency of Disruptive Behavior Symptoms. In the guidance, it is noted that these behaviors should be associated with a "disorder". Must this disorder be an actual diagnosis, or simply the assessing clinician's observation of symptoms that may be associated with a diagnosis? [Q&A EDITED 10/23; EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 10/15 Q2]

A124.8. The behaviors identified for the purpose of responding to M1740 - Cognitive, Behavioral, and Psychiatric Symptoms and M1745 - Frequency of Disruptive Behavior Symptoms could be determined to be associated with a significant neurological, behavioral or psychiatric disorder either by diagnosis and/or in the assessing clinician's clinical judgment.

Q125. [Q&A RETIRED 05/22]

Q126. [Q&A RETIRED 01/11; No longer applicable]

Q126.1 & Q126.2. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q127. [Q&A RETIRED 05/22]

Q127.1. M1800 - M1870. Are service animals considered a form of assistance? [Q&A EDITED & ITEM NUMBER UPDATED 05/22; ADDED 01/11; Previously CMS OCCB Q&A 10/09 Q27]

A127.1. If required for a patient's safe function, service animals should be considered an assistive device for purposes of selecting responses to the OASIS items. Service animals should not be equated to human assistance (e.g., "someone must assist…")

Q127.2. M1800, M1830, M2102a, GG0130E. OASIS excludes shampooing of hair from Bathing and Grooming…Is this captured any other place? [Q&A EDITED 05/22; EDITED 10/18; EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB Q&A 01/10 Q10]

A127.2. Shampooing of the hair is excluded from the M1830 - Bathing and M1800 - Grooming. Shampooing the hair is also excluded from GG0130E - Shower/bathe self. Shampooing may be included as one of the ADLs in M2102a - Types and Sources of Assistance; ADL assistance, as this question is concerned broadly with types of assistance, not just the ones specified in other OASIS items.

Q127.2.1. M1800s, GG0130, & GG0170. Should we expect to see consistency between a patient's OASIS "M" and "GG" function codes? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 04/19 Q9]

A127.2.1. Not necessarily. There are differences between items that have the same or similar names. Coding differences may be a result of:

- What is included or excluded in the activity, or
- What coding instructions apply to the activity

Each OASIS item should be considered individually and coded based on guidance specific to that item.

Q127.2.2. M1800s, GG0130, & GG0170. 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? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/20 Q6]

A127.2.2. 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 polypharmacy), 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.

Q127.3. M1800 - M1870. About M1800 - M1870: I don't understand the difference between "willingness" and "adherence" (which do not impact OASIS scoring) and "cognitive/mental/emotional/behavioral impairment" (which may impact OASIS scoring). For instance, if a person is unwilling to bathe appropriately, resulting in poor hygiene, an offensive odor and increased risk for infection, isn't the patient suffering from some sort of cognitive, mental, behavioral or emotional problem that would cause this unwillingness and non-adherence? It seems that such unwillingness is a symptom of a deeper psychological problem. Please clarify. [Q&A EDITED 10/23; EDITED & ITEM NUMBER UPDATED 05/22; EDITED 06/14; ADDED 01/11; Previously CMS OCCB Q&A 07/10 Q13]

A127.3. In absence of pathology, patients may make decisions about how and when they perform their activities of daily living that may differ from what the clinician determines to be acceptable. A patient may choose to shave and brush their teeth infrequently because they

don’t value doing it at a frequency that the clinician deems as socially appropriate. There are differences in the frequency at which grooming or bathing is performed, or expected to be performed based on age, religion, culture and familial practices, and this is not necessarily indicative of pathology.

A patient may demonstrate that they can safely ambulate while using a walker, but then as a *matter of choice*, decide to walk without it. Another patient may demonstrate that they can safely ambulate while using a walker, but then consistently walk without it, *forgetting* that they have a walker. For the purposes of OASIS scoring, non-conformity or non-adherence should not automatically be considered indicative of a deeper psychological impairment. The assessing clinician will have to use clinical judgment to determine if the patient’s actions are more likely related to impairment, or to personal choice made in awareness of the potential related risk.

Q127.4. M1800 - M1870. When the M item response states "assisted or supervised by another person" is that referring to a single person? [Q&A EDITED AND ITEM NUMBER UPDATED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 07/11 Q11]

A127.4. The response related to "assistance of another person" includes those patients needing assistance of one or more person(s) to safely complete included tasks.

Q127.5. M1800 - M1870. My staff are confused about when a patient's ability to access the location and/or implements needed to complete the M function items should be considered when scoring the OASIS. For instance, should I include a patient's ability to get to the tub for M1830 - Bathing, or to get to the kitchen to eat for M1870 - Feeding or Eating? [Q&A EDITED 05/22; EDITED 10/18; ADDED & EDITED 06/14; Previously CMS Qtrly Q&A 04/13 Q7]

A127.5. The OASIS M function items consider the patient’s ability to access the needed items and/or location where the task is performed unless item guidance specifically excludes these from consideration. The M function items where there are exclusions are:

M1830, Bathing - The focus is on the patient's ability to access the tub/shower, transfer in and out, and bathe the entire body once the needed items are within reach. The ability to access bathing supplies and prepare the water in the tub/shower are excluded from consideration when assessing the patient's bathing ability.

M1845, Toileting Hygiene - The focus is on the patient's ability to access needed supplies and implements and manage hygiene and clothing once at the location where toileting occurs. The ability to access the toilet or bedside commode, transfer on and off the bedpan and to use the urinal are excluded from consideration when assessing the patient's toileting hygiene ability.

M1870, Feeding/Eating - The focus is on the patient's ability to eat, chew and swallow once the meal is placed in front of the patient and needed items are within reach. The ability to access the location where the meal is prepared and consumed, and transporting food to the table are excluded from consideration when assessing the patient's feeding/eating ability.

Q128 & 128.1. [Q&As RETIRED 09/09; Outdated]

Q129. M1800. Must I see the patient comb their hair or brush their teeth in order to respond to this item? [Q&A EDITED 05/22; REVIEWED 09/09]

A129. No, an assessment of the patient’s coordination, manual dexterity, upper-extremity range of motion (hand to head, hand to mouth, etc.), and cognitive/emotional status will allow the clinician to evaluate the patient’s ability to perform grooming activities.

Q129.1. M1800. Please confirm that the assessment of the patient's ability to perform the grooming tasks identified in M1800 - Grooming also includes getting to where the grooming utensils are stored. [Q&A EDITED 05/22; EDITED 06/14; ADDED 12/12; Previously CMS Qtrly Q&A 10/12 Q6]

A129.1. Patient access must be considered when determining grooming ability (e.g., grooming aids, mirror, sink). If there is an environmental barrier preventing safe access or the patient has an impairment that causes them to require someone's assistance to gain access to needed items or locations, whether the assistance was to take the items to the patient, or to assist the patient to get to the items, Response 1 - Grooming utensils must be placed within reach before able to complete grooming activities would be appropriate, assuming the patient could then groom independently in a majority of the more frequently performed grooming tasks.

This item addresses the patient's ability to safely perform grooming given the current physical and mental/emotional/cognitive status, activities permitted and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by environmental barriers (e.g., accessing grooming aids, mirror and sink).

Q129.2. M1800. OASIS guidance tells us that the ability to access the location and items needed to complete grooming tasks are considered in M1800 - Grooming, 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 response 1. Some clinicians refer to M1800 response 1 for grooming as "set up". 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 response 1, or is it considered providing assistance and scored a response 2 as long as the majority of the grooming tasks required this assistance? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 07/19 Q10]

A129.2. Response 1 for M1800 - Grooming 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 the 05 - Setup or clean-up assistance code used for the GG0130 activities which includes assistance a helper provides only prior to or following the activity, but not during the activity. Each OASIS item should be considered individually and coded based on the guidance provided for that item

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.

Q130. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q130.1. [Q&A RETIRED 05/22]

Q131. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q132. M1810. What if the patient must dress in stages due to shortness of breath? What response must be marked? [Q&A EDITED 05/22; M number updated 09/09]

A132. If the patient is able to dress themself independently, then this is the response that should be marked, even if the activities are done in steps. If the dressing activity occurs in stages because verbal cueing or reminders are necessary for the patient to be able to complete the

task, then Response 2 is appropriate. (Note that the shortness of breath would be addressed in M1400 - Dyspnea.)

Q132.1. M1810 & M1820. In the dressing items, how do you answer if a disabled person has everything in their home adapted for them; for instance, closet shelves & hanger racks have been lowered to be accessed from a wheelchair. Is the patient independent with dressing? [Q&A ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q25]

A132.1. M1810 & M1820 - Current Ability to Dress Upper/Lower Body, Response 0 indicates a patient is able to safely access clothes and put them on and remove them (with or without dressing aids). Because in these specific OASIS items, the use of special equipment does not impact the score selection, at the time of the assessment, if the patient is able to safely access clothes, and safely dress, then Response 0 would be appropriate even if the patient is using adaptive equipment and/or an adapted environment to promote independence.

Q132.2. [Q&A RETIRED 05/22]

Q132.3. M1810 & M1820. I have a patient who could not obtain their clothes, but could dress without assistance if clothes were laid out (Response 1). If the environment was adapted (a new "usual" storage place for clothing was selected) so that the patient could obtain, put on and remove the clothing without any assistance, would the patient then be considered independent in dressing? [Q&A EDITED 05/22; ADDED 09/09; Previously CMS OCCB Q&A 10/08 Q8]

A.132.3. When a patient's ability varies on the day of assessment, the clinician reports what was true for a majority of the time. If the patient was unable to access clothing but could put on and remove the majority of clothing items safely when they were laid out for them, the appropriate score would be a "1". If the environment is permanently modified (e.g., the patient decides to start storing clothing in the dresser instead of hanging in the closet), and the patient can now access clothes from a location without anyone's help, then this new arrangement could now represent the patient's current status (e.g., clothing's new "usual" storage area and patient's ability). The appropriate score would be a "0" if the patient was also able to put on and remove a majority of their clothing items safely.

If however, the patient explained that while they are feeling weak, they will temporarily modify their dressing practice (e.g., place their clothes on the chair by the bed instead of putting them in the usual storage area - the closet), since the clothing lying on the chair is not in its "usual" storage area and the patient does not intend on making the chair their usual storage area for their clothes, then they are currently unable to obtain the clothing from its usual location, and the patient would be scored a "1". The patient could then work to gain independence in accessing clothing from its usual storage location, or decide to make long-term environmental modifications, and possibly achieve improvement in the outcome if successful.

Q132.4. M1810 & M1820. The guidance in M1810 - Current Ability to Dress Upper Body & M1820 - Current Ability to Dress Lower Body states that you assess the patient's ability to obtain, put on and remove the clothing items usually worn. Other guidance states that items such as prosthetics, corsets, cervical collars, hand splints, Teds, etc. are considered dressing apparel. Do we include the other items, like a splint, if the patient doesn't usually wear it? Our patient just injured their wrist and will only be wearing it for

a week; he doesn't usually wear a splint. [Q&A EDITED 05/22; ADDED 09/09; M number updated 09/09; Previously CMS OCCB Q&A 04/09 Q10]

A132.4. M1810 & M1820, Current Ability to Dress Upper/Lower Body, includes all the dressing items the patient usually wears and additionally any device the patient is ordered to wear, e.g., prosthetic, splint, brace, corset, Teds, knee immobilizer, orthotic, AFO, even if they have not routinely worn/used them before. If they are wearing the device/support (or ordered to wear the device/support) on the day of assessment, it is to be included when assessing and scoring M1810 & M1820.

Q132.5. M1810 & M1820. At my agency, we are asked to score M1810 - Current Ability to Dress Upper Body and M1820 - Current Ability to Dress Lower Body as Response 2 - Someone must help the patient put on upper/lower body clothing" if the patient takes longer than the usual time to dress self even if they live alone and are perfectly capable of dressing themselves. Is this correct? [Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB Q&A 04/09 Q11]

A132.5. There is no requirement that a patient dress within a specific amount of time in order to be independent in dressing. A patient may take longer than "usual", but as long as they can safely access their clothing from its usual storage location, put on and take off a majority of their routine clothing items safely, the patient is scored a "0" in Upper and Lower Body Dressing.

Q132.5.1. M1810 & M1820. Please clarify the guidance included in M1810 - Current Ability to Dress Upper Body and M1820 - Current Ability to Dress Lower Body, Response-Specific Instructions which states "In cases where a patient's ability is different for various dressing upper/lower body tasks, pick the response that best describes the patient's level of ability to perform the majority of dressing upper/lower body tasks." What does the term "dressing tasks" mean? Is it the pieces of clothing and devices the patient wears or is it the individual steps in dressing, e.g. picking up the item, lifting their arm, sliding the arm into the sleeve, buttoning the buttons, etc.? [Q&A EDITED 05/22; EDITED 06/14; ADDED 01/12; Previously CMS OCCB Q&A 01/11 Q14]

A132.5.1. When scoring M1810 and M1820, Current Ability to Dress Upper/Lower Body, in cases where a patient's ability is different for various upper or lower body dressing tasks, you will select the response that best describes the patient's level of ability to perform the majority of dressing tasks. The tasks are the individual clothing items routinely worn, as well as any supportive or prosthetic devices the patient is wearing or ordered to use during the day of the assessment.

The majority of the tasks rule is not referencing the individual steps the patient must take in order to get, put on or take off clothing, but rather what is true for greater than 50% of the clothing items/devices usually worn on the upper/lower body.

Q132.5.2. M1810 & M1820. Are wound dressings included as an upper and lower body dressing task when determining a patient's ability for M1810 - Current Ability to Dress Upper Bodyand M1820 - Current Ability to Dress Lower Body? [Q&A ADDED 06/14; Previously CMS Qtrly Q&A 07/13 Q14]

A132.5.2. Wound dressings are NOT one of the included dressing items when scoring M1810 - Upper Body Dressing and M1820 - Lower Body Dressing. Note that elastic bandages, including ACE Wrap brand, worn for support and compression should be considered as a lower body dressing item, but wraps utilized solely to secure a wound dressing would not be considered a dressing (clothing) item for M1810 or M1820.

Q132.6. M1820. If the patient has a physician's order to wear elastic compression stockings and they are integral to their medical treatment, (e.g. patient at risk for DVT), but the patient is unable to apply them, what is the correct response for M1820 - Current Ability to Dress Lower Body? [Q&A EDITED 05/22; EDITED 01/10; Previously CMS OCCB Q&A 07/06 Q35]

A132.6. M1820 - Current Ability to Dress Lower Body identifies the patient's ability to obtain, put on, and remove their lower body clothing, including lower extremity supportive or protective devices. Elastic compression stockings, air casts, etc., should be considered when scoring M1820. The patient in this situation would be scored based on their ability to obtain, put on and remove the majority of their lower body dressing items.

Q132.6.1. [Q&A RETIRED 05/22]

Q133. [Q&A RETIRED 09/09; Outdated]

Q134. M1830. Given the following situations, what would be the appropriate responses to M1830 - Bathing?

a) **The patient's tub or shower is nonfunctioning or is not safe for use.**

b) **The patient is on physician-ordered bed rest.**

c) **The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again.**

d) **The patient chooses not to navigate the stairs to the tub/shower.**

[Q&A EDITED 10/23; EDITED 05/22; EDITED 06/14; M number updated 09/09]

A134. a) The patient's environment can impact their ability to complete specific functional tasks. If the patient's tub or shower is nonfunctioning or not safe, then the patient is currently unable to use the facilities. Response 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities outside the tub/shower.

b) The patient's medical restrictions mean that the patient is unable to bathe in the tub or shower at this time. Select Response 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode, 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person, or 6 - Unable to effectively participate in bathing and is bathed totally by another person, whichever most closely describes the patient's ability at the time of the assessment.

c) If the patient's fear is a barrier to their ability to get in/out of the shower safely, then their ability to bathe in the tub/shower may be affected. The clinician will need to determine whether there is a physical, cognitive, or emotional barrier that is temporarily or permanently limiting their ability to use the tub/shower. If due to fear, they refuse to enter the shower even with the assistance of another person; either Response 4, 5, or 6 would apply, depending on the patient's ability at the time of assessment. If they are able to bathe in the shower when another person is present to provide required supervision/assistance, then Response 3 would describe their ability.

d) The patient's environment must be considered when responding to the OASIS items. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then the need for that supervision should be considered when selecting a code.

Q134.1. M1830. My patient is allowed to bathe in the tub, but is medically restricted from getting the cast on their lower leg and foot wet. They are unable to put the water protection sleeve on, but once someone applies the protective sleeve for them, they can get into and out of the bathtub using a transfer bench and wash all of their body with a handheld shower. Does this medical restriction impact the patient's ability when scoring M1830 - Bathing? [Q&A EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 04/13 Q5]

A134.1. Medical restrictions that impact the OASIS-included bathing tasks are considered when determining the score for M1830 - Bathing. Therefore, the tasks required to allow compliance with medically prescribed precautions for bathing could impact the patient's ability. In the scenario above, Response 2 is appropriate since the patient needs intermittent human assistance.

Q134.2. M1830. At start of care (SOC), the patient was not taking a shower due to a fear of falling. The patient was safely sponge bathing at the sink without assistance. They had fallen in the shower and is fearful of falling again. The RN, at SOC, had the patient get into the shower using a tub bench and after cues for proper technique, determined the patient needed contact guard for the transfer. Once sitting, the patient was able to bathe themself using a long-handled sponge. How should M1830 - Bathing be answered? [Q&A EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 10/13 Q7]

A134.2. Response 4 - Unable to bathe in tub/shower but independent in bathing at sink, would be selected if, on the day of the assessment, the patient's usual status was that they were unable to bathe in the tub/shower due to fear, even with assistance, but was independent in bathing at the sink. In your scenario the patient's ability changed after clinical intervention. After the nurse's instruction, the patient could bathe themself in the tub/shower with the intermittent assistance of another person for the tub transfer only, but the new changed ability was not the patient's usual status (more than 50% of the time) on the day of assessment. At the next OASIS data collection time point, if the patient remained at that new functional level, it would be appropriate to select M1830 Response 2 - Able to bathe in tub/shower with intermittent assistance.

Q135. M1830. How should I respond to this item for a patient who is able to bathe in the shower with assistance, but chooses to sponge bathe independently at the sink? [Q&A EDITED 05/22; EDITED 06/14]

A135. The item addresses the patient's ability to bathe in the shower or tub, not preference, regardless of where or how the patient currently bathes. Willingness and adherence are not the focus of the item. If assistance is needed to bathe in the shower or tub, then the level of assistance needed must be noted, and Response 2, or 3 should be selected.

Q136. M1830. Should the clinician consider the patient's ability to perform bathing-related tasks, like gathering supplies, preparing the bath water, shampooing hair, or drying off after the bath in responding to this item? [Q&A EDITED 05/22; EDITED 09/09; ADDED 06/05; M number updated 09/09; Previously CMS OCCB Q&A 08/04 Q12]

Q136. When responding to M1830 - Bathing, the patient's ability to transfer in and out of the tub/shower and then "wash the entire body" should be considered. Bathing-related tasks, such as those mentioned, should <u>not</u> be considered in scoring this item.

Q137. M1830. If a patient can perform most of the bathing tasks (i.e. can wash most of their body) in the shower or tub, using only devices, but needs help to reach a hard to reach place, would the response be "1" because they are independent with devices with

a "majority" of bathing tasks? Or are they a "2" because they require the assist of another "for washing difficult to reach areas?" [Q&A EDITED 05/22; EDITED 01/12; ADDED 06/05; Previously CMS OCCB Q&A 8/04 Q13]

A137. The correct response for the patient described here would be Response 2 - Able to bathe in the shower or tub with the assistance of another person: c) for washing difficult to reach areas, because that response describes that patient's ability at that time.

Q138. M1830. Please clarify how the patient's ability to access the tub/shower applies to M1830 - Bathing. [Q&A EDITED 05/22; EDITED 09/09; ADDED 06/05; Previously CMS OCCB Q&A 10/04 Q6]

A138. The intent of the bathing item is to identify the patient's ability to wash the entire body. Guidance for this item indicates that when medical restrictions, environmental or other barriers prevent the patient from accessing the tub/shower, their bathing ability will be 'scored' at a lower level. The ability to transfer into and out of the tub/shower is evaluated and also impacts the score when responding to M1830 - Bathing. If the patient requires assistance to transfer into or out of the tub/shower, they would be scored a 2 or 3, based on the amount of human supervision or assistance is required throughout the bath.

Q138.1. M1830. Please confirm something I heard during OASIS training at my office. They said that getting to the bathroom for bathing is also included in the data collection for bathing even though the responses for M1830 - Bathing only address the transfer in and out of the shower/tub and washing the body. Is that true? For example, my patient needs assistance to get down the hallway to the bathroom, but once they are in the bathroom they can safely transfer in and out of the shower and wash their body without assistance or equipment. Until the meeting today, I would have scored them a 0 for independent, but now it seems I should be scoring them a 2 - needs intermittent assistance. Which score is correct? [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 04/16 Q8]

A138.1. For M1830 - Bathing, the amount of assistance the patient requires to get to the location bathing occurs would be considered. In the scenario cited, the patient requires assistance (another person to provide verbal cueing, stand-by or hands-on assistance) to safely ambulate down the hallway and no other assistance with transfer and bathing. This is intermittent assistance, therefore Response 2 - Able to bathe in shower or tub with the intermittent assistance of another person should be reported.

Q139. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q140 & 141. [Q&A RETIRED 09/09; Outdated]

Q141.1. M1830. Based on my Start of Care (SOC) comprehensive assessment, I determine that my patient requires assistance to wash their back and feet safely in the tub. At the time of the assessment, I believe the patient *could* wash their back and feet safely *if* they had adaptive devices, like a long-handled sponge. Should the initial score be response 1 - With the use of devices, is able to bathe self or response 2 - intermittent assistance of another person to wash difficult to reach areas? [Q&A EDITED 10/23; EDITED 05/22; EDITED 06/14; ADDED 08/07; Previously CMS OCCB Q&A 07/06 Q36]

A141.1. Since at the time of the assessment the patient requires intermittent assistance of another person to wash difficult to reach areas, then Response 2 should be selected. If the clinician determined that the patient could become more independent (i.e., require less

assistance) with the use of adaptive equipment, then such equipment could be obtained or recommended as part of the home health Plan of Care. If at discharge the patient is able to wash their entire body using the equipment provided, then Response 1 should be reported. If even with the equipment the patient continues to require intermittent assistance, then Response 2 would apply.

Q141.2. [Q&A RETIRED 09/09; Outdated]

Q141.3. M1830. For M1830 - Bathing, even the normal person requires a long-handled sponge or brush to wash their back. If a patient can do everything except wash their back & requires a long-handled sponge or brush, would they be marked a response 1? [Q&A EDITED 05/22; EDITED 09/09; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q27]

A141.3. Assistive devices promote greater independence for the user by enabling them to perform tasks they were previously unable to or had great difficulty safely performing. The intention of the use of the term “devices” in the Response 1 for M1830 - Bathing is to differentiate a patient who is capable of washing their entire body in the tub/shower independently (Response 0), from that patient who is capable of washing their entire body in the tub/shower only with the use of (a) device(s). This differentiation allows a level of sensitivity to change to allow outcome measurement to capture when a patient improves from requiring one or more assistive devices for bathing, to a level of independent function without devices. Individuals with typical functional ability (e.g., functional range of motion, strength, balance, etc.) do not "require" special devices to wash their body. An individual may choose to use a device (e.g., a long-handled brush or sponge) to make the task of washing the back or feet easier. If the patient’s use of a device is optional (e.g., it is their preference, but not required to complete the task safely), then the score selected should represent the patient’s ability to bathe without the device. If the patient requires the use of the device in order to safely bathe, then the need for the device should be considered when selecting the appropriate score. CMS has not identified a specific list of equipment that defines “devices” for the scoring of M1830. The clinician should assess the patient’s ability to wash their entire body and use their judgment to determine if a device, assistance, or both is required for safe completion of the included bathing tasks.

Q141.4. M1830. If a patient uses the tub/shower for storage, is this an environmental barrier? Is the patient marked a 4 or 5 in M1830 - Bathing? [Q&A EDITED 05/22; EDITED 09/09; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q28]

A141.4. Upon discovering the patient is bathing at the sink, the clinician should evaluate the patient in attempts to determine why they are not bathing in the tub/shower. If it is the patient’s personal preference to bathe at the sink (e.g., “I don’t get that dirty.” “I like using the sink.”), but they are physically and cognitively able to bathe in the tub/shower; the clinician will pick the response option that best reflects the patient’s ability to bathe in the tub/shower. If the patient no longer bathes in the tub/shower due to personal preference and has since begun using the tub/shower as a storage area, the patient would be scored based on their ability to bathe in the tub/shower if it was empty.

If the patient has a physical or cognitive/emotional barrier that prevents them from bathing in the tub/shower and therefore has since starting using the tub/shower as a storage area, the clinician will score the patient either as a Response 4, 5, or 6, depending on the patient’s ability at the time of assessment. Note that the responses of 4, 5, and 6 are due to the patient’s inability to safely bathe in the tub/shower (even with help) due to the physical and/or cognitive barrier, not due to the alternative use of the tub for storage.

Q142. M1840. If my patient has a urinary catheter and does not void in the toilet. Would I code totally dependent in toilet transferring for M1840? [Q&A EDITED 05/22; EDITED 09/09]

A142. M1840 – Toilet Transferring does not differentiate between patients who have urinary catheters and those who do not. The item simply asks about the patient's ability to get to and from the toilet or bedside commode and their ability to transfer on and off toilet/commode. This ability can be assessed whether or not the patient uses the toilet for urinary elimination.

Q143. M1840. If the patient can safely get to and from the toilet and transfer independently during the day, but uses a bedside commode independently at night, what is the appropriate response to this item? [Q&A REVIEWED 05/22]

A143. If the patient chooses to use the commode at night (possibly for convenience reasons), but is able to get to the bathroom, then Response 0 would be appropriate.

Q143.1. M1840. My patient lives alone. They can safely get to/from and use the bathroom toilet by themself without difficulty during the day. The daughter requests that the patient use the bedside commode at night in their bedroom because their vision and balance are compromised at night, resulting in a previous nighttime fall. The patient demonstrates safe transfers on and off the bedside commode. I think they would be safe walking to the bathroom at night with supervision, but they live alone. Do I score them based on the use of the bedside commode, or based on the need for supervision? [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 04/16 Q9]

A143.1. For M1840 - Toilet Transferring, if the patient's ability or status varies on the day of assessment, report the patient's usual status, or what is true greater than 50% of the day of assessment. Day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home for the visit.

If the patient is able to get to and from the toilet safely and independently during the daytime; and if, for this patient, this represents more than 50% of the day of assessment, then M1840 would be Response 0 - Able to get to and from the toilet and transfer independently with or without a device, regardless of what the patient's status is for the remainder of the day of assessment. If the factors that make the patient not safe getting to/from the bathroom safely (vision and balance in this scenario) were to be present for more than 50% of the day of assessment, and if in your clinical judgment, during these times the patient would be safe walking to the bathroom with supervision, then Response 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer would be the appropriate response, even if the patient does not have a caregiver available.

Q144. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q145. [Q&A RETIRED 09/09; Outdated]

Q146. M1840. If a patient is able to safely get to and from the toilet and perform the transfer with assistance of another person, but they live alone and have no caregiver so they are using a bedside commode, what should be the response to M1840 - Toilet Transferring? [Q&A EDITED 05/22; EDITED 09/09; ADDED 06/05; Previously CMS OCCB Q&A 03/05 Q9]

A146. The OASIS item response should reflect the patient's ability to safely perform a task, regardless of the presence or absence of a caregiver. If the patient is able to safely get to and

from the toilet and transfer with assistance, then Response 1 should be selected, as this reflects their ability, regardless of the availability of a consistent caregiver in the home.

Q146.1. M1840. My male patient is bedfast and can place and remove the urinal, but not the bedpan. What response should be selected for M1840, Toilet Transferring? [Q&A ADDED 01/12; Previously CMS OCCB Q&A 07/11 Q13]

A146.1. If the bedfast patient needs assistance to get on/off the bedpan, the appropriate M1840 Response is 4 - Is totally dependent in toileting even if they can place and remove the urinal.

Q147. [Q&A RETIRED 09/09; Outdated]

Q147.5. M1840. We have a patient with multiple sclerosis who is transferred via a mechanical lift device, e.g. Hoyer. They are non-weight bearing. How do we answer M1840 - Toilet Transferring? Except for minimal movement of the arms and holding onto the sling (which doesn't really contribute to the transfer process), they cannot participate in the transfer. Should they be scored a response 1 or a response 4? [Q&A EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 01/11 Q15]

A147.5. Toilet Transferring Response 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer means the patient is able to perform the included tasks if they are "assisted" by another person. It is not the appropriate response in a case where the patient is totally dependent on another person to transport them to the toilet and transfer them on and off the toilet. In order to be scored a 1 the patient must be able to effectively participate by contributing effort toward the completion of some of the included tasks, getting to and from and getting on and off the toilet. If the patient can be moved to the toilet and transferred on and off, but cannot effectively participate in the effort required, they are scored a 4 - Is totally dependent in toileting.

In your scenario, since the patient cannot effectively participate in the tasks required in the Toilet Transferring item, the patient would be scored a 4 - Is totally dependent in toileting.

Q148. M1840. If a patient uses a bedside commode over the toilet, would this be considered "getting to the toilet" for the purposes of responding to M1840 - Toilet Transferring? [Q&A EDITED 05/22; EDITED 09/09; ADDED 06/05; Previously CMS OCCB Q&A 03/05 Q11]

A148. Yes, a patient who is able to safely get to and from the toilet and transfer should be scored at response levels 0 or 1, even if they require the use of a commode over the toilet. Note that the location of such a commode is not at the "bedside," and the commode is functioning much like a raised toilet seat.

Q148.01. [Q&A RETIRED 05/22]

Q148.02 M1840. If you have a patient that can't get to the toilet, for instance whose only toilet is on the second floor and they are medically restricted from climbing the stairs, or there is no toilet in the home would they be dependent in toilet transfers? [Q&A ADDED 10/16; Previously CMS Qtrly Q&A 10/15 Q3]

A148.02. For M1840 - Toilet Transferring, if the patient cannot access a toilet in the home (or in the absence of a toilet in the home), the assessing clinician would need to determine if the patient is able to use a bedside commode (with or without assistance) (Response 2) or is able to use a bedpan/urinal independently (Response 3). If the patient is not able to use the bedside commode or a bedpan/urinal as defined in the responses, or if such equipment is not present in

the home to allow assessment, then Response 4 - Is totally dependent in toileting would be appropriate.

Q148.03. M1840. 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 for M1840 - Toilet Transferring? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 01/20 Q7]

A148.03. If the patient is unable to get to and from the toilet or bedside commode and they only use a bed pan (i.e., for both voiding and bowel movements), then for M1840 - Toilet Transferring, response code 3 would apply if the patient is independent in safely getting on and off a bed pan.

Q148.1. [Q&A RETIRED 05/22]

Q148.2. M1840 & M1850. Regarding M1840 - Toilet Transferring Response 1 (reminded, assisted, or supervised by another person) & M1850 - Transferring Response 1 (minimal human assistance or with assistive device), what exactly do the terms "assisted" & "minimal human assistance" mean? In the therapy world, minimal assistance means the caregiver must provide less than 25% of the effort required to assist the patient in completing the task safely. Is this what the clinician is supposed to look at or could minimal human assistance mean verbal cueing or stand by assist only? [Q&A EDITED 10/23; EDITED 05/22; EDITED 06/14; ADDED 01/11; Previously CMS OCCB Q&A 04/10 Q19]

A148.2. The current OASIS Guidance Manual, Chapter 1 Conventions explains " When an OASIS item refers to **assistance**, this means assistance from another person. Assistance is not limited to physical contact and can include necessary verbal cues and/or supervision."

When completing M1840, Toilet Transferring, if the patient can participate, but requires any degree of hands-on assistance and/or standby assistance and/or verbal cueing/reminders to get to/from the toilet and/or transfer on/off the toilet safely, select Response 1. An example of Response 1 could be a patient who requires verbal cues regarding safe use of walker while ambulating to the toilet.

When completing M1850, Transferring, minimal human assistance referenced in Response 1 would include a minimal degree of any combination of verbal cueing, environmental set-up and/or actual hands-on assistance. In order for the assistance to be considered minimal, it would mean the individual assisting the patient is contributing less than 25% of the total effort required to perform the transfer.

An example of Response 1 could be a patient that requires hands-on assistance during the change in position from supine to sitting at the edge of bed, where the effort contributed by the individual assisting is less than 25% of total effort required to perform the transfer.

Q149. [Q&A RETIRED 09/09; Duplicative of Q151.3]

Q150. [Q&A RETIRED 05/22]

Q150.1. M1850. When completing M1850 - Transferring, do I consider the patient's gait impairment if they must ambulate 12 feet from the bed to get to the closest sitting

surface and the need for assistance of another person? [Q&A EDITED 12/12; ADDED 01/12; Previously CMS OCCB Q&A 10/11 Q9]

A150.1. The need for assistance with gait may impact the M1850 - Transferring score if the closest sitting surface applicable to the patient's environment is not next to the bed.

M1850 reports the patient's ability to move from the supine position in bed (or the current sleeping surface) to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a sitting surface at the bedside. If there is no chair at the bedside, report the ability to transfer from the sleeping surface to whatever sitting surface is applicable to the patient's environment and need. If the sleeping surface is in the bedroom and the sitting surface is down the hall in the bathroom and the patient is independent moving from the supine to sitting position, sitting to standing, and then standing to sitting, but requires minimal human assistance or an assistive device to ambulate from the bed to the sitting surface, the appropriate M1850 score would be a "1". If the patient requires more than minimal assistance or requires both minimal human assistance and an assistive device to be safe, the appropriate score would be response 2.

Q151. [Q&A RETIRED 05/22]

Q151.1. M1850. When scoring M1850 - Transferring, response 1 indicates that that patient requires minimal human assistance or the use of an assistive device to safely transfer. What constitutes an "assistive device" for the purposes of differentiating "truly independent" transferring (response 0) from "modified independent" transferring (response 1 or transferring with equipment)? [Q&A EDITED 05/22; EDITED 01/12; ADDED 08/07; Previously CMS OCCB Q&A 08/04 Q16]

A151.1. CMS does not provide a definitive list of assistive devices to apply when determining relevant OASIS responses. Use your clinical judgment and examples of devices included in OASIS items and related Q&As in determining what are considered assistive devices when scoring OASIS items.

Q151.2. [Q&A RETIRED 05/22]

Q151.3. M1850. A quadriplegic is totally dependent, cannot even turn self in bed, however, they do get up to a gerichair by Hoyer lift. For M1850 - Transferring, is the patient considered bedfast? [Q&A EDITED 10/23; EDITED 05/22; ADDED 08/07; M item updated 09/09; Previously CMS OCCB Q&A 05/07 Q29]

A151.3**.** A patient who can tolerate being out of bed is not "bedfast." If a patient is able to be transferred to a chair using a Hoyer lift, Response 3 is the option that most closely resembles the patient's circumstance; the patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because the patient is transferred to a chair, they would not be considered bedfast ("confined to the bed") even though they cannot help with the transfer. Responses 4 and 5 do not apply for the patient who is not bedfast. The frequency of the transfers does not change the response, only the patient's ability to be transferred and tolerate being out of bed.

Q151.4. M1850. How do you select a score for M1850 - Transferring, for the patient who is not really safe at response 1, but moving to response 2 seems a bit aggressive? Response 1 uses the word "or" NOT "and". If a patient requires both human assist AND an assistive device, does this move them to response 2, especially if they are not safe? It seems these patients can do more than bear weight and pivot--but it is the next best

option. If they require human assist AND an assistive device, should we automatically move the patient to a response 2, whether they are safe or not? [Q&A EDITED 05/22; ADDED 08/07; M number updated 09/09; Previously CMS OCCB Q&A 07/07 Q15]

A151.4. If the patient is able to safely transfer with either minimal human assistance (but no device), or with the use of an assistive device (but no human assistance) then they should be reported as a 1 - Able to transfer with minimal human assistance or with use of an assistive device. If the assessing clinician determines the patient is not safe in transferring with either of the above circumstances, (e.g., they transfer with only an assistive device but not safely, minimal assistance only is not adequate for safe transferring, or they require both minimal human assistance and an assistive device to transfer safely), then the patient would be scored a 2 - Able to bear weight and pivot during the transfer process but unable to transfer self (assuming the patient could bear weight and pivot). Safety is integral to ability. If the patient is not safe when transferring with just minimal human assistance or with just an assistive device, they cannot be considered functioning at the level of Response 1.

For the purposes of Response 1, minimal human assistance could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance, where the level of assistance required from someone else is equal to or less than 25% of the total effort to transfer and the patient is able to provide >75% of the total effort to complete the task. Examples of environmental set-up as it relates to transferring would be a patient who requires someone else to position the wheelchair by the bed and apply the wheelchair locks in order to safely transfer from the bed to the chair, or a patient who requires someone else to place the elevated commode seat over the toilet before the patient is able to safely transfer onto the commode.

Q151.5. [Q&A RETIRED 09/09; Outdated]

Q151.6. M1850. When scoring M1850 - Transferring, the assessment revealed difficulty with transfers. The patient was toe touch weight bearing on the left lower extremity and had pain in the opposite weight bearing hip. The patient had a history of falls and remained at risk due to medication side effects, balance problems, impaired judgment, weakness, unsteady use of device and required assistance to transfer. The concern is the safety of the transfers considering all of the above. Would response 2 or response 3 be the appropriate response? [Q&A EDITED 05/22; ADDED 09/09; M item updated 09/09; Previously CMS OCCB Q&A 10/07 Q22]

A151.6. Safety is integral to ability, if the assessing clinician determines the patient requires more than minimal human assistance or they need minimal assistance and an assistive device to safely transfer, and can bear weight and pivot safely, Response 2 should be reported. If the assessing clinician determines the bearing weight and pivoting component of the transfer is not safe even with assistance, then the patient is not able to bear weight or pivot and the appropriate selection would be Response 3 – Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

Q151.6.1. M1850. When answering M1850 - Transferring, do the responses that reference weight bearing and pivoting include an individual that uses a sliding board and would be weight bearing and pivoting using only the upper extremities, not the lower? [Q&A ADDED 06/14; Previously CMS Qtrly Q&A 07/13 Q15]

A151.6.1. The term "bear weight and pivot" in M1850, Transferring, may include both a standing pivot transfer and multiple sitting pivot transfers, such as those utilized when performing a bed-to-chair transfer with a sliding board.

If the patient does not have use of the lower extremities and transfers with the use of a sliding board, but no human assistance, select Response 1 - Able to transfer with minimal human assistance or with use of an assistive device. If the patient requires both minimal human assistance and the sliding board to transfer safely, select Response 2 - Able to bear weight and pivot during the transfer process but unable to transfer self. If the patient can bear weight and pivot utilizing their upper extremities, but requires more than minimal human assist, Response 2 should be marked. The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, select Response 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

Q151.7. M1850. For M1850 - Transferring, does the transfer from bed to chair include evaluation from a seated position in bed to a seated position in a chair or from supine in bed to seated in a chair? [Q&A ADDED 09/09; EDITED 01/10; Previously CMS OCCB Q&A 07/08 Q15]

A151.7. The bed to chair transfer includes the patient's ability to get from the bed to a chair and from the chair back into bed. For most patients, this will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair.

Q151.7.1. M1850. Is M1850 - Transferring assessed for the patient who has slept for years in a recliner? [Q&A EDITED 05/22; EDITED 12/12; ADDED 01/11; Previously CMS OCCB Q&A 01/10 Q13]

A151.7.1. M1850 - Transferring, must be assessed for all patients requiring OASIS data collection. The item includes assessment of the bed to chair/chair to bed transfers. If your patient no longer sleeps in a bed (e.g., sleeps in a recliner or on a couch), you will assess the patient's ability to move from the supine position on their current sleeping surface to a sitting position and then transfer to another sitting surface, like a bedside commode, bench, or chair, and then back to their current sleeping surface.

Q151.7.2. M1850. How do we score M1850 - Transferring, when the patient is temporarily sleeping in the recliner because there is a physician's order not to climb stairs and the patient's bed is located on the second floor? [Q&A EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 04/13 Q6]

A151.7.2. In the situation described, the medical restriction against climbing stairs does not impact the patient's ability. The assessing clinician will report the patient's ability to move from the supine position on the current sleeping surface to a sitting position at the side of the sleeping surface, then some type of standing, stand-pivot, or sliding board transfer to a sitting surface, and then back to their current sleeping surface.

Certain medical restrictions could impact ability, e.g., an order to maintain strict bed rest means the patient is scored as bedfast. Other medical restrictions that may prevent access to the usual sleeping surface DO NOT impact ability as M1850 – Transferring reports the patient's ability to move from the bed or current sleeping surface, e.g., an order not to climb stairs or an order to sleep in hospital bed.

Q151.8. [Q&A RETIRED 05/22]

Q151.14. M1850 & M1860. How is “bedfast” defined for M1850 - Transferring and M1860 - Ambulation/Locomotion? Do I only count what my patient could do during the visit? [Q&A EDITED 05/22; EDITED 06/14; ADDED 01/12; Previously CMS OCCB Q&A 04/11 Q10]

A151.14. M1850 - Transferring and M1860 - Ambulation/Locomotion report the patient's ability on the day of the assessment. Day of assessment is the 24 hours immediately preceding the visit and the time spent in the home. Ch. 3 of the current OASIS Guidance Manual in the M1850 Response-Specific Instructions defines bedfast. "Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed." If the patient can tolerate being out of bed, they are not bedfast unless they are medically restricted to the bed. The patient is not required to be out of bed for any specific length of time. The assessing clinician will have to use their judgment when determining whether or not a patient can tolerate being out of bed. For example, a severely deconditioned patient may only be able to sit in the chair for a few minutes and is not considered bedfast as they are able to tolerate being out of bed. A patient with Multiple System Atrophy becomes severely hypotensive within a minute of moving from the supine to sitting position and is considered bedfast due to the neurological condition which prevents them from tolerating the sitting position.

Q151.20. [Q&A RETIRED 10/18; Duplicative of OASIS Guidance Manual]

Q.151.21., Q152. [Q&As RETIRED 05/22]

Q153. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q154. [Q&A RETIRED 05/22; Q&A combined with Cat. 4b Q154.1.]

Q154.1. M1860. Does the usual status convention apply to all patients: ambulatory, chairfast and bedfast, when scoring M1860 - Ambulation/Locomotion?

For example, if a patient uses a wheelchair for 75% of their mobility and walks for 25% of their mobility, then should they be scored based on their wheelchair status because that is their mode of mobility >50% of the time? Or should they be scored based on their ambulatory status, because they do not fit the definition of “chairfast? [Q&A EDITED 05/22; ADDED 04/15; Previously CMS Qtrly Q&A 07/14 Q6]

A154.1. Because of the structure of the response options, the usual status convention (what is true greater than 50% of the time) does not apply for M1860 - Ambulation/Locomotion. For the patient who on the day of assessment is able to both walk with or without assistance, and use a wheelchair, code M1860 Ambulation based on their ability to ambulate.

For the ambulatory patient who needs assistance ambulating during any part of the day of assessment, but at times or in certain circumstances on the day of assessment can ambulate safely without assist, Response 2 is selected. A patient’s ability must be that they are safe when independent of human assistance at all times during the day of assessment in order to select either Response 0 or 1. Response 3 is selected when, on the day of assessment, a patient needs human assistance at all times in order to safely ambulate.

For a non-ambulatory patient who is not bedfast, Response 4 - Chairfast, unable to ambulate but is able to wheel self independently is selected if the patient does not require any assistance wheeling self at any time during the day of assessment. Response 5 - Chairfast, unable to ambulate and unable to wheel self is selected if the patient requires any assistance to wheel self on the day of assessment. If the patient can wheel self safely for part of the day but requires assistance at times, Response 5 is selected.

In order to be considered bedfast, a patient must be medically restricted to the bed or unable to tolerate being out of bed.

Q155. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q155.1. [Q&A RETIRED 05/22]

Q155.1.01. M1860. My patient does not have an assistive device but demonstrates the ability to walk safely constantly holding on to their caregiver. Their neighbor loaned them a walker to try out during our assessment visit. My patient liked it and was safe walking on level surfaces with no help, but still needed help on the stairs. I have ordered a walker for the patient, and it will be delivered in 2 days. How do I score M1860 - Ambulation/Locomotion for the day of assessment? With or without the use of a walker? [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 04/16 Q10]

A155.1.01. For M1860 - Ambulation/Locomotion, the clinician must consider what the patient is able to do on the day of the assessment, which is the 24 hours that precedes the visit plus the time in the home. If after assessment it is determined that the patient's usual status is that they can ambulate safely with a walker and no assistance, then Response 2 - Requires use of a two-handed device to walk alone on level surfaces should be reported. This is true even if the walker does not belong to the patient and may not remain in the home.

Q155.1.1. M1860. When looking at the use of a cane to ambulate, how would the canes used by the blind to navigate be considered when scoring M1860 - Ambulation/Locomotion? [Q&A EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 10/11 Q10]

A155.1.1. If a patient needs no human assistance but must use a cane to ambulate safely and independently on even and uneven surfaces and negotiate stairs, Response 1 would be appropriate when scoring M1860 - Ambulation/Locomotion.

Q155.2. M1860. For M1860 - Ambulation/Locomotion, does able to walk "on even and uneven surfaces" mean inside the home or outside the home or both?

If the patient is scored a 0, does this mean the patient is a safe community ambulator and therefore is not homebound? [Q&A EDITED 05/22; EDITED 01/10; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q30]

A155.2. "Even and uneven surfaces" refers to the typical variety of surfaces that the particular home care patient would routinely encounter in their environment. Based on the individual residence, this could include evaluating the patient's ability to navigate carpeting or rugs, bare floors (wood, linoleum, tile, etc.), transitions from one type or level of flooring to another, stairs, sidewalks, and uneven surfaces (such as a graveled area, uneven ground, uneven sidewalk, grass, etc.).

To determine the best response, consider the activities permitted, the patient's current environment and its impact on the patient's normal routine activities. If, on the day of assessment, the patient's ability to safely ambulate varies among the various surfaces the patient must encounter, determine if the patient needs some level of assistance at all times (Response 3), needs no human assistance or assistive device on any of the encountered surfaces (Response 0), needs a one-handed device but no human assistance, (Response 1) or needs a two-handed device and/or human assistance at times but not constantly (Response 2).

Response 0, Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device), is not intended to be used as a definitive indicator of homebound status. Some patients are homebound due to medical restrictions, behavioral/emotional impairments and other barriers, even though they may be independent in ambulation.

Refer to the Medicare Coverage Guidelines for further discussion of homebound criteria at http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf.

Q155.3. M1860. A patient is able to ambulate independently with a walker, but the patient chooses to not use the walker, therefore not being safe. When selecting a response for M1860 - Ambulation/Locomotion, should I select Response 2, that the patient is able to ambulate safely with the walker or should I select Response 3 that the patient is only safe when walking with another person at all times, because they choose to not use the walker? [Q&A EDITED 05/22; EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 01/09 Q12]

A155.3. The OASIS items should report the patient's physical and cognitive ability, not their adherence or willingness to perform an activity. You state the patient is able to ambulate independently with a walker, so we will assume you meant that the patient is able to ambulate without human assistance safely with the walker. This would be scored as response 2 for M1860 - Ambulation/Locomotion. You state the patient is unsafe ambulating because they choose not to use the walker. This patient would still be scored a response 2 unless, as you pointed out, the clinician identified some other physical, cognitive or environmental barrier that prevents the patient from utilizing the walker to assist with ambulation, e.g. fear, memory impairment, undisclosed pain associated with walker use, or other emotional, behavioral or physical impairments. If there was a barrier preventing the patient from safely utilizing the walker during ambulation, the clinician would need to determine if the patient needed someone to assist at all times in order to ambulate safely and if so, the appropriate score for M1860 would be response 3. If the patient only needed assistance intermittently, the correct response would be response 2.

Q155.3.1. M1860. We have a patient who is ambulating in the home. The clinician assesses that the patient is not safe ambulating with an assistive device, even with the supervision of another person at all times. The patient does not have a wheelchair in the home. What is the appropriate response to M1860 - Ambulation/Locomotion, for this patient? [Q&A ADDED 01/12; Previously CMS OCCB Q&A 04/11 Q11]

A155.3.1. A patient is considered chairfast if they cannot be made safe ambulating even with the combination of a device and the assistance of another person at all times. They are not bedfast unless they are medically restricted to the bed or cannot tolerate being out of bed. If there is no wheelchair in the home, the assessing clinician cannot make assumptions about their ability to propel it safely. The appropriate M1860 - Ambulation/Locomotion response in this case is 5 - Chairfast, unable to ambulate and is unable to wheel self".

Q155.3.2. M1860. What is the correct response for M1860 - Ambulation/Locomotion, for a patient who ambulates safely with a straight cane, but requires a stair lift to get up and down stairs in her home? [Q&A EDITED 05/22; ADDED 12/12; Previously CMS Qtrly Q&A 01/12 Q9]

A155.3.2. In the situation described, if the patient requires no human assistance while ambulating and negotiating the stairs, but requires a stair lift to traverse the stairs safely, because the stair lift

is considered an assistive device for the purposes of coding M1860 - Ambulation/Locomotion, they would be scored a response 2 for if they need two hands to use the stair lift and a response 1 if they only need one hand to safely use the stair lift.

Q155.3.3. M1860. Our patient requires maximum assistance to ambulate (over 75% of the effort necessary for ambulation is contributed by someone other than the patient) and only ambulates with the therapist during gait training activities. The patient is extremely unsafe when attempting to ambulate without the therapist's assistance. Is this patient considered ambulatory for M1860 - Ambulation/Locomotion and scored as response 3 (with constant assistance) or is this patient chairfast and scored as response 4 or response 5, at this time? [Q&A EDITED 05/22; ADDED 06/14; Previously CMS Qtrly Q&A 01/13 Q12]

A155.3.3. If the assessing clinician determines the patient is safe ambulating with constant human assistance, they are ambulatory. This is true whether the assistance needed is verbal cueing, reminders, contact guard, or any level of hands-on assistance. If the patient is not bedfast and is not safe ambulating even with a combination of continuous assistance and a device, they are chairfast. If the patient can only take 1 or 2 steps to complete a transfer and otherwise is unable to ambulate, they are not ambulatory.

Q155.3.4 M1860. If a patient is safely using a knee scooter to facilitate non-weight bearing on one lower extremity, what response would be selected for M1860 - Ambulation/Locomotion? [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 07/15 Q9]

A155.3.4 To determine the accurate response for M1860 - Ambulation/Locomotion, the assessing clinician must determine if the knee scooter will be considered an assistive device for the purpose of ambulation. If the assessing clinician determines the knee scooter is an assistive device, then the clinician must determine if the patient is safe without the assistance of another person and assess the number of hands (one-hand or two-hands) the patient requires to safely use the device.

Q155.3.5 M1860. Patient is wheelchair bound and cannot ambulate but can wheel self. Patient also has advanced dementia or cognitive decline and although the patient can wheel self independently, they are unable to do so with any purpose, (i.e., patient could not follow simple instructions to get to another room or could not self-evacuate in the event of an emergency). What response should be selected? [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 10/15 Q4]

A155.3.5 For M1860 - Ambulation/Locomotion Responses 4 and 5, the assessing clinician must consider the non-ambulatory patient's ability to safely use the wheelchair, given the patient's current physical and mental/emotional/cognitive status, activities permitted, and environment. In the scenario cited, the patient's advanced dementia/cognitive decline is noted as a concern because the patient is unable to wheel self with purpose. Other than addressing safety on surfaces the patient would routinely encounter in their environment, CMS guidance does not detail specific criteria regarding patient ambulation or wheelchair use (i.e., how far the patient must walk, or wheel self; of if they use ambulation or wheelchair mobility with specific purpose, regularity, or efficiency). It is left to the judgment of the assessing clinician to determine the patient's ability (i.e., does the patient's mental status impact their safety?) and select a response accordingly.

Q155.4. M1840, M1850 & M1860. Is it true that when the word "OR" appears in a question and the patient's condition meets both sides of the statement that the patient should automatically be marked at the next level down on the scale? Also, if the patient is marked as a "3" on M1860, Ambulation, can the patient be a "0" independent in toileting transferring? [Q&A ADDED & EDITED 09/09; Previously CMS OCCB Q&A 01/08 Q21]

A155.4. When scoring the OASIS, clinicians should avoid applying "always", "never", or "automatically" rules. Each item, the response options contained in the item, and additional available guidance in the form of Q&As and from Chapter 3 should be reviewed and the most accurate response should be selected. It is not a universally true statement to say that if conditions on both sides of the word "OR" pertain to the patient, then the patient should be automatically scored at the next level down. For instance, Response 0 for M1830 - Bathing says, "Able to bathe self in shower or tub independently, including getting in and out of tub/shower". If the patient was able to bathe in the shower independently AND also able to bathe in the tub independently, it would not be appropriate to score them at the next level down simply because conditions on both sides of the word "OR" are met.

When scoring M1860 - Ambulation/Locomotion, response option 3 is selected when the patient requires human supervision or assistance at all times in order to ambulate safely. Response 0 is selected if the patient requires no human assistance and no assistive devices to ambulate safely on even and uneven surfaces. All other combinations of needing assistance intermittently are reported as 2.

For M1850 - Transferring, Response 1 - Able to transfer with minimal human assistance or with use of an assistive device, it is true that if the patient requires BOTH minimal human assistance AND an assistive device to transfer safely, then the response option 2 should be selected (See CMS OASIS Q&A Category 4b Questions 151.4.)

If a patient requires constant human supervision or assistance in order to ambulate safely, they are scored a 3 for M1860 - Ambulation/Locomotion. A patient can only be scored a 0 for M1840, Toilet Transferring, if they can get to and from the toilet and transfer independently with or without a device. It would be possible for a patient to be a "3" for M1860, Ambulation/Locomotion and also be reported as a "0" for M1840, Toilet Transferring, if the patient required assistance at all times to ambulate but was able to get to and from the toilet and transfer safely and without assistance using a wheelchair.

Q156. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q156.1. M1870. If a patient is receiving TPN and is also taking in nutrients orally, is the correct answer for M1870 - Feeding or Eating response 0, response 1 or response 2? They do not have a tube in place. [Q&A EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 07/11 Q14]

A156.1. M1870 - Feeding or Eating, identifies the patient's ability to feed themself food and does not include total parenteral nutrition (TPN). If the patient is receiving TPN and is also taking in nutrients orally, the answer will be response 0, response 1, or response 2. Response 5 would apply if the patient is not able to take in nutrients orally or by tube feeding and is receiving all nutrition intravenously or for patients who are only receiving IV hydration.

Q156.2. M1870. My patient was recently hospitalized for aspiration pneumonia. They can feed themself but need to be closely observed/supervised during the entire meal because they tend to pocket food, forget to swallow, and then sometimes doze while eating. How

should I answer M1870 - Feeding or Eating? [Q&A EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 10/11 Q11]

A156.2. If a patient requires constant supervision throughout the meal in order to eat or feed self safely, the appropriate M1870 - Feeding or Eating response is 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.

Q156.3. M1870. We have a patient whose medical team is considering recommending a feeding tube due to the patient's inability to safely take in oral nutrition due to risk (and recent history) of aspiration.

In this situation, would M1870 be answered as a 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack or a 5 - Unable to take in nutrients orally or by tube feeding? The patient has the motor skills to bring the food to their mouth; however, is having difficulty with swallowing. [Q&A EDITED 10/23; ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 07/20 Q8]

A156.3. M1870 - Feeding or Eating identifies the patient's ability to feed themself, including the process of eating, chewing, and swallowing food. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely self-feed, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. Responses 4 and 5 include non-oral intake.

In your scenario, the patient is feeding themself orally and is at risk for aspiration due to difficulty swallowing. If a patient requires constant supervision throughout the meal in order to complete this activity safely, the appropriate M1870 response is 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.

Response 5 - Unable to take in nutrients orally or by tube feeding, is the best response for patients who are not able to take in nutrients orally or by tube feeding. This may be the case for patients who receive all nutrition intravenously (such as TPN) or for patients who are receiving only intravenous hydration.

Q157 & 157.1. [Q&As RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q158, Q158.5 & Q158.6. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q159. [Q&A RETIRED 09/09; Outdated]

Q159.1., **Q159.2.** [Q&As RETIRED 05/22; Item deleted from OASIS]

Q159.3. [Q&A RETIRED 12/12; Guidance found in related Q&As]

Q159.4. [Q&A RETIRED 05/22; Item deleted from OASIS]

Q159.5. [Q&A RETIRED 12/12; No longer relevant]

Q159.5.1., Q159.5.2., Q159.6., Q159.7., Q159.7.1., Q159.8. [Q&As RETIRED 05/22; Item deleted from OASIS]

Q159.8.1. [Q&A RETIRED 10/18]

Q159.8.2. [Q&A RETIRED 05/22; Item deleted from OASIS]

Q160. [Q&A RETIRED 09/09; Outdated]

Q160.1. & Q160.2. [Q&As RETIRED 05/22]

Q160.3. [Q&A RETIRED 06/14; Duplicate of Q&A 160.2]

Q160.3.1. M2001. In therapy only cases, can an LPN in the office work cooperatively with the therapist to complete the Drug Regimen Review (DRR) by performing elements of the DRR that the therapist will not be completing? [Q&A EDITED 10/18; EDITED 10/16; ADDED 01/12; Previously CMS OCCB Q&A 01/11 Q16]

A160.3.1. Only registered nurses, physical therapists, speech language pathologists and occupational therapists are qualified to perform comprehensive assessments. LPNs are not qualified to perform comprehensive assessments; however, the assessing clinician (RN or therapist) may seek collaboration from other agency staff, including LPNs, in order to complete any or all OASIS items. All staff are expected to function within the scope of their practice and state licensure.

Q160.3.2. M2001. On therapy only cases, can the therapist collaborate with a pharmacist when completing the Drug Regimen Review? [Q&A EDITED 10/16; EDITED 06/14; ADDED 01/12; Previously CMS OCCB Q&A 07/11 Q16]

A160.3.2. In a therapy only case, it would be acceptable for the therapist to collaborate with a pharmacist when performing the drug regimen review. Agency policy and practice will determine how the pharmacist participates in the drug regimen review process and how it is documented.

Q160.3.3. M2001. For therapy only cases, can we have our therapist complete the entire comprehensive assessment, except the Drug Regimen Review (DRR), and then have our agency send a nurse out to complete the entire DRR, including providing responses to the medication related OASIS questions to the assessing clinician? [Q&A EDITED 05/22; EDITED 10/18; EDITED 10/16; EDITED 04/15; ADDED 06/14; Previously CMS Qtrly Q&A 10/13 Q9]

A160.3.3. Yes. The comprehensive assessment continues to be the responsibility of one clinician, the "assessing clinician". Collaboration, however, is allowed on any and all OASIS items, including the medication/DRR tasks and items. One example of collaboration allows the assessing clinician to visit the patient at home and conduct the actual patient assessment, compiling the medication list and evaluating the patient's status (e.g., presence of potential ineffective drug therapy, side effects or patient nonadherence).

In another example of collaboration, the "collaborating clinician" might contact the patient by phone, to discuss issues with the patient regarding side effects they may be experiencing, or effectiveness of the medication. In any case, it is the assessing clinician who is ultimately responsible for ensuring a complete DRR was performed and for reporting the appropriate responses for medication related OASIS items.

Note that collaboration options also allow a second clinician to contribute to the drug regimen review by allowing the assessing clinician to utilize information gathered from a second clinician's in-home assessment, during the timeframe in which collaboration is allowed.

Agency policy and practice will determine the agency's processes and documentation expectations. The 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.

It should be noted that in situations where nursing is admitting for a therapy only patient, the nurse could not complete or even start the comprehensive assessment (including drug review tasks) prior to the SOC date.

Q160.3.4. [Q&A RETIRED 05/22]

Q160.3.5. M2001. Would the use of essential oils be included in the Drug Regimen Review (DRR), whether taken orally, diffused, or used topically? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 07/19 Q11]

A106.3.5. The Drug Regimen Review (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.

Q160.3.6. M2001. We have educated clinicians that it is a requirement that medication reconciliation be done. With this in mind, is it acceptable to electronically restrict clinicians from using a dash (–) as a response to M2001 - Drug Regimen Review by eliminating it as a response option in the Electronic Medical Record (EMR), understanding that there still may be scenarios where the dash is the only correct response to this item? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/21 Q3; Also posted in Cat. 4a Q24.5]

A106.3.6. A dash (–) is a valid response for M2001 - Drug Regimen Review. CMS expects dash use to be a rare occurrence. If elements of the drug regimen review were skipped, (for example drug-to-drug interactions were not completed), a dash should be reported, indicating the drug regimen review was not completed. A dash is also a valid response for this item and indicates no information is available.

To be compliant, a dash must be available for clinician use where the dash is a valid response option for the OASIS item.

Q160.4. M2001 & M2003. The assessing clinician identifies a problem with medications. The patient has not picked up a prescription because they were not sure they absolutely needed it. If the assessing clinician's education results in the resolution of the situation prior to the completion of the comprehensive assessment, can the clinician indicate on M2001 - Drug Regiment Review that there is no clinically significant problem, eliminating the need to address it in M2003 - Medication Follow-up? [Q&A EDITED 05/22; EDITED 10/16; Previously CMS Qtrly Q&A 10/16 Q20; ADDED 01/11; Previously CMS OCCB Q&A 10/09 Q33]

A160.4. If a medication related problem is identified and resolved by the agency staff not requiring physician/allowed practitioner (or physician-designee) contact by midnight of the next calendar day, the problem does not meet the definition of an actual or potential clinically significant medication issue in M2001- Drug Regimen Review.

Q160.4.1. [Q&A RETIRED 10/16; replaced with new C2 manual guidance]

Q160.4.2. M2001 & M2003. With the expanded one clinician convention – would it be appropriate if a second clinician completed the Drug Regimen Review (DRR) <u>in its entirety</u> by phone and collaborated with the assessing clinician to respond to M2001 - Drug Regimen Review and M2003 - Medication Follow-up? [Q&A ADDED 05/22; Previous CMS Qtrly Q&A 04/18 Q10]

A160.4.2. While the expanded one clinician convention allows a second clinician to complete the drug regimen review (DRR) in its entirety and collaborate with the assessing clinician, it is expected that an in-person assessment would be included as appropriate in the process. While portions of the DRR may be conducted over the phone and/or by a clinician in the office (i.e., evaluating the medication list to assist with reconciling discrepancies), other portions of the DRR may require in-person assessment (e.g., evaluating the patient for effectiveness of medications or for the presence of significant side effects). The assessment must be completed within the required timeframe, and all requirements for the collaboration must be met. (See Cat. 2 Q15.3.1.)

Q160.5. M2003. A clinically significant medication issue is identified on a weekend, and the agency phones the physician on-call. The physician on-call responds with instructions for the agency to contact the primary care physician on Monday. Can the clinician select Response 1 - Yes; Physician or physician-designee was contacted by midnight of the next calendar day and prescribed/recommended actions were taken? [Q&A EDITED 05/22; EDITED 10/16; Previously CMS Qtrly Q&A 10/16 Q21; ADDED 01/11; Previously CMS OCCB Q&A 01/10 Q16]

A160.5. When completing M2003 - Medication Follow-up, if the physician/allowed practitioner or physician designee responds by midnight of the next calendar day and there is a resolution to the clinically significant medication issue, Response 1 - Yes should be entered. In your scenario, you describe a situation where the physician was contacted and informed of the medication issue, but then due to the contacted physician's unfamiliarity with the patient, you were directed to contact the primary care practitioner on Monday. In cases where the physician/allowed practitioner (or physician-designee) recommends an action that will take longer than the allowed time to complete, then Response 1 - Yes should be entered as long as by midnight of the next calendar day, and within the assessment timeframe the agency has taken whatever actions are possible to comply with the recommended action.

Q160.5.1. M2003. I am aware that in order to mark response 1 - Yes, the two-way communication AND prescribed/recommended actions must be completed by midnight of the next calendar day after the problem was identified. Does that "next calendar day" have to be within the 5 days after the SOC? That is, if the nurse finds a problem with the patient's meds while completing the comprehensive assessment on day 5 after the SOC, and the physician is notified and the problems are resolved but not until day 6 after the SOC, (although it is within the one calendar day), can 1 - Yes be marked? [Q&A EDITED 05/22; EDITED 10/16; Previously CMS Qtrly Q&A 10/16 Q22; EDITED 04/15; ADDED 01/11; Previously CMS OCCB Q&A 01/10 Q17]

A160.5.1. M2003 - Medication Follow-up, is only collected at the SOC and ROC. The item must be answered within the timeframe allowed at the SOC/ROC to ensure compliance with the Condition of Participation regarding the completion of the comprehensive assessment. If a problem is identified, the communication and completion of prescribed/recommended actions to the extent possible must occur by midnight of the next calendar day after identification and before the end of the allowed timeframe in order to answer 1 - Yes.

If a medication issue is identified on day 5 after the SOC, the physician is contacted by midnight of the next calendar day and responds back with a plan to resolve the problem on day 6 after the SOC, this 2-way communication could not be captured at the SOC.

Q160.5.2. M2003. On my Tuesday admission visit, my patient reported a new rash which had continually worsened since initiating a new antibiotic 4 days ago. I considered this a

potential clinically significant medication issue and contacted the physician the same day. The next morning the physician returned my call to report he had called in a new antibiotic prescription,and to notify the patient to discontinue the old med and start with the new. I notified the patient and family that day and the son agreed to pick up the new medication. On the Thursday visit the patient says they are less itchy and uncomfortable since they started the new medication last night. The rash is still present and therefore this issue has not been resolved, although considerably less severe. How do I code M2003 - Medication Follow-up? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/19 Q25]

A160.5.2. M2003 - Medication Follow-up identifies if potential or actual clinically significant medication issues identified though the drug regimen review were communicated to the physician/allowed practitioner (or physician-designee) with prescribed/recommended actions completed by midnight of the next calendar day. In the scenario described, the communication occurred, and the prescribed/recommended action (communicate medication change to patient) was completed prior to midnight of the next calendar day after the issue was identified. Code M2003 as 1 - Yes. It is not necessary for the issue, in this scenario the rash, to be resolved by midnight of the next calendar day, as long as the physician communication and completion of the prescribed/recommended actions were completed.

Q160.6. [Q&A RETIRED 05/22]

Q160.6.1. [Q&A RETIRED 10/18; Duplicative of OASIS Guidance Manual]

Q160.6.2. M2003 & M2005. Multiple clinically significant medications issues were identified as I completed the SOC assessment. Only one was resolved by midnight of the next calendar day. How do I answer M2003 – Medication Follow-up and then M2005 – Medication Intervention? [Q&A EDITED 05/22; EDITED 10/16; EDITED 06/14; ADDED 01/12; Previously CMS OCCB Q&A 01/11 Q17]

A160.6.2. In order to select response 1 - Yes to M2003 - Medication Follow-up, the physician must have been notified by midnight of the next calendar day regarding all clinically significant medication issues that were identified during the SOC/ROC comprehensive assessment. In addition to the physician notification, you must have completed any prescribed/recommended actions to the extent possible by midnight of the next calendar day to answer 1-Yes.

In order to select response 1 - Yes for M2005 - Medication Intervention, all clinically significant medication issues that were identified at the time of or at any time since the SOC/ROC must have been resolved in the same manner as stated above.

Q160.6.3. M2003 & M2005. What is meant by "communication can be directly to/from the physician, or indirectly through physician's office staff on behalf of the physician, in accordance with the legal scope of practice"? Can the physician's secretary be considered office staff if they speak directly to the physician with the clinician's questions and then gives the information directly back to the clinician? [Q&A EDITED 10/18; EDITED 06/14; ADDED 01/11; Previously Cat. 4a Q23; CMS OCCB Q&A 01/10 Q&A Q3]

A160.6.3. The reference to "in accordance with the legal scope of practice" refers to the State requirements defining who can take orders from physicians. Each HHA should have a policy and procedure consistent with State law that describes who can take orders from the physician. It is important to understand that all orders must come from the physician/allowed practitioner and eventually be signed by the physician/allowed practitioner.

Q160.6.4. M2003 & M2005. When completing M2003 - Medication Follow-up or M2005 - Medication Intervention, does the midnight of the next calendar day "clock" start when the assessing clinician identifies the clinically significant medication issue, even if the issue is identified, for instance, on Day 2 of the episode? [Q&A EDTED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 01/19 Q6]

A160.6.4. M2003 - Medication Follow-up and M2005 - Medication Intervention ask if two-way communication and completion of any prescribed/recommended actions occurred by midnight of the next calendar day when a clinically significant issue is identified. For M2003, the timeframe is "by midnight of the next calendar day" from the time the potential clinically significant medication issue was identified and within the Start of Care (SOC) or Resumption of Care (ROC) comprehensive assessment timeframe. For M2005, the timeframe is "by midnight of the next calendar day" each time a potential clinically significant medication issue was identified at the time of, or at any time since, the most recent SOC/ROC assessment.

Q160.7. M2001, M2003, M2005, M2010, M2020. Our patient has nine herbal supplements that have been prescribed by their physician. Are herbal supplements considered medications when answering the OASIS items? [Q&A EDITED 05/22; EDITED 10/16; ADDED 04/15; Previously CMS Qtrly Q&A 07/14 Q7]

A160.7. Herbal products, when prescribed or taken as a medication, are considered medication when completing the M OASIS Medication items (M2001, M2003, M2005, M2010, M2020). For example, Echinacea taken daily by mouth to stimulate the immune system, would be considered a medication for M2020 - Management of Oral Medications.

Q161. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q161.1. [Q&A RETIRED 05/22]

Q161.1.1. M2005. 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? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 07/21 Q6]

A161.1.1. The intent of M2005 - Medical Intervention is to identify if all 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.

Q161.2. M2010. Regarding M2010 - Patient/Caregiver High-Risk Drug Education, if the assessing clinician discovered the patient was taking a discontinued high-risk medication in error and then correctly educated the patient to discontinue it and follow the current medication orders, which did not include any high-risk medications. How should the clinician complete M2010? Our dilemma focused on whether the clinician should consider only those medications currently prescribed, or, in this case, include high-risk medications being taken but not presently prescribed for the patient's use. [Q&A EDITED 05/22; ADDED & EDITED 06/14; Previously CMS Qtrly Q&A 04/14 Q10]

A161.2. The current OASIS Guidance Manual M2010 Ch. 3 guidance states that M2010 – Patient/Caregiver High-Risk Drug Education identifies if clinicians instructed the patient and/or

caregiver about all high-risk medications the patient takes. High-risk medications are those identified by an authoritative source as having considerable potential for causing significant patient harm when they are used erroneously.

If the patient was taking a high-risk medication in error, as you described, and was educated by your staff to discontinue the medication as well as the special precautions they need to take and how and when to report a problem that occurs as a result of taking that medication, M2010 may be answered 1 - Yes.

Q161.3. M2010. How would Patient/Caregiver High-Risk Drug Education for M2010 be impacted for patients living in assisted living where the medications are managed by facility staff? [Q&A EDITED 05/22; EDITED 10/16; ADDED 01/11; Previously CMS OCCB Q&A 01/10 Q19]

A161.3. When completing M2010 - Patient/Caregiver High-Risk Drug Education, for patients residing in an assisted living facility, it may be appropriate to educate the patient and/or the staff administering the medication on the topics included in each item. As with patients who live at home, the decision to direct the teaching to the patient, caregiver, or both should be made by the assessing clinician, based on the specific circumstances. For the purposes of selecting a response, the facility staff would be considered caregivers.

Q161.4. M2010. If agency staff other than the assessing clinician provided education to the patient/caregiver on high-risk medications, could this education include an office nurse giving the education over the phone to the patient? [Q&A EDITED 05/22; EDITED 10/18; EDITED 10/16; EDITED 04/15; ADDED 01/11; Previously CMS OCCB Q&A 01/10 Q20]

A161.4. A clinician other than the assessing nurse or therapist may provide drug education by phone to the patient and/or caregiver. When agency staff other than the assessing clinician provide medication education to the patient/caregiver, this information may be communicated to the assessing clinician for consideration so that the appropriate response for M2010 - Patient/Caregiver High-Risk Drug Education may be selected.

Q161.5. M2010. When scoring M2010 - Patient/Caregiver High-Risk Drug Education, does the clinician need to follow up a response of 1 - Yes with a list of all high-risk medications they educated the patient/caregiver on, or is it acceptable to score this item as 1 - Yes either with "all" listed or is any additional documentation required at all? [Q&A EDITED 05/22; EDITED 10/16; ADDED 04/15; Previously CMS Qtrly Q&A 10/14 Q12]

A161.5. It would be expected that instructions on ALL high-risk medications would be documented in the clinical record following agency policy.

Q162. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q162.1. [Q&A RETIRED 05/22; Item deleted from OASIS]

Q162.2. [Q&A RETIRED 10/16; changed look back period in C2]

Q162.3., Q162.4. [Q&As RETIRED 05/22; Item deleted from OASIS]

Q163. M2020. I have had several patients who use a list of medications to self-administer their meds. Would this be considered a drug diary or chart? [Q&A EDITED 05/22; EDITED 08/07]

A163. Yes, this is considered a drug diary or chart. The statement for response 1b - another person develops a drug diary or chart pertains to someone other than the patient developing the aid. Assess whether the patient must use this list to take the medications at the correct times.

If they do require the list and also require someone else to create it, then Response 1 is the appropriate choice.

Q164. [Q&A RETIRED 05/22]

Q164.1. [Q&A RETIRED 05/22]

Q164.2. M2020 & M2030. Can a patient residing in an assisted living facility (ALF) be coded 0 - Able to independently take correct oral medication(s) for M2020 - Management of Oral Medications if the ALF staff must unlock the medications to allow patient access at each administration time? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 04/22 Q4]

A164.2. M2020 - Management of Oral Medications is not automatically assigned a specific code just because a patient resides in a facility, such as an assisted living facility (ALF). M2020 should report the patient's ability to take the correct dose(s) of the correct oral medication(s) at the correct times. The assessing clinician uses clinical judgment to determine the patient's current ability based on observation and 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. Assessment of a patient in an ALF includes consideration of whether a patient can get to the location where the medications are routinely stored at the correct times, can recognize the correct medication dose(s), and take their oral medications, recognizing that someone would need to make the medication available to the patient once they are at the location (e.g., nursing office or medication cart).

A patient residing in an ALF could be coded with a response 0, 1, 2 or 3 depending on the level and timing of assistance required on the day of assessment to allow the patient to take the correct dose(s) of all oral medications reliably and safely at the correct times.

Code 0 - Able to independently take the correct oral medications(s) and proper dosages at the correct times, if at each administration time, the patient can independently get to the location where the medications are routinely stored, confirm the correct dose, and take all oral medications safely. This is true even though a staff member must unlock and make the medication available at each administration time.

Apply this same guidance for M2030 - Management of Injectable Medications when access to a patient's injectable medications is restricted by ALF policies.

Q165. [Q&A RETIRED 09/09; Outdated]

Q166. M2020. When scoring M2020, Management of Oral Medications, should medication management tasks related to filling and reordering/obtaining the medications be considered? [Q&A EDITED 09/09; 06/05; Previously CMS OCCB Q&A 08/04 Q19]

A166. No.

Q167. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q167.1. M2020. A patient is typically independent in managing their own oral medications. At the time of assessment, the patient's daughter and grandchildren are staying with the patient during their recovery, and the daughter has placed the meds out of reach for safety. This now requires someone to assist the patient to retrieve the medications. How should M2020 - Management of Oral Medications be answered? [Q&A EDITED 05/22; Previously CMS Qtrly Q&A 01/22 Q6; EDITED 01/12]

A167.1. M2020 - Management of Oral Medications assesses the patient's ability to prepare and take oral medications reliably and safely. Tasks include the ability to obtain the medication from

where it is routinely stored, ability to read the label (correct medication), open the container, select the pill/tablet or milliliters of liquid (correct dosage), and orally ingest at the prescribed time (take). In some cases, the family or caregiver may impose a temporary barrier that limits the patient's ability to access their medications from where they are routinely stored, e.g. a family that relocates the medications out of the reach of visiting children for the child's safety - not the patient's. In the situation where the medications are in a home location that the patient would require assistance to access, 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.

Q167.2. M2020. The patient with schizophrenia is not compliant with their medication regimen when they must pour their oral medications from bottles. The nurse discovers that if the pharmacist prepares the medications in bubble packs, the patient is less paranoid, is able to open the pack and will safely and reliably take their medication doses at the correct time. Since the patient is able to manage the medications once they are in the home in a bubble pack is the patient considered independent (Response 0) in medication management or is the special packaging requirement considered a type of assistance and is response 1 the correct answer? [Q&A EDITED 05/22; EDITED 06/14; ADDED 08/07; Previously CMS OCCB Q&A 07/07 Q18]

A167.2. M2020 - Management of Oral Medications is asking if the patient has the ability to prepare and take oral medications reliably and safely - the correct dosage at the correct times. Preparation includes the ability to obtain the medication from where it is routinely stored, the ability to read the label (or otherwise identify the medication correctly, e.g., patients who cannot read and/or write may place a special mark or character on the label to distinguish between medications), open the container, select the pill/tablet or milliliters of liquid, and orally ingest it at the correct times. Some patients may require medications to be dispensed in bottles with easy-open lids, while others may not. Arranging to have medications dispensed in bubble packs is an excellent strategy that may enable a patient to become independent in the management of their oral medications. Because a patient utilizes a special method or mechanism in order to take the correct medication, in the correct dose, at the correct time, does not necessarily make them dependent in the management of their oral medications. All patients are dependent on their pharmacist to dispense their medications in containers appropriate to their needs. Once in the home, if the patient requires someone else to prepare individual doses, or fill a pill box or planner, or create a diary or med list in order to take the correct med in the correct dose at the correct time, the patient would be scored as response 1 indicating they require someone's else's assistance.

Q167.3 & 167.4. [Q&A RETIRED 09/09; Outdated]

Q167.5. M2020. What is the appropriate response to M2020 - Management of Oral Medications, when the nurse sets up a medication dispenser that has a visual alarm (flashing light) and an automated verbal message reminding the patient to take the medication? This medication dispenser also calls to alert a caregiver if the patient does not respond to the alarms by taking the medication from the dispenser. [Q&A EDITED 05/22; EDITED 04/15; ADDED 09/09; Previously CMS OCCB Q&A 10/08 Q9]

A167.5. If the patient requires another person (e.g., nurse, family member, friend, caregiver) to give them daily reminders AND the patient has taken all of their oral medications on the day of assessment they are considered a response 2. If the patient requires an automated dispensing system with visual or audio reminders, they continue to be scored a response 2 if someone

other than the patient must program the device. If the patient successfully and independently programs/manages the device and takes all oral medications appropriately on the day of assessment, the patient would be scored a response 0.

Q167.5.1. M2020. Please explain and provide examples for M2020 - Management of Oral Medications Response 3 - Unable to take medications unless administered by another person . [Q&A EDITED 05/22; ADDED 01/11; Previously CMS OCCB Q&A 04/10 Q25]

A167.5.1. Response 3 - Unable to take medication unless administered by another person, describes a patient who does not have the physical or cognitive ability on the day of assessment to take all their medications at the correct dose every time it is ordered to be administered, and it is not yet clear if new strategies (a drug diary, a med box, etc.) will allow the patient to take medications independently or with reminders. At a subsequent visit the clinician could reassess to determine if the interventions were adequate strategies allowing the patient to take all medications safely, possibly resulting in a more independent code then response 3 at a subsequent assessment timepoint.

Some examples of Response 3, (but not a finite list) include:

- A patient who decided not to take their new medications, because the varying doses worried them, and they were unsure of the instructions. There had not been a medication organizer/box set-up, nor reminders tried. The clinician would select Response 3 if it is unclear if the interventions will be successful.
- A patient who, upon assessment, was not able to take prescribed medications at the correct time and doses even though reminded.
- A patient who, on the day of assessment, was prescribed oral medications, but was unable to safely swallow without supervision.

Q167.5.2. M2020. 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? [Q&A EDITED 05/22; Previously CMS Qtrly Q&A 01/22 Q8; ADDED 01/12; Previously CMS OCCB Q&A 01/11 Q19]

A167.5.2. 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 are currently 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 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, 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.

Q167.5.2.1. M2020 & M2030. Would a patient be scored as response 3 - Unable to take medications unless administered by another person for M2020 - Management of Oral Medications or for M2030 - Management of Injectable Medications if they simply choose

not to fill a prescription? [Q&A EDITED 05/22; Previously CMS Qtrly Q&A 01/22 Q7; EDITED 06/14; ADDED 12/12; Previously CMS Qtrly Q&A 04/12 Q20]

A167.5.2.1. In situations where one or more medications that 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, 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.

Q167.5.3. M2020. I have a question regarding the appropriate response for scenarios where the patient is unsteady while ambulating and requires supervision for ambulation. They possess the knowledge to take their medications reliably and safely if the bottles are placed near them, or if they have supervision while ambulating to the medication storage area. Please advise how this patient would be scored for M2020 - Management of Oral Medications. The item intent instructions include guidance related to the patient's ability to access the medication, how does this play into the question when the physical impairment causes the patient to require human supervision or assistance and not the cognitive aspect (such as for reminders)? [Q&A EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 04/11 Q13]

A167.5.3. M2020 - Management of Oral Medications reports a patient's ability on the day of the assessment to take the correct oral medications at all the correct times. This would include the tasks of accessing the medications from the location where they are routinely stored in the home, preparing the medications (including opening containers or mixing oral suspensions), selecting the correct dose and safely swallowing the medications, typically involving having access to a beverage.

If someone other than the patient must do some part of the task(s) that are required for the patient to access and/or take the medication at the prescribed times, then the patient would NOT be considered independent (Response 0).

If another person's assistance is required to provide set up in advance of the administration times, and with this level of assistance, the patient is capable of self-administering the correct meds at the correct times and dosages on the day of assessment, then Response 1 would apply.

The following are examples of how the need for assistance or an environmental barrier could impact ability:

Scenario: Medications are routinely stored in the refrigerator located downstairs. The patient requires someone to assist them at medication administration time to walk to the location where the medications are routinely stored, or someone must retrieve the medications and bring them to the patient; Response 3 would apply. In this situation, just someone preparing the doses in advance did not enable the patient to self-administer their medications.

Scenario: The patient requires someone to prepare the medication doses in advance (e.g., visually they can't discern the appropriate dose) and to walk with them at all times to be safe. In advance of the administration time someone prepares the medi-planner and sets it within the patient's reach with the water they will need to take the meds. The appropriate score is 1, as the

patient can access the medications from where they are routinely stored and has the water available to swallow the medication safely.

If the medications were routinely stored in the kitchen and/or the water was not available for the patient to self-administer and the patient required someone to assist them to the location where the meds were stored and or to water, the appropriate score would be 3.

Scenario: Patient does not need doses prepared in advance, but the medications are routinely stored in a location that the patient cannot access due to a physical, sensory, or environmental barrier. The patient is scored 3. During the episode, an environmental modification was made, e.g., changing the medication storage and water supply to a location that the patient can access, the patient could be scored 0 at the next OASIS data collection time point.

Q167.5.4. M2020. Are inhaled meds and sublingual meds considered in M2020 - Management of Oral Medications? [Q&A EDITED 05/22; ADDED 12/12; Previously CMS Qtrly Q&A 10/12 Q8]

A167.5.4. No. Medications given per an inhaler or sublingually are not considered when answering M2020 - Management of Oral Medications. When you assess M2020 consider those medications which are administered per the oral (p.o.) route. P.O. medications are swallowed and absorbed through the GI system. Sublingual medications are absorbed through the mucosal membranes under the tongue.

Q167.5.5. [Q&A RETIRED 05/22]

Q167.5.6. M2020. At start of care (SOC), patient was only prescribed two P.O. medications, Tamiflu 30 mg daily for 7 days and Ativan 0.5 mg, take ½ tab at bedtime as needed. Three weeks later, the patient is discharged. At discharge (D/C), 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? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 07/19 Q12]

A167.5.6. M2020 - Management of Oral Medications 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.

Q167.6. M2020 & M2030. The guidance states that if a HH nurse is ordered to administer a medication, the patient is considered dependent for that (oral or injectable) medication. At SOC, if a patient has been in the hospital where all medications were administered by hospital nursing staff, would this make the patient dependent because the medications

over the past 24 hours were administered by the acute care nurse at the hospital? [Q&A EDITED 05/22; EDITED 01/12; ADDED 09/09; Previously CMS OCCB Q&A 01/09 Q13]

A167.6. In the case of an admission to home care following a discharge from an inpatient facility, M2020 - Management of Oral Medications and M2030 - Management of Injectable Medications should be scored based on the orders relevant to medications that will be taken/administered in the home and will not include a reporting of medications that were administered while the patient was an inpatient. Restrictions imposed during a recent hospitalization should not impact the reporting of the patient's current status.

If the patient had been discharged from an inpatient facility on the day of the assessment (24 hours immediately preceding the visit and the time spent in the home), the clinician would gather information by report regarding the patient's cognitive and physical status prior to the assessment and assess the patient's status during the assessment and make a determination regarding the patient's ability to manage all the medications ordered to be administered in the home at all times. At the SOC, the clinician has up to five days after the SOC date to complete the comprehensive assessment, including the patient's ability to manage medications.

The intent of M2020 is to identify the patient's ability to take all oral medications reliably and safely at all times. If the patient's ability to manage the home medications varied on the day of the assessment, the clinician would report the patient's ability to manage the medication for which the most assistance was needed.

Q167.7. [Q&A RETIRED 10/18; Duplicative of OASIS Guidance Manual]

Q167.8. M2020. If a patient can't swallow their meds but is able to do all the other requirements for oral medication administration, how would you answer M2020 - Management of Oral Medications? [Q&A EDITED 05/22; ADDED 09/09; M number updated 09/09; Previously CMS OCCB Q&A 10/07 Q23]

A167.8. M2020 - Management of Oral Medications reports the patient's ability to prepare and take (ingest) oral medications reliably and safely at the appropriate dosage and times. On the day of assessment, if the clinician discovers the patient has not been able to swallow prescribed oral medications in the past 24 hours, Response 3 - Unable to take medication unless administered by another person should be selected, as it is the best response option available.

If it is identified that the route of administration of the medications (which may have originally been prescribed as "oral medications") had been changed to administration "per tube" due to the patient's inability to swallow, and this has been the patient's usual status on the day of assessment, then Response NA - No oral medications prescribed should be selected.

Q167.9. M2020. The patient is on multiple medications which span 3 times a day. Yesterday, the doctor started them on a varying dose of Prednisone. The patient admits to being confused about the directions and right dosage. The clinician observes that the med box the patient set up is filled correctly with all usual medications, but not correctly with the prescribed Prednisone administration. The clinician also notes that the medication for last evening remained in the pill planner. Upon questioning, the patient admits to being tired and forgetting to take the evening medication. The nurse discusses the use of an alarm clock to remind the patient to take the evening medication and fixes the Prednisone dosage for the rest of the week. What is the correct scoring

with rationale for this situation? [Q&A EDITED 05/22; ADDED 01/11; Previously CMS OCCB Q&A 04/10 Q24]

A167.9. The patient you described would be scored as response 3 – Unable to take medication unless administered by another person because on the day of the assessment, the patient did not possess the ability to take the Prednisone at the correct time and dose and demonstrated that through their report and actions. The pill planner had not enabled them to take the medications as ordered and a reminder could not have enabled the patient to take a medication when they didn't have any idea what time and dose they needed to take the medications.

Rationale: First, note you are to report your patient's ability on the day of the assessment (24 hours prior to the assessment, and the time spent by the clinician conducting the assessment) and if ability varied, you report what was true regarding the medication that required the most assistance during that time period. This would mean you would not report ability after skilled intervention, as this is not a reflection of what was true in the most dependent medication during the day of assessment.

A patient who does not have the requisite knowledge and no existing compensatory mechanisms to take the medication(s) as prescribed would be scored 3 until after they received the required education and demonstrated to the clinician that they were able to take ALL medications at the correct dose and time or until the clinician has introduced an assistive device, such as a pill planner, and the patient has demonstrated success at taking meds as ordered, at all times.

Q167.10. [Q&A RETIRED 05/22]

Q167.100. M2020 & M2030. 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? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 01/22 Q5]

A167.100. In situations where one or more medications that 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, 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.

Q167.101. M2020 & M2030. My patient has unreliable transportation and is unable to get their medications from the pharmacy when needed. The lack of transportation caused the patient to miss three doses of a new oral medication, and one dose of a prescribed injectable that they were unable to refill timely. Guidance states that we assess a patient's ability based on "patient characteristics, including cognitive status, vision, strength, manual dexterity, and general mobility." The patient's lack of consistent transportation is impacting access to their medications. Do we consider this as part of our assessment of M2020 – Management of Oral Medications and M2030 – Management

of Injectable Medications? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 04/22 Q3]

A167.101. M2020 - Management of Oral Medications identifies the patient's ability to take all oral (p.o.) medications reliably and safely on the day of assessment. M2030 - Management of Injectable Medications identifies the patient's ability to take all injectable medications reliably and safely on the day of assessment. Note that any assistance or transportation required to get the medication(s) into the home is not considered when coding M2020 and M2030.

Include assessment of the patient's ability to obtain medications from where they are routinely stored in the home, the ability to read the labels (or otherwise identify the medications correctly, for example patients unable to read and/or write may place a special mark or character on the label to distinguish between medications), open the containers, select the appropriate dose (pill/tablet, milliliters of liquid, etc.) and orally ingest (or inject) at the correct times.

Once the medication(s) is/are in the home, if someone other than the patient must do some part of the task(s) that are required for the patient to access and/or take the medication at the prescribed times, then the assistance required would be considered when determining the code for M2020 and M2030.

Q167.102. M2020 & M2030. When assessing M2020 - Management of Oral Medications and M2030 - Management of Injectable Medications, please explain what is meant by "routinely stored". Would this mean where a facility normally stores patient medications, or where the patient would store them if they were at home? For example, a patient with normal cognitive abilities living in an assisted living facility may routinely store their medications in their apartment where they can safely and correctly take their medications. However, because of the patient's living situation and the Assisted Living Facility (ALF) policy, the medications are stored in a medication room down the hall which is kept locked. [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 07/22 Q7]

A167.102. In the situation where the medications are locked up in the assisted living facility (ALF) nursing office, 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.

Assess the patient's ability to access medications based on where the medications are routinely stored. If the routine location has been temporarily modified, continue to code based on an assessment of the patient's ability to access from the location where the medications are routinely stored.

Q168. [Q&A RECALLED 08/07]

Q168.1. M2030. **The patient has B12 injections ordered monthly which are/will be given in the home. At the SOC/ROC visit, the schedule for the injection does not fall on the day of the SOC/ROC visit. Since our assessment should reflect what is true on the day of assessment, is N/A, No Injectable medications prescribed the correct response to M2030 - Management of Injectable Medications in this circumstance?** [Q&A EDITED 05/22; EDITED 10/18; ADDED 09/09; Previously CMS OCCB Q&A 01/08 Q24]

A168.1. The M2030 - Management of Injectable Medications Response NA - No injectable medication prescribed would not be appropriate in the situation described because the patient has an order to receive injectable medication during the episode. Even though the medication will not be injected on the day of the assessment, the clinician would assess and report the

patient’s ability by following the guidance in the Chapter 3 assessment strategies. It states, “If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration."

Q168.1.01. M2030. On my SOC visit, the patient did not have their insulin due to a problem at the pharmacy. How would I code M2030 - Management of Injectable Medications, when I was not able to assess my patient's ability to prepare and take the SQ medication? [Q&A EDITED 05/22; Previously CMS Qtrly Q&A 01/22 Q9; ADDED 06/14; Previously CMS Qtrly Q&A 04/13 Q8]

A168.1.01. When completing M2030 - Management of Injectable Medications, you 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 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 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, 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.

Q168.1.1., Q168.2. [Q&As RETIRED 05/22]

Q168.3. M2030. We have a patient that is receiving injections at their physician's office, mainly for financial reasons, do we include those injections? [Q&A EDITED 05/22; EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 04/08 Q12]

A168.3. When a patient is receiving an injectable medication in the physician's office or other setting outside the home; it is not included in the assessment of M2030 - Management of Injectable Medications.

M2030 reports the patient's ability to prepare and take (inject) all prescribed injectable medications that the patient is receiving in the home while under the home health Plan of Care. M2030 requires an assessment of the patient's cognitive and physical ability to draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly.

M2030 includes all injectable medications the patient has received or will receive in the home during the home health Plan of Care. Note that if an injectable medication is given by a nurse, the clinician will need to determine if the administration by the nurse was for convenience, or if administration by the nurse was ordered by the physician which represents a medical restriction inferring that the patient is unsafe/unable to self-inject. If that was the case, the appropriate response for M2030 would be 3 - Unable to take injectable medications unless administered by another person.

M2030 would also include one-time injections that were ordered to occur in the home as long as the administration occurred during the period of time covered by the Plan of Care. If the patient administered the medication, the clinician would report the patient's ability to complete the included tasks on the day of the assessment. If the injection was ordered but not to be administered on the clinician’s day of assessment, the clinician will use the assessment of the

patient’s cognitive and physical ability and make an inference regarding what the patient would be able to do.

Q168.3.1. M2030. I understand from CMS guidance that "M2030 requires an assessment of the patient's cognitive and physical ability to draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly." My patient, at the SOC, was throwing their used needles and syringes into the trash. They stated they were never told how to properly dispose of them. Which M2030 - Management of Injectable Medications response would be appropriate? [Q&A EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 10/11 Q13]

A168.3.1. If the patient lacked the knowledge regarding safe needle and syringe disposal on the day of the assessment, the patient was unable to take injectable medication unless administered by another person, Response 3. If the patient needed reminders regarding safe needle/syringe disposal, they would be scored as response 2.

Q168.4. M2030. Our patient has orders for Vitamin B12 to be injected by the RN once a month and SQ Insulin to be injected by the patient 3 times a day. How would M2030 - Management of Injectable Medications be reported in this situation? [Q&A EDITED 05/22; EDITED 01/11; ADDED 09/09; Previously CMS OCCB Q&A 07/08 Q17]

A168.4. When completing M2030 - Management of Injectable Medications, the clinician must consider all prescribed injectable medications that the patient is receiving in the home. In situations where the patient’s ability to inject their various medications varies on the day of assessment, the clinician must report what is true for the medication requiring the most assistance.

In the situation described, the patient self-injects insulin 3 times a day and the Vitamin B12 injection is administered by the RN only once a month. Since the order requires the nurse to administer the Vitamin B12, the patient would be considered unable to administer that medication and would represent the patient’s ability for the medication requiring the most assistance. Response 3 - Unable to take injectable medications unless administered by another person, would be the appropriate response.

Q168.5. M2030. How would you respond to M2030 - Management of Injectable Medications if a patient is able to self-inject a pre-filled injectable medication such as Lovenox? Obviously the patient cannot be observed "preparing" a pre-filled injectable. Which response best fits this scenario? [Q&A EDITED 05/22; ADDED 09/09 and M number updated 09/09; Previously CMS OCCB Q&A 1/09 Q14]

A168.5. When the medication is supplied by the manufacturer/pharmacy in a pre-filled syringe, the clinician will not include assessment of the patient's ability to fill the syringe. The included tasks in this situation would be handling the syringe using aseptic and safe technique, selecting the correct location in which to inject the medication and injecting it using proper technique and disposing of the needle and syringe appropriately, and the patient could be a response 0, 1, 2, or 3.

Q168.5.01. M2030. Does the need for assistance to walk to the refrigerator to obtain an injectable medication impact the score of M2030 - Management of Injectable Medications? [Q&A ADDED & EDITED 06/14; Previously CMS Qtrly Q&A 04/13 Q9]

A168.5.01. Yes. M2030 - Management of Injectable Medications reports the patient's ability to prepare and take (inject) all prescribed injectable medications that the patient is receiving in the

home while under the home health Plan of Care and would include the tasks of accessing the medications from the location where they are routinely stored in the home. If the medications are routinely stored in the refrigerator and the patient requires someone to assist them at medication administration time to walk to the location where the medications are routinely stored, or someone must retrieve the medications and bring them to the patient; Response 3 - Unable to take injectable medication unless administered by another person would apply.

Q168.5.1. M2030. If we give a physician ordered one-time influenza vaccination and the patient does not have any injectable medications otherwise, is the answer to M2030 – Management of Injectable Medications NA - No injectable medications prescribed or response 3? [Q&A EDITED 05/22; ADDED 01/11; Previously CMS OCCB Q&A 04/10 Q26]

A168.5.1. If there is an order for the patient to receive the influenza vaccine SQ in the home, it would be included when responding to M2030 - Management of Injectable Medications, even if it was a one-time injection during this quality episode. Anytime the physician has ordered the RN to administer an injection, the patient's ability would be reported as response 3 - Unable to take injectable medication unless administered by another person as you must report the patient's ability to inject the medication for which the most assistance is needed and an order for the RN to administer the injection is viewed as a medical restriction, preventing the patient from self-administering.

Q168.5.2. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q168.5.5. M2102. Do the responses for M2102 - Types and sources of assistance, reflect the patient's needs on the day of assessment or another time period, like the recent past? [Q&A EDITED 05/22; EDITED 10/18; EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB Q&A 04/10 Q28]

A168.5.5. When completing M2102 - Types and Sources of Assistance, at the SOC/ROC, the assessing clinician will determine, to the best of their ability through observation and interview, what is known on the day of assessment regarding the ability and willingness of non-agency caregivers to provide help related to M2102f - Supervision and safety for the upcoming episode of care. For example, if the patient's family report that they often need to provide reminders to the patient to take their medication, and to not wander out of the house, but this level of assistance has not been needed yet on the day of assessment, the assistance is reported, as it has been and is anticipated to be the ability and willingness of caregiver to meet this patient need. At Discharge, the assessing clinician is reporting what is known on the day of assessment regarding the ability and willingness of caregivers to provide assistance to the patient at the time of the discharge.

Q168.5.6. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q168.5.7. M2102. Guidance is clear that for M2102 -Types and Sources of Assistance that "caregiver" refers to non-agency caregivers and excludes care by agency staff. What if the agency has two provider numbers, one for Medicare Skilled Home Health and one as a Medicaid In-Home provider? Does this item also exclude staff from the Medicaid In-Home side? [Q&A EDITED 05/22; ADDED 04/15; Previously CMS Qtrly Q&A 01/15 Q9]

A168.5.7. If the agency has a different provider identification number for each provider type, Medicare Skilled Home Health and Medicaid In-Home, the care provided by the staff employed by the Medicaid In-Home provider would be considered non-agency caregivers for the purpose of responding to M2102 - Types and Sources of Assistance. The entities must be separate and distinct agencies.

Q168.5.8. M2102a. We have a patient, who at discharge is able to bathe in the shower with assist of their daughter, however they prefer to sponge bathe at the sink and are able to do so independently now. The clinician has marked response 2 for M1830 - Bathing to reflect their ability to perform the task safely. The question is should the clinician answer M2102a -Types and Sources of Assistances; ADL assistance Response 1, reflecting assistance needed for showering as answered in M1830 or can the clinician choose response 0 - No assistance needed because the patient is able to sponge bathe independently and safely. The patient is able to do all other ADLs independently. The clinician's documentation in the clinical record reports patient's preference with bathing. [Q&A EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 10/15 Q5]

A168.5.8. M1830 - Bathing addresses the patient's ability to bathe in the shower or tub, not preference, regardless of where or how the patient currently bathes. Willingness and adherence are not the focus of the item. If assistance is needed to bathe in the shower or tub, then the level of assistance needed must be noted, and Response 1, 2, or 3 should be selected.

M2102a - Types and Sources of Assistance; ADL assistance is based on the ability and willingness of the caregiver(s) (other than home health agency staff) to provide the assistance needed by the patient to perform ADLs, including bathing. The item does not specify the bathing must be in the tub or shower. In the scenario cited, the assessing clinician has determined the patient to be independent in all ADLs, including bathing. Therefore, response 0 - No assistance needed for M2102a. would be appropriate.

Q168.6. [Q&A RETIRED 10/18; Duplicative of OASIS Guidance Manual]

Q169. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q170 & 170.1. [Q&As RETIRED; Outdated]

Q170.2, Q170.3, Q170.4 & Q170.5. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q170.6. M2102. For M2102d - Types and Sources of Assistance; Medical procedures/treatments, do I only include treatments or procedures ordered by the physician/allowed practitioner when considering types and sources of assistance in M2102d? For example, if my therapy only patient has a dressing on a chronic wound that needs no skilled intervention and is not included in the Plan of Care, do I include it when selecting a response to M2102d. Medical procedures? [Q&A EDITED 05/22; EDITED 10/18; EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB Q&A 10/09 Q38]

A170.6. M2102d - Types and Sources of Assistance; Medical procedures/treatments includes but is not limited to wound care and dressing changes, along with other procedures/treatments described in the OASIS Guidance Manual Response Specific Instructions for M2102. A physician/allowed practitioner order is not required for a procedure/treatment to be considered in this response.

Q170.7. M2102. When completing M2102 - Types and Sources of Assistance for a patient with a Foley catheter, what areas, under type of assistance, should be considered? [Q&A EDITED 05/22; EDITED 10/18; EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB Q&A 04/10 Q27]

A170.7. The types of assistance that a foley catheter patient might need may be captured in more than one row in M2102, Types and Sources of Assistance, as described below:

- M2102a - ADL assistance as part of toileting hygiene - Examples: cleansing around the catheter/peri care
- M2102d - Medical procedure Examples: insertion/removal of catheter, e.g., self cath or intermittent catheterization

Q170.8. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q170.9. M2102c. How do I answer M2102c - Types and Sources of Assistance; Medication administration, for a patient who has a caregiver assisting with management of oral medication but receives their B12 injections at the physician's office? [Q&A EDITED 05/22; EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB Q&A 07/10 Q19]

A170.9. M2102c - Types and Sources of Assistance; Medication administration, includes all medications, by any route administered in the home and does not include medications received at physician's offices or other locations outside the home setting.

Q170.9.1. [Q&A RETIRED 05/22]

Q170.9.2. M2102c. How is medication administration defined for M2102c - Types and Sources of Assistance; Medication administration? Is it the same definition and tasks described for M2020 - Management of Oral Medication? Would it include the need for a caregiver to fill a medication box? [Q&A EDITED 05/22; EDITED & M number updated 06/14; ADDED 12/12; Previously CMS Qtrly Q&A 10/12 Q10]

A170.9.2. M2102c - Types and Sources of Assistance; Medication administration asks the clinician to determine the level of caregiver ability and willingness to provide assistance with the administration of medications by any and all routes. The broad category of Medication administration includes all tasks related to the patient's ability to self-administer all prescribed and OTC medications, by any route. Tasks included in M2020 - Management of Oral Medications and M2030 - Management of Injectable Medications as defined in current CMS guidance would be included, along with any other assistance provided/needed with any medication, by any route. The clinician must use clinical judgment to determine if the patient needs assistance with any medication and if so, describe the caregiver's ability and willingness to provide the needed assistance.

In your example, it would be correct to select Response 2 - Non-agency caregiver(s) need training/supportive services to provide assistance if the caregiver needs help to correctly fill a medication box.

Q170.10. M2102. Which category of assistance would taking care of a wound VAC fall under for M2102 - Types and Sources of Assistance? [Q&A EDITED 05/22; EDITED 10/18; EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB Q&A 01/10 Q22]

A170.10. The application/changing/removal of the wound dressing, including the foam and drape used with a wound VAC would constitute a "Medical procedure" as other dressing changes do. This would be considered and reported under M2102d - Types and Sources of Assistance; Medical procedures/treatment.

Q170.11. M2102. What is the appropriate response for M2102d - Types and Sources of Assistance; Medical procedures/treatments, in cases where the physician has ordered

the RN to provide the treatment, e.g. a wound VAC procedure? [Q&A EDITED 05/22; EDITED & M number updated 06/14; ADDED 01/12; Previously CMS OCCB Q&A 01/11 Q21]

A170.11. Response 3 - Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance is the appropriate response for M2102 - Types and Sources of Assistance, in situations where the physician has ordered the skilled clinician perform a treatment or procedure. In this situation, the patient needs assistance and the physician/allowed practitioner has indicated by the order that it must be performed by a skilled clinician, in which case the caregiver should be considered unable to provide the needed care.

Q170.12. M2102. How is "Assistance needed, but no non-agency caregiver(s) available" defined? Would it apply to a son who at discharge is assisting with ADLs, but is unwilling to assist with medication administration? [Q&A EDITED 05/22; EDITED 10/18; EDITED 04/15; M number updated 06/14; ADDED 01/12; Previously CMS OCCB Q&A 04/11 Q15]

A170.12. Response 4 - Assistance needed, but no non-agency caregiver(s) available means the patient has no one involved in providing any level of care to them at all. If at discharge the son was willing and able to assist with ADLS, the appropriate response for Row a would be response 1- Non-agency caregiver(s) currently provide assistance. If the son was unwilling to assist with medication administration, the appropriate responses for M2102c - Types and Sources of Assistance; Medication administration would be response 3 - Non-agency caregiver(s) are <u>not likely</u> to provide assistance OR it is <u>unclear</u> if they will provide assistance because this response is defined as including situations where the caregiver is unwilling or unable to provide the needed care.

Q170.13. M2102. When answering M2102 - Types and Sources of Assistance, do we include the assistance provided to the patient at an Adult Day Care center? [Q&A EDITED & M number updated 06/14; ADDED 01/12; Previously CMS OCCB Q&A 04/11 Q14]

A170.13. M2102, Types and Sources of Assistance, is referring to the assistance needed by the patient in the home and the availability and ability of a caregiver to meet those needs. It does not capture assistance provided to the patient outside of the home setting such as they might receive at Adult Day Care or a dialysis center. Assistance needed to transport the patient out of the home, (e.g., to/from medical appointments) is included, but services received once outside the home setting should not be considered.

Q170.14. M2102d. Are vital signs, blood glucose or blood pressure considered a "procedure" when scoring M2102d - Types and Sources of Assistance; Medical procedures/treatments? [Q&A EDITED 05/22; EDITED & M number updated 06/14; Previously CMS Qtrly Q&A 04/14 Q11]

A170.14. Measurement of vital signs and blood glucose are considered medical procedures.

Q170.15. M2102. At the SOC, my patient's children are present. They live out of town and have been staying with my patient for 1 week. They will be leaving in 3 days, after which the patient will go back to not having any in person caregiver to provide needed supervision. How should M2102 - Types and Sources of Assistance be answered? [Q&A EDITED 05/22; EDITED 10/18; ADDED 04/15; Previously CMS Qtrly Q&A 04/15 Q6]

A170.15. At SOC/ROC, the assessing clinician should report on M2102f - Types and Sources of Assistance; Supervision and safety what is known on the day of assessment regarding ability and willingness of caregivers to provide help for supervision and safety needs (due to cognitive

impairment), for the upcoming episode of care. The assessing clinician would utilize their clinical judgment to determine the type of assistance needed by the patient, the ability and willingness of caregivers (other than home health agency staff) to provide the needed assistance, and how long the episode of care is expected to be. In the scenario described the assessing clinician knows the patient needs supervision and knows that that the children are leaving in one week. These details, along with the anticipated length of the home care episode would be considered when determining the appropriate response for M2102f.

For example, the relative is staying to care for the patient for a week, and the clinician expects the home care episode to last for 5-6 weeks, using clinical judgment the assessing clinician may determine that the relative's temporary presence should not be considered when selecting a response for M2102f. Alternatively, if the patient is only expected to receive home care services for one or two weeks before transitioning to outpatient then the assessing clinician, using their clinician judgment may determine that the relative's temporary presence should be considered for M2102f.

Q171 through 171.5. [Q&As RETIRED 09/09; Outdated]

Q171.5.1. [Q&A RETIRED 10/18]

Q171.5.2. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q171.6., Q171.7., Q171.8., Q171.9., Q171.10., Q171.11. [Q&As RETIRED 05/22]

Q172. [Q&A RETIRED 09/09; Outdated]

Q172.1, Q172.2, Q172.3, Q172.4, Q172.4.1, Q172.5, Q172.5.1, Q172.5.2, Q172.5.3, Q172.6, Q172.8 & Q172.8.1. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q172.8.2. [06/14 Renumbered 172.9.09]

Q172.8.3. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q172.9. M2401c. Does the inclusion of existing ordered antidepressant medications on the medication profile equate to a 1 - Yes response to Depression Interventions on M2401c - Intervention Synopsis; Depression interventions? [Q&A EDITED 05/22; EDITED 10/18; EDITED 10/16; EDITED 06/14; ADDED 01/11; Previously CMS OCCB Q&A 01/10 Q26]

A172.9. M2401c - Intervention Synopsis; Depression interventions, reports whether the physician ordered Plan of Care includes depression interventions and if they were implemented. If the patient has a diagnosis of depression, the presence of an existing antidepressant medication in the medication profile/Plan of Care is considered a depression intervention. If there is an anti-depressant ordered and no diagnosis of depression, the assessing clinician would need to confirm why the medication was prescribed as anti-depressants are often indicated for diagnoses other than depression. If the medication was not prescribed specifically for depression, it would not be considered a depression intervention.

Q172.9.01. [Q&A RETIRED 05/22]

Q172.9.02. M2401c. During a SOC visit, the assessing clinician determines the patient is not depressed, has no symptoms of depression and no diagnosis of depression. Because the clinician has assessed for signs & symptoms of depression as part of the comprehensive assessment and will continue to assess the patient for signs & symptoms of depression as part of the psychosocial assessment during the revisits, they select the intervention "Skilled observation and assessment of signs and symptoms of depression " on the Plan of Care. At Transfer/DC, may we answer 1 - Yes on M2401c -

Intervention Synopsis; Depression intervention(s) since the Plan of Care has a depression intervention? [Q&A EDITED 05/22; EDITED 10/18; ADDED & EDITED 06/14; Previously CMS Qtrly Q&A 01/14 Q9]

A172.9.02 If the clinician determines it would be appropriate for a specific patient and obtains an order for "Skilled observation and assessment for signs and symptoms of depression" from the physician at the time of or any time since the most recent SOC/ROC, M2401c may be answered 1 - Yes even if the formal assessment was negative and/or the patient has not been formally diagnosed with depression.

Note, just checking off an intervention on a Plan of Care does not equate to "obtaining a physician order."

Q172.9.03. M2401c. Best practice interventions for depression include "referral for other treatment". If the patient's depression screen was positive and the assessing clinician suggests the patient join a depression support group or schedule an appointment with a psychiatrist, would this be considered a "referral for other treatment"? [Q&A EDITED 05/22; EDITED 10/18; EDITED 10/16; ADDED & EDITED 06/14; Previously CMS Qtrly Q&A 04/14 Q12]

A172.9.03. In M2401c - Intervention Synopsis; Depression intervention(s), a referral for services for further evaluation or treatment meets the criteria for a response of "Yes" only if there is an order in the physician-ordered Plan of Care for the referral at the time of or since the most recent SOC/ROC AND the referral was made by the agency. The order in the physician-ordered Plan of Care can be a referral for agency services (such as an evaluation by psychiatric nursing or social work). Alternatively, it can be an order for a referral to an external provider or organization (such as for evaluation or treatment by a psychiatrist or to a community mental health center). Merely suggesting the patient seeks further evaluation or treatment, however, does not constitute providing a referral. The agency must provide the patient with sufficient written information (for example: name and phone number) to enable them to make an appointment or obtain the service. Likewise, the HHA can make contact directly with the provider or organization to facilitate an appointment for the patient. Once a referral has been made, it is not required that the patient has followed through or received the services related to the referral by the time of transfer to an inpatient facility or discharge for a response of 1 - Yes in M2401c.

Q172.9.04. [Q&A RETIRED 10/18]

Q172.9.08. M2401d. If the patient is taking a medication that could be used for pain control, (e.g. aspirin 81 mg daily), does this automatically count as an intervention to mitigate pain when completing M2401d - Intervention Synopsis; Interventions to monitor and mitigate pain, even though the medication was prescribed for its cardiovascular effects? Do we need to clarify if the aspirin is being used for pain control? [Q&A EDITED 05/22; EDITED 10/18; ADDED 04/15; Previously CMS Qtrly Q&A 07/14 Q8]

A172.9.08. In order to select 1 - Yes for any plan/intervention in M2401 – Intervention Synopsis, there must be a physician order for an intervention(s) that specifically addresses the patient's needs. In order to select 1 -Yes for M2401d – Intervention Synopsis; Interventions to monitor and mitigate pain, the physician-ordered plan of care must include both an order to monitor pain and an order to relieve/mitigate the individual patient's specific pain. Evidence that the order was implemented would also be necessary to select 1 -Yes.

Q172.9.09. M2401d. A patient is documented to have chronic arthritic joint pain that interferes with activity at least daily and is taking a pain medication daily as previously ordered. If the clinician only has orders to assess the effectiveness of the current pain medication treatment, is this order only an order to MONITOR pain (M2401d "No"), or would this be enough to answer as 1 - Yes, that we have an order to both monitor and mitigate pain? [Q&A EDITED 05/22; EDITED 10/18; EDITED 06/14; ADDED 01/11; Previously CMS OCCB Q&A 10/10 Q15; Renumbered from Cat 4b 172.8.2 06/14]

A172.9.09. An ordered pain medication is considered an intervention to mitigate pain. Assessing for the effectiveness of the pain medication is considered an intervention to monitor pain. If both the pain medication and an order related to pain assessment are included in the physician-ordered Plan of Care, and both orders were implemented at the time of or at any time since the most recent SOC/ROC, M2401d – Intervention Synopsis; Interventions to monitor and mitigate pain would be 1 -Yes.

Q172.9.1. [Q&A RETIRED 10/18]

Q172.9.1.1. [Q&A RETIRED 10/18; Item deleted from OASIS]

Q172.9.1.2. M2401f. Our home health agency has a physical therapy only patient with a Stage 2 pressure ulcer. Although we are assessing the patient's skin as part of the comprehensive assessment requirements, the wound care for the pressure ulcer is being provided by an outpatient wound center and family members in the home and includes moist wound healing interventions. Since the wound care is not part of the home health plan of care, or being billed for by the agency, no orders for moist wound treatment were obtained from the physician by our agency. How should M2401f - Intervention Synopsis; Pressure ulcer treatment based on principles of moist wound healing (at transfer and discharge) be answered? [Q&A EDITED 10/23; EDITED 05/22; EDITED 10/18; EDITED 10/16; ADDED 04/15; Previously CMS Qtrly Q&A 04/15 Q7]

A172.9.1.2. In the scenario you describe response 1 - Yes is not appropriate because there are no interventions on the plan of care. The response N/A is also not appropriate because the patient does have pressure ulcers for which moist wound healing is indicated. Response 0 - No is the most appropriate.

Q172.9.2. [Q&A RETIRED 05/22]

Q172.9.3. M2401f. Is it the clinician's clinical decision or the physician's that will determine if the patient has had any pressure ulcers with need for moist wound healing at the time of or at any time since the most recent SOC/ROC assessment? [Q&A EDITED 05/22; EDITED 10/18; EDITED 10/16; EDITED 06/14; ADDED 01/11; Previously CMS OCCB Q&A 04/10 Q37]

A172.9.3. The clinician would discuss the patient's pressure ulcers with the physician/allowed practitioner and not make the decision regarding appropriate treatment alone. When it is determined by the clinician/physician team or solely by the physician/allowed practitioner that moist wound healing was not appropriate for any pressure ulcer at the time of or any time since the most recent SOC/ROC, the Response "NA" would be chosen.

Q172.9.3.1. [Q&A RETIRED 10/18]

Q172.9.4. [Q&A RETIRED 10/18; Duplicative of OASIS Guidance Manual]

Q172.9.5. [Q&A RETIRED 05/22]

Q172.9.6. [Q&A RETIRED 10/18; Duplicative of OASIS Guidance Manual]

Q172.9.7. [Q&A RETIRED 10/18]

Q173. [Q&A RETIRED 05/22]

Q174. [Q&A RETIRED 09/09; Outdated]

Q175. [Q&A RECALLED 08/07]

Q176, 177, & 178. [Q&As RETIRED 09/09; Outdated]

Q178.1. [Q&A RETIRED 06/14; No longer relevant]

Q179. M2301. If a patient is admitted to an inpatient facility after initial access in the emergency room, can there be a situation in which that emergent care would NOT be reported on M2301 - Emergent Care, (i.e., patient is only briefly triaged in ER with immediate and direct admit to the hospital)? [Q&A EDITED 05/22; EDITED 10/16; EDITED 06/14; ADDED 06/05; REVISED 01/11; Previously CMS OCCB Q&A 10/04 Q11]

A179. M2301 - Emergent Care includes the entire period at or since the most recent SOC/ROC data were collected, including current events. Any access of hospital emergency department care, regardless of how brief the encounter, should be reported on M2301 – Emergent Care if it occurred at the time of or at any time since the most recent SOC/ROC assessment.

Q180. [Q&A RETIRED 05/22]

Q181, 181.1 & 181.2. [Q&As RETIRED 09/09; Outdated]

Q181.3. [Q&A RETIRED 10/18]

Q181.3.1. M2301. In regard to CMS Q&A Cat 2 Q17.1 and 17.1.1, both describe scenarios in which a SOC OASIS assessment was initiated but not completed prior to a patient being re-hospitalized. Please explain the sequence when an Initial Assessment is completed, establishing eligibility, but the patient goes to the Emergency Department with a hospital admission before the HH comprehensive assessment is completed. The patient returns home, and the Comprehensive Assessment and SOC OASIS are completed within the 5-day window from the SOC date. Is a Transfer and ROC completed and if so, how is M2301 - Emergent Care completed since it asks, "At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department"? An OASIS assessment had not been completed previously in this scenario, but the Initial Assessment was completed on the SOC date. [Q&A EDITED 10/23; EDITED 05/22; ADDED 10/16; Previously CMS Qtrly Q&A 07/16 Q8]

A181.3.1. When within the assessment timeframe, the start of care date has been established and the patient experiences a qualifying inpatient facility admission of 24 hours or longer for reasons other than diagnostic testing, the Transfer and Resumption of Care assessment would be required. In the situation where the SOC date was established, when completing M2301 - Emergent Care at Transfer, look back to the SOC date and report the use of the emergent care.

Q181.4. [Q&A RETIRED 09/09; Outdated]

Q181.5. M2310. We had a patient who attempted suicide using Coumadin. He was sent to the Emergency Room and then admitted to the hospital. When completing the Transfer OASIS data collection, we reported Response 1 - Improper medication administration, side effects, etc. as a reason for emergent care on M2310 - Reason for Emergent Care. Was Response 1 the correct answer, since it was a deliberate action chosen by the

patient? [Q&A EDITED 05/22; EDITED 06/14; ADDED 09/09; M number updated 09/09; Previously CMS OCCB Q&A 10/08 Q11]

A181.5. The appropriate response for M2310 - Emergent Care would be response 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis whenever the patient sought emergent care as a result of improper medication administration, regardless of who (patient, caregiver, or medical staff) administered the medication improperly.

Q181.5.1. [Q&A RETIRED 06/14; Guidance in Ch. 3]

Q181.5.2 & Q181.5.3. [Q&As RETIRED 10/18; Item response deleted from OASIS]

Q182. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q182.1. M2401. Is the clinician allowed to respond 1 - Yes (interventions on the POC and implemented) if a standardized, validated tool was <u>not</u> used in the assessment of M2401 – Intervention Synopsis b through e? [Q&A EDITED 05/22; Edited 10/18; EDITED 10/16; EDITED 06/14; ADDED 01/11; Previously CMS OCCB Q&A 01/10 Q29]

A182.1. You may code 1 - Yes to M2401 - Intervention Synopsis b - e, if the specified clinical interventions were included in the physician ordered Plan of Care and implemented at the time of or at any time since the most recent SOC/ROC assessment whether or not a formal assessment was performed.

Q182.2. [Q&A RETIRED 06/14; Guidance in Ch. 3]

Q182.2.1. [Q&A RETIRED 05/22]

Q182.2.2. M2401. For situations where best practices are provided during an initial assessment visit that is conducted BEFORE the SOC date, would those clinical assessments/interventions be considered as being provided "at the time of or at any time since the most recent SOC/ROC assessment" or "within the quality episode"? For example, in a situation of a Friday referral for a therapy only case, the RN makes a non-billable visit on a Saturday to meet the federal requirement that the initial assessment visit must occur within 48 hours of the referral. No nursing need existed and no billable service was provided, therefore Saturday was not the SOC date. [Q&A EDITED 10/23; EDITED 05/22; EDITED 10/16; ADDED & EDITED 06/14; Previously CMS Qtrly Q&A 01/13 Q16]

A182.2.2. None of the interventions that the nurse provided on the initial assessment visit would be considered when responding to M2401 - Intervention Synopsis, even if orders existed, because the interventions were completed before the quality episode began on the SOC date.

Q182.3. M2401. M2401c - Intervention Synopsis; Depression intervention(s) includes "referral for other treatment" as a "qualifying" intervention to report related to depression. If I obtain a referral, can I consider the intervention to be implemented when answering M2401 - Intervention Synopsis, regardless of whether or not the ordered referral ever occurs? For example, I obtained an order for a psychiatric nursing evaluation for a patient who exhibited symptoms of depression, and then before the psych nurse could visit, the patient moved out of the service area. When completing the discharge assessment, how should M2401c be answered? [Q&A EDITED 05/22; EDITED 10/16; ADDED 01/11; Previously CMS OCCB Q&A 10/09 Q44]

A182.3. Since "referral for other treatment" is specifically listed as a qualifying intervention in item M2401 - Intervention Synopsis, then 1 - Yes should be reported for the situation in which

the referral is made for other treatment for depression, even if the treatment is never actually provided before the Transfer or Discharge time point. Obtaining the order for the referral is considered to be an implementation of the intervention, whether or not the order was carried out. This is only specifically stated and true for interventions related to depression (row c), not for other treatment areas (e.g., falls prevention interventions, pressure ulcer prevention interventions, etc.)

Q182.4. M2401. If I included a physician-ordered intervention in my Plan of Care and attempted to implement it, but the patient either refused or did not need the intervention, can I report the education as being implemented in M2401 - Intervention Synopsis?. [Q&A EDITED 05/22; EDITED 10/16; EDITED 06/14; ADDED 01/11; Previously CMS OCCB Q&A 10/09 Q45]

A182.4. If the education component of the intervention was ordered, attempted, and not provided because of a documented lack of need for the education, the clinician can answer "Yes" to the Intervention Synopsis item. The intervention was implemented when the attempt to provide it was made, and the lack of need identified. This is distinctly different than stating an attempt was made to educate and the patient refused or otherwise declined to receive the needed instruction with no further attempt, in which case, the refused education should not be reported as being "implemented" on M2401 – Intervention Synopsis.

Q182.5. M2401. If a clinician teaches fall and/or pressure injury/ulcer prevention etc. on the discharge visit without specific orders for these interventions, what would be the best way to answer M2401 - Intervention Synopsis? [Q&A EDITED 05/22; EDITED 10/18; EDITED 10/16; EDITED 04/15; ADDED 01/11; Previously CMS OCCB Q&A 07/10 Q26]

A182.5. The response for M2401 Intervention Synopsis is "No" if there are no physician orders present for these best practices during the "look back" time period at transfer or discharge. In order to answer M2401 - Intervention Synopsis "Yes", the current physician-ordered Plan of Care and/or other addendum orders present at the time of or at any time since the most recent SOC/ROC assessment must have included the specified best practice intervention, in addition to evidence that the intervention(s) were implemented.

Q182.6. M2401. At the time of a visit, the patient reports mild pain and the nurse observes that the patient's functioning is not limited by the mild pain. Pain management interventions on the POC are offered however the patient feels the pain is tolerable and elects no intervention at this time.

Can I select 1 - Yes for M2401d - Intervention Synopsis; Interventions to monitor and mitigate pain, because the intervention was implemented when the attempt to provide it was made and the lack of need was identified by the patient and the nurse? [Q&A EDITED 05/22; EDITED 10/16; EDITED 06/14; ADDED 01/12; Previously CMS OCCB Q&A 07/11 Q18]

A182.6. In order to answer 1 - Yes for M2401d - Intervention Synopsis; Interventions to monitor and mitigate pain the record review at Transfer/Discharge must reveal that at the time of or at any time since the most recent SOC/ROC assessment, there were orders to assess for pain and mitigate pain, as well as evidence that both interventions were implemented. If both interventions were not implemented, you may not answer M2401d as 1 - Yes.

If there were orders to relieve pain, e.g., prn analgesic, and record review revealed the clinician assessed pain, educated the patient regarding the pain mitigation intervention, but the patient

never had pain that required the ordered analgesic, M2401d may be answered as 1 -Yes. The education regarding the prn pain mitigation would be an implementation of the order.

Q182.7. M2401. We have orders on the Plan of Care to monitor pain and teach pain management, instruct on pharmacological and non-pharmacological approaches to pain management, types of pain, signs and symptoms of pain, and pain medications. The patient requests discharge before all the ordered pain mitigation interventions were completed. The clinical record does include documentation the pain monitoring and pain mitigation orders were implemented at or since the most recent SOC/ROC assessment.

Can we respond "Yes" to M2401d - Intervention Synopsis; Interventions to monitor and mitigate pain if pain mitigation orders were implemented but not completed prior to discharge? [Q&A EDITED 10/23; EDITED 05/22; EDITED 10/16; EDITED 06/14; ADDED 01/12; Previously CMS OCCB Q&A 10/11 Q15]

A182.7. If there are multiple interventions to address a specific problem included in M2401, (e.g., assess for pain each visit, instruct on non-pharmacological approaches to pain, educate regarding pain medication, etc.), the assessing clinician may answer "Yes" at Transfer/Discharge if there is evidence that the required assessment component was implemented AND evidence that at least one of the pain mitigation orders were implemented.

Q182.8. M2401. If we have a foley cath patient for several cert periods, what type of orders would we need related to fall prevention, pressure ulcer prevention, etc. If we have assessed and taught the patient/caregiver in the past and they are knowledgeable then, this would not be a billable skill for nursing as there is no "knowledge deficit." Could we put a note on the 485 saying that the patient/caregiver has been assessed and is knowledgeable in the intervention whichever it is or do we have to have fall prevention/pressure ulcer prevention techniques, etc. on our 485 and teach on it again? [Q&A EDITED 05/22; EDITED 10/16; EDITED 06/14; ADDED 12/12; Previously CMS Qtrly Q&A 07/12 Q9]

A182.8. M2401 - Intervention Synopsis, reads "At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented? " The time period under consideration is from the current Transfer or Discharge back to and including the most recent SOC/ROC assessment. If there are no orders for the applicable best practices during that time period, the answer to M2401 is 0 - No. If there was an order but there is no evidence of implementation, the M2401 response is 0 - No.

In order to select the M2401 Response 1 - Yes for long-term patients, orders for the applicable best practices must be present at the time of or at any time since the most recent SOC/ROC assessment, AND there must be evidence of implementation within the time period beginning with the most recent SOC/ROC and ending with the Transfer/Discharge. During that time period, if specific orders were present, and the clinician confirmed the patient/caregiver possessed the knowledge regarding the best practice, the intervention may be considered implemented.

Q182.9. M2401. If an agency has an unplanned discharge and the only teaching (such as PU prevention) is performed after the last qualified clinician's visit, can M2401 – Intervention Synopsis be answered as "Yes" based off that teaching? [Q&A EDITED

10/23; EDITED 05/22; EDITED 10/18; EDITED 10/16; ADDED 06/14; Previously CMS Qtrly Q&A 04/14 Q13]

A182.9. In situations of planned or unplanned discharges, when completing M2401 - Intervention Synopsis on the discharge assessment, the qualified clinician responsible for the assessment can report any ordered interventions that were implemented at the time of or any time since the most recent SOC/ROC up until the time of discharge (the M0906 date). This includes taking credit for education provided at a home visit by an LPN or therapy assistant.

Q183. M2410. A patient receiving skilled nursing care from an HHA under Medicare is periodically placed in a local hospital under a private pay arrangement for family respite. The hospital describes this bed as a purely private arrangement to house a person with no skilled services. This hospital has acute care, swing bed, and nursing care units. The unit where the patient stays is not Medicare certified. Should the agency do a Transfer and Resumption of Care OASIS? How should the agency respond to M2410 - To Which Inpatient Facility? [Q&A EDITED 10/23; EDITED 05/22; ADDED 06/05; M number updated 09/09]

A183. Yes, if the patient was admitted to an inpatient facility, the agency will need to contact the inpatient facility to verify the response to M2410. If the patient is using a hospital bed, Response 1 applies; if the patient is using a nursing home bed, Response 3 applies. If the patient is using a swing-bed it is necessary to determine whether the patient was occupying a designated hospital bed (Response 1 would apply) or a nursing home bed (Response 3 would apply). The hospital utilization department should be able to advise the agency of the type of bed and services the patient utilized.

Q183.1. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q184., Q184.1., Q184.2 [Q&As RETIRED 05/22]

Q185. [Q&A RETIRED 09/09; Outdated]

Q185.1 & Q185.2. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q186 & 187. [Q&As RETIRED 09/09; Outdated]

Q188. [Q&A RETIRED 10/18]

Q189, Q189.1, Q189.2. [Q&As RETIRED 10/18; Item deleted from OASIS]

Q189.3. M2420. 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)? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/22 Q11]

A189.3. 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.

Q190. M0906. When a speech therapist is the last service in a patient's home, our agency has chosen to use an RN to complete the Discharge assessment (with OASIS) as a non-billable visit. If the patient meets the speech therapist's goals on day 50 of the episode, but we cannot schedule an RN until day 51 of the episode, how do we respond to M0906 -

Discharge/Transfer/Death Date? [Q&A EDITED 10/23; EDITED 05/22; EDITED 10/18; ADDED 06/05]

A190. If the agency policy is to have an RN complete the comprehensive assessment in a therapy-only case, the RN can perform the Discharge assessment after the last visit by the SLP. This planned visit should be documented on the Plan of Care. The RN visit to conduct the Discharge assessment is a non-billable visit. The date for M0906 (Discharge/Transfer/Death Date) would be determined by agency policy.

Q191. M0906. My patient died at home 12/01 after the last visit of 11/30. I did not learn of their death until 12/04. How do I complete M0906 - Discharge/Transfer/Death Date? What about M0090 – Date Assessment Completed? [Q&A EDITED 05/22; EDITED 10/18; EDITED 08/07]

A191. You will complete an RFA 8 – Death at Home OASIS. M0090 - Date assessment completed would be 12/04 -- the date you learned of the patient's death and completed the assessment. M0906 - Discharge/Transfer/Death Date would be 12/01.

Q191.1. M0906. How do you answer M0906 - Discharge/Transfer/Death Date on a Transfer OASIS when a patient is transferred to an inpatient facility (hospital) during the evening of 1/24 but doesn't get admitted to the inpatient facility until 1/25? [Q&A EDITED 10/23; EDITED 05/22; ADDED 08/07; Previously CMS OCCB Q&A 05/07 Q36]

A191.1. Transfer is not defined as the date the patient was transported to the inpatient facility, or the date that the patient was transported and/or treated in the emergency department. Assuming the patient's inpatient admission lasted 24 or more hours, and included care/services other than diagnostic testing, the Transfer date would be the actual date the patient was admitted to the inpatient facility. If, as in your example, the transportation occurred during the evening of 1/24, but the inpatient facility admission did not occur until 1/25, M0906 - Discharge/Transfer/Death Date would be 1/25.

Q192. M1800s, GG0130, & GG0170. Should we expect to see consistency between a patient's OASIS "M" and "GG" function codes? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 04/19 Q9]

A192. Not necessarily. There are differences between items that have the same or similar names. Coding differences may be a result of:

- What is included or excluded in the activity, or
- What coding instructions apply to the activity

Each OASIS item should be considered individually and coded based on guidance specific to that item.

Q192.1. M1800s, GG0130, & GG0170. 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? [Q&A ADDED 05/22; Previously CMS Qtly Q&A 01/20 Q6]

A192.1. 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 polypharmacy), 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.

Q196. GG0100C. Prior to injury, the patient was able to climb and descend 3 stairs to enter her home independently. They were unable to manage the full flight of stairs to the 2nd floor of their home, therefore stayed on the first floor. The patient reports that they did not use stairs in the community. Could you please advise as to the appropriate response for item GG0100C - Prior Functioning: Everyday Activities - Stairs? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 01/20 Q10]

A196. 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 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 their home independently. Code GG0100C Prior Functioning - Stairs as Code 3 - Independent.

Q198. GG0100, GG0130 & GG0170. Does the "majority of tasks" convention apply to all Section GG items? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/19 Q8]

A198. The "majority of tasks" convention that applies for the M1800 Activities of Daily Living (ADL)/Instrumental Activities of Daily Living (IADL) items does not apply to the GG Prior Functioning, Self-Care, and Mobility items.

In situations where the patient's prior ability varied between the listed GG activities, group all activities together and code based on patient's ability considering all activities together. For example, for GG0100 - Prior Functioning, if a patient completed all of the activities by themselves, with or without an assistive device, with no assistance from a helper, code as "3. Independent." If a patient needed partial assistance from another person to complete any of the activities, code as "2. Needed Some Help." If a helper completed all of the activities for the patient because the patient could not assist, code as "1. Dependent."

For the GG0130 - Self-Care and GG0170 - Mobility activities that include multiple activities (e.g., Upper body dressing for a patient who wears an undershirt, blouse, and sweater), code using the 6-point scale based on the patient's ability to complete all relevant tasks.

Q200. GG0110. Since GG0110C - Prior Device Use; 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? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/20 Q11]

A200. No - this item is intended to refer to mechanical devices or equipment such as a Hoyer lift or stair lift that involve some type of machine required for lifting or supporting the patient's body weight.

Q200.1. GG0110. Should a transport chair be considered a "wheelchair" for GG0110 - Prior Device Use? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/21 Q4]

A200.1. The intent of GG0110 - Prior Device Use is to indicate which devices and aids were used by the patient prior to the current illness, exacerbation, or injury. The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how prior device use applies for each individual patient.

For the response categories in GG0110 (e.g., Mechanical lift, wheelchair), CMS does not provide an exhaustive list of assistive devices that may be used when coding prior device use.

Q250. GG0110D & GG0170. When responding to GG items, would a knee scooter/walker be considered a walker or a scooter? The product is sold under and referenced by both titles. [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 04/19 Q2]

A250. For GG0110D - Prior Device Use - Walker: "Walker" refers to all types of walkers (*for example*, pickup walkers, hemi-walkers, rolling walkers, and platform walkers), and would include a knee walker.

A knee walker/scooter would not be considered as a wheelchair/scooter for GG0170Q - Does the patient use a wheelchair and/or scooter?.

Q401. GG0130A. 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. [Q& ADDED 05/22; Previously CMS Qtrly Q&A 07/19 Q15]

A401. 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 concerns would be reported as the discharge goal.

Q401.1. GG0130A. For GG0130A - 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/clean-up 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? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/20 Q12]

A401.1. 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.

Q401.2. GG0130A. How would the following scenario for GG0130A - Eating be coded? A patient was admitted and at Start of Care (SOC) required only set up assistance for

eating. The following day, the patient went to the Emergency Department and returned within 24 hours with an overall decline in status and an order for no oral intake due to dysphagia. Would we code 05 - Setup or clean-up assistance based on initial ability or code 88 - Not attempted due to medical condition or safety concerns because this is the new baseline following the decline? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/21 Q5]

A401.2. 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.

At SOC/ROC, the self-care or 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.

In the scenario provided, use Code 05 - Setup or clean-up assistance for GG0130A - Eating if this represents the patient's baseline status.

Use of an "activity not attempted" code should only be used if the patient was not able to complete the activity prior to the benefit of services and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities.

Q401.3. GG0130A. 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? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 07/21 Q9]

A401.3. 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.

Q401.4. GG0130A. A patient is independent with self-feeding but requires encouragement for adequate intake. Would the encouragement to increase food and/or fluid intake be considered when scoring GG0130A - Eating? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 04/22 Q5]

A401.4. 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. The adequacy of the patient's nutrition or hydration is not considered for GG0130A - Eating.

When coding activities in Section GG, clinicians should code based on the type and amount of assistance required allowing the patient to perform the activity as independently as possible, as long as they are safe. If the patient is able to meet the intent of the activity with no assistance (physical, verbal/nonverbal cueing, setup/clean-up) then code 06 - Independent.

Q403. GG0130C. Does GG0130C - Toileting Hygiene that includes clothing adjustment before and after voiding, also include incontinence briefs and pads? Does this item

include the safe retrieval of the supplies needed to perform the hygiene task? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 01/19 Q10]

A403. GG0130C - Toileting Hygiene includes “the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.”

Toileting hygiene includes managing undergarments, clothing, and incontinence pad/briefs, etc., and performing perineal hygiene.

If the patient can complete toileting hygiene and clothing management tasks only after a helper retrieves or sets up supplies necessary to perform included tasks, code 05 - Setup or clean-up assistance.

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.

Q405.50. GG0130F & GG0130G. How would you code items GG0130F - Upper body dressing and GG0130G - Lower body dressing if you are working with a patient who typically wears a dress or Mumu robe/dress and prefers not to wear undergarments? Can you code both of these items based on putting on and taking off a dress/Mumu alone? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/19 Q31]

A405.50. We interpret your question to indicate that the patient does not wear underwear/briefs. If the patient does not wear underwear, nor any other type of clothing that just covers their lower body, code GG0130G - Lower body dressing with the appropriate “activity not attempted” code. Any assistance provided by a helper to put on or remove the dress or Mumu would be considered when coding GG0130F - Upper body dressing.

Q405.51. GG0130F & GG0130G. If a patient is independent with dressing but requires supervision to gather their clothes from the closet and take them to the bed before they can get dressed, are they “independent” for dressing, “supervision” for dressing or “set-up” for dressing? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/20 Q14]

A405.51. The intent of the items GG0130F - Upper body dressing and GG0130G - Lower body dressing is to assess 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 Code 05 - Setup or clean-up assistance 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 or clean-up assistance.

Q406. GG0130G. For GG0130G - Lower body dressing, if a patient is wearing a dressing gown and underwear during the first assessment, is this scenario acceptable to code lower body dressing? Or, at a visit the following day within the assessment timeframe, if the patient is wearing more items including underwear and shorts/pants, should we use this

later scenario instead as a true baseline of their lower body dressing ability? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 04/20 Q7]

A406. The intent of GG0130G - Lower body dressing is to assess the patient's ability to dress and undress below the waist, including fasteners, if applicable, in clothing routinely worn by the patient. At SOC/ROC, the self-care or 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.

Clinicians should use clinical judgment to determine if observing the patient dress and undress in the lower body clothing (i.e., underwear) worn during the first assessment allows the clinician to adequately determine the patient's ability to complete the activity of lower body dressing (GG0130G) in clothing routinely worn by the patient. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires.

Q450. GG0130 & GG0170. With the GG0130 - Self Care and GG0170 - Mobility items, does the patient need to have a caregiver available to assist? Can I be the helper on the day of assessment in lieu of a caregiver in order to determine which performance code 06 - 01 is correct instead of using an "activity not attempted"? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 04/19 Q12]

A450. For the GG0130 and GG0170 items, the assessing clinician would code based on the type and amount of assistance needed to complete the activity safely, not based on the availability of such assistance. The assessing clinician can be the helper on the day of assessment in order to determine which code 06 - 01 accurately reflects the needed assistance to complete the activity, rather than using a "activity not attempted" code 07, 09, 10, or 88, solely because the patient does not have a caregiver.

Q450.1. GG0130 & GG0170. Does the "day of assessment" convention apply to the GG0130 - Self-Care and GG0170 - Mobility items? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 04/19 Q13]

A450.1. Yes, the day of assessment convention applies to GG0130 - Self-Care and GG0170 - Mobility. For most OASIS items, including the function items, the time period under consideration is the "day of assessment", which is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home. For GG0130 and GG0170, code the patient's functional status based on a functional assessment that occurs at or soon after the patient's start of care/resumption of care (SOC/ROC). The SOC/ROC function scores are to reflect the patient's SOC/ROC baseline status and are to be based on observation of activities, to the extent possible. Other assessment strategies include coding patient functional status based on patient and/or caregiver report. When using patient or caregiver report, it is expected that the patient and caregiver are reporting on the patient's status within the time period under consideration, (e.g., reporting on the patient's ability to complete the car transfer within the past 24 hours).

Q450.2. GG0130 & GG0170. The OASIS Guidance Manual for Section GG clarifies that Code 03 - Partial/moderate assistance indicates the helper is providing less than half the effort and Code 02 - Substantial/maximal assistance indicates the helper is providing more

than half the effort. If a helper provides exactly half the effort, how would an activity be coded? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 04/20 Q9]

A450.2. In the situation you describe the helper and patient each are providing exactly half of the effort to complete a GG activity. If the patient performs exactly half of the effort, code the activity 03 - Partial/moderate assistance.

Q450.3. GG0130 & GG0170. For the GG functional items, I understand that verbal cueing during an activity would be coded 04 - Supervision or touching assistance. Can a verbal cue provided prior to the initiation of the task be considered as 05 - Setup or clean-up assistance, as long as no further cues were provided during the actual activity? For example, prior to the "Picking up an item from the floor" activity, the therapist needed to cue the patient on where to place their hand for stability; then the patient completed all of the activity safely and without any assistance or additional cues. Would this be Code 05 - Setup or clean-up assistance or Code 04 - Supervision or touching assistance? Additionally, the OASIS Guidance Manual indicates via an example for chair/bed to chair transfers, that "locking chairbrakes" prior to the transfer is 05 - Setup or clean-up assistance, as long as no further assistance was required during the activity. Could a verbal cue reminding a patient to lock wheelchair brakes prior to the initiation of the transfer be considered 05 - Setup or clean-up assistance as well, as long as no further cueing or touching was provided during the activity? [Q&A EDITED 10/23; ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 04/20 Q10]

A450.3 When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as they are safe. At Start of Care/Resumption of Care (SOC/ROC), the self-care or 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. This may be achieved by having the patient attempt the activity prior to providing any instruction that could result in a more independent code, and then coding based on the type and amount of assistance that was required prior to the benefit of services provided by your agency staff.

Communicating the activity request (e.g., "Can you stand up from the toilet?") would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity (e.g., "Push down on the grab bar", etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient- Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual

In the scenarios described, assuming the verbal cues were only required prior to the activity, were provided prior to the benefit of services, and no other assistance was needed in order for the patient to complete the activity safely, then the verbal cues fit the definition for Code 05 - Setup or clean-up assistance.

Q450.4. GG0130 & GG0170. We understand that if a patient initially refuses to attempt a GG activity during the assessment timeframe, and later agrees to perform the activity, the code which represents the patient's actual performance will supersede the refusal code (07). If the clinical staff determine on day 1 or day 2 that the patient has a safety or medical issue which prevents them from attempting an activity, but on day 3 has progressed to the point where they can now perform the activity, would that code supersede the earlier code (88)? A patient may not be safe to attempt the activity on day 1 (their baseline prior to the benefit of services), but after two days of therapy, may then

be safe to perform the activity. Which code would be reported on the OASIS: Code 88 - Not attempted due to medical condition or safety concerns or a performance code 06 - 01? [Q&A EDITED 10/23; ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 10/20 Q7]

A450.4. At Start of Care/Resumption of Care (SOC/ROC), the self-care or 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.

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

"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's baseline status prior to the benefit of services was that the activity could not be completed due to a medical or safety concern and the performance code could not be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of a similar activity, code 88 - Not attempted due to medical condition or safety concerns, even if the patient's status changes and they are able to complete the activity on a later day during the assessment timeframe.

Q450.5. GG0130 & GG0170. 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 scores GG0170D - Sit to stand as Code 88 - Not attempted due to medical condition 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 condition or safety concerns or Code 01 - Dependent? [Q&A EDITED 10/23; ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 01/22 Q12]

A450.5. At Start of Care/Resumption of Care (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 timeframe, report the baseline function code.

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

Q450.6. GG0130 & GG0170. The guidance for GG0130 - Self Care and GG0170 - Mobility states "the assessing clinician would code each activity based on the type and amount of assistance required to complete the activity safely, not based on the availability of such assistance". Can you provide an example of "not based on the availability of such assistance?" [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 07/22 Q4]

A450.6. When assessing and coding GG activities allow the patient to perform the activity as independently as possible, as long as they are safe. As stated, code based on the type and amount of assistance required to complete the activity, not based on the availability of assistance.

For example, a patient requires a physical therapist to provide assistance to ambulate 10 feet safely. However, when the therapist is not available, the patient is unable to ambulate 10 feet safely. The walking activity would be coded based on the type and amount of assistance required (assistance to walk 10 feet), even though a physical therapist may not always be available to provide the needed assistance.

Q500. GG0170. How do we assess GG0170 - Mobility activities when the patient doesn't have equipment? Such as a car transfer or 12 steps if the patient does not have a car or a flight of stairs? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 01/19 Q28]

A500. If the car transfer activity (GG0170G) or the stair activities (GG0170M, N and O) are not completed because no car or stairs are available, and the patient's status cannot be determined based on patient or caregiver report, collaboration with other agency staff, or assessment of similar activities, enter Code 10 - Not attempted due to environmental limitations.

The assessing clinicians can use professional clinical judgment to determine if a car transfer, or stair activity, or other GG self-care or mobility activity, may be assessed using a similar activity as an acceptable alternative. For example, for item GG0170O - 12 Stairs, the combination of going up and down 4 stairs 3 times consecutively is an acceptable alternative to meet the intention of this activity.

Q500.1. GG0170. If a patient is dependent for all GG0170 bed mobility activities, would it be acceptable to code the patient as dependent for all other GG0170 mobility activities even if those activities were not specifically assessed? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 01/21 Q6]

A500.1. At Start of Care/Resumption of Care (SOC/ROC), the mobility performance code is to reflect the patient's baseline ability to complete the activity, and is based on observation of activities, to the extent possible. Clinicians may assess the patient's performance based on direct observation (preferred) as well as reports from the patient and/or family, assessment of similar activities, collaboration with other agency staff, and other relevant strategies to complete all GG items.

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

It is important to determine whether the appropriate code for each activity is a performance code (including Code 01 - Dependent) vs. an "activity not attempted" code.

It is also important to note that a helper cannot complete the walking activities for a patient. A walking activity cannot be considered completed without some level of patient participation that allows patient ambulation to occur the entire stated distance for that activity. For instance, if

even with assistance a patient was not able to participate in walking a distance of 10 feet, an "activity not attempted" code (rather than 01 - Dependent) would be selected.

Q500.2. GG0170. CMS guidance for the GG0170 walking activities and wheelchair activities state: "The 90-degree turn should occur at the patient's ability level." What does "at the patient's ability level" mean? Can you please provide an example? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 07/22 Q5]

A500.2. When assessing and coding the GG0170 - Mobility activities allow the patient to complete each activity as independently as possible, as long as they are safe. For example, if the added difficulty of making two 90-degree turns while walking 150 feet affects the patient's safety, then a helper(s) should provide assistance as needed to allow safe completion of the activity. If completing a 90-degree turn is unsafe even with assistance of 1 or more helpers, then consider the walking 150 feet with 2 turns activity to not have been completed and use the appropriate "activity not attempted" code.

Q503. GG0170C. If the patient sleeps in an electric recliner (which is the patient's bed), and the patient pushes a button for the chair to return to a sitting position, how is GG0170C - Lying to sitting on side of bed coded? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/19 Q17]

A503. If a patient is able to complete the activity using an assistive device without assistance, code as 06 - Independent.

Q505. GG0170E. We have a patient who required substantial to max assistance to perform a transfer during the assessment, so is coded 02 - Substantial/maximal assistance for this activity. This maximal assist transfer is not safe for the elderly family to complete, so two family members will be using a Hoyer lift to transfer the patient from bed to chair. Would the correct code for Chair/bed-to-chair transfer be 02 - Substantial/maximal assistance, based on the maximal assist transfer required when the therapist transfers the patient; or would the correct code be 01 - Dependent, because the transfer will be carried out by 2 family members? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 10/20 Q8]

A505. The intent of GG0170E - Chair/bed-to-chair transfer is to assess the patient's ability to transfer to and from a bed to a chair (or wheelchair).

When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as they are safe.

If the patient performed the activity during the assessment timeframe, code based on that assessment using the 6-point scale.

If when allowed to complete the activity as independently as possible, the patient was able to complete the transfer activity with substantial to max assist safely, code 02 - Substantial/maximal assistance.

Q506. GG0170F. If a patient gets up off the side of the bed, walks to the bathroom, and then sits down on the toilet, is the effort necessary to lift up off the bed considered for coding GG0170F - Toilet transfer? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 07/20 Q10]

A506. No, in the scenario described the effort necessary to lift up off the bed does not count towards the toilet transfer in GG0170F - Toilet transfer.

The intent of GG0170F - Toilet transfer is to assess the patient's ability to get on and off a toilet (with or without a raised toilet seat) or commode once the patient is at the toilet or commode.

Q506.1. GG0170F. A patient completes a toilet transfer with supervision only. As they were ambulating with contact guard assistance back to the bed, they lost their balance and required assistance to steady themselves. Would the contact guard assist and assistance to steady themself be considered when determining the performance code for GG0170F - Toilet transfer? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 01/21 Q8]

A506.1. The intent of GG0170F - Toilet transfer is to assess the patient's ability to get on and off a toilet (with or without a raised toilet seat) or commode once the patient is at the toilet or commode.

In the scenario described, the assistance provided while ambulating to the bed should not be considered when coding the GG0170F - Toilet transfer activity.

Q507. GG0170G. When coding GG0170G - Car transfer based on a simulation, what equipment or environmental setup would we need to have in order to make the activity similar enough to the car transfer? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/21 Q10]

A507. The intent of GG0170G - Car transfer is to assess the patient's ability to transfer in and out of a car or van seat on the passenger side.

The performance code is to reflect the patient's baseline ability to complete the activity, and is based on observation of activities, to the extent possible. The assessing clinician may, as needed, combine general observation, assessment of similar activities, patient/caregiver report, collaboration with other agency staff, and other relevant strategies to complete all GG items.

In situations where specific equipment may not be available (e.g., 12 steps, a vehicle), the assessing clinician may determine that assessment of a similar activity adequately represents the patient's ability to complete the activity. This practice will serve to minimize the use of an "activity not attempted" code in favor of a performance code determined to represent the patient's status in the given self-care or mobility activity. While CMS does not provide specific parameters or a complete list of what is and is not an acceptable proxy activity, providers are expected to use clinical judgment in determining if the "similar activity" meets the intent of the target activity to make it a reasonable substitute when making a coding determination.

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

If, using clinical judgment, simulating the car transfer adequately represents the patient's ability to transfer in and out of a car, code GG0170G - Car transfer based on the type and amount of assistance required to complete the activity.

Q508. GG0170I, GG0170J, GG0170K, & GG0170L. How would the following walking scenarios be coded:

a. **Patient ambulates 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, they are 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 activity.

b. **Patient ambulates with the use of oxygen. The therapist obtains 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?**

[Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 01/20 Q17]

A508. The intent of the GG0170 walking items is to assess the patient's ability to ambulate safely for each of the stated distances.

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 or 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.

Q508.1. GG0170I, GG0170J, GG0170K, GG0170L. 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? [Q&A EDITED 10/23; ADDED 05/22; Previously CMS Qtrly Q&A 04/21 Q7]

A508.1. At Start of Care/Resumption of Care (SOC/ROC), the GG0130 - Self-Care and GG0170 - 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.

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.

Q513. GG0170M. For GG0170M - 1 step (curb), at Start of Care 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 GG0170M - 1 step (curb) as 88 - Not attempted due to medical condition or safety concerns 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? [Q&A EDITED 10/23; ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 01/20 Q18]

A513. The intent of the GG0170 stair items is to determine the type and amount of assistance required by a patient to go up and down the stairs, by any safe means.

At Start of Care/Resumption of Care (SOC/ROC), 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.

Q513.1. GG0170M. Regarding the GG0170M - 1 step (curb) item, when we initiate the assessment to code this item with a curb and the patient is not able to perform due to medical/safety reasons, are we then required to assess using a single step? [Q&A EDITED 10/23; ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 07/20 Q11]

Q513.1. There is no requirement to assess a patient going up and down both a curb AND a step. However, coding GG0170M - 1 step (curb) with a 07, 09, 10 or 88 when a patient is unable to go up and down a curb results in skipping GG0170N - 4 Steps and GG0170O - 12 Steps. Providers may want to consider assessing the patient’s ability to go up and down 1 step in order to capture performance codes of 06 through 01 for one or more of the stair items if the patient can complete the activities with a railing.

Q514.500. GG0170N & GG0170O. Guidance for the GG step activities 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. [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 01/22 Q13]

A514.500. 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.

Q517. GG0170Q, GG0170R, & GG0170S. On admission, my patient reported that they only use a wheelchair when they visit their cardiologist because of the distance from the car to the office. They shared that because of hospital policies, they also had an aide push them in a wheelchair as they were being discharged from the hospital two days ago. Because GG0170Q - Does patient use wheelchair and/or scooter 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 - Wheel 50 feet with two turns and GG0170S - Wheel 150 feet if the patient doesn't own a wheelchair? [Q&A ADDED AND EDITED 05/22; Previously CMS Q&A 01/20 Q19]

A517. The intent of the item GG0170Q - Does 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 - Wheel 50 feet with two turns and GG0170S - Wheel 150 feet, if a patient does not complete the wheelchair activities during a 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 you cannot determine their status on patient and/or caregiver report or on assessment of similar activities, then select the appropriate "activity not attempted" code.

Q517.1. GG0170Q, GG0170R & GG0170S. 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? [Q&A ADDED 05/22; Previously CMS Qtrly Q&A 01/22 Q14]

A517.1. 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.

Q600. J1800. Regarding J1800 - Any Falls Since SOC/ROC, if a patient's wheelchair or other sitting surface breaks while he/she is seated in it, and the patient falls to the floor, do we score this as a fall in J1800? [Q&A ADDED AND EDITED 05/22; Previously CMS Qtrly Q&A 04/19 Q15]

A600. J1800 - Any Falls Since SOC/ROC identifies if the patient had any witnessed or unwitnessed falls since the most recent SOC/ROC. From the OASIS-E Guidance Manual, "fall" is defined as: "Unintentional change in position coming to rest on the ground, floor, or onto the

next lower surface (such as a bed or chair)". In the situation that you describe, this would be coded as a fall.

Q650. [Q&A RETIRED 10/23]

Q660. A1005, A1010, A1110, & A1250. A number of items in section A (A1005 - Ethnicity, A1010 - Race, A1110 - Language, A1250 - Transportation) state that a proxy can be used. Who would be considered a proxy? Can it be a caregiver, family member, friend or can it only be the Power of Attorney (POA), or health care representative? [Q&A ADDED AND EDITED 10/23; Previously CMS Qtrly Q&A 01/23 Q3]

A660. For the items in Section A that reference a proxy, the assessing clinician determines who the appropriate proxy is based on the item specific guidance and the patient's unique circumstances. This can include but is not limited to family, caregiver, friend, Power of Attorney (POA) or health care representative.

Q661. A1005, A1010, A1110, A1250, B1300, & D0700. Can information collected prior to Start of Care/Resumption of Care be used to complete the new OASIS items such A1005 - Ethnicity, A1010 - Race, A1110 - Language, A1250 - Transportation, B1300 - Health Literacy, and D0700 - Social Isolation? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 10/22 Q2]

A661. If information used to complete the OASIS is gathered prior to the patient's admission this information should be verified, and coded following applicable coding guidance, during an assessment that occurs during the SOC/ROC assessment timeframe. An agency's software may not "answer" or "generate" the OASIS response for the assessing clinician.

Please note that based on coding guidance, the medical record should not be used as the data source for coding Health Literacy and Social Isolation. Also note that the medical record should not be used as the data source for coding Ethnicity, Race, Language, and Transportation unless the patient and proxy are unable to respond during each specific assessment period during the SOC/ROC or discharge assessment time periods.

Q665.500. A1250 & B1300. Please provide an example where the coding for A1250 - Transportation and B1300 - Health Literacy would be different from Start of Care/Resumption of Care to Discharge. [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 10/22 Q3]

A665.100. The intent of A1250 - Transportation is to identify if a lack of transportation has kept the patient from medical appointments, meetings, work, or from getting things needed for daily living over the past 6 to 12 months.

The intent of B1300 - Health Literacy is to identify how often the patient needs to have someone help them when they read instructions, pamphlets, or other written material from their doctor or pharmacy.

The assessing clinician must consider each patient's unique circumstances and use clinical judgment to determine how transportation and health literacy applies for each individual patient at both the Start of Care/Resumption of Care and Discharge time points.

It is possible that the SOC/ROC and discharge coding are the same.

Q670. C0200-C0500. I know we can administer the Brief Interview for Mental Status (BIMS) either verbally or in writing and there are specific directions around this. When administering the BIMS in writing can we present the cue card questions via laptop

rather than an actual paper form for those patients who are hearing impaired etc., or does it need to be given in paper or card format? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 10/22 Q4]

A670. The agency may develop their own process for how to administer the BIMS in writing. Whatever processes used must follow the exact language as that in the item set.

Q675. C1310. How should C1310 - Signs and Symptoms of Delirium (from CAM ©) be coded when a patient is comatose at baseline and at the time of assessment? [Q&A ADDED 10/23; Previously CMS Qtly Q&A 07/23 Q4]

A675. C1310 - Signs and Symptoms of Delirium (from CAM ©) identifies any signs or symptoms of acute mental status changes as compared to the patient's baseline status and if there are any signs or symptoms of delirium present at the time of assessment. If the patient was comatose at baseline and at the time of assessment, code the items as follows:

C1310A - Acute Onset of Mental Status Changes as Code 0 - No

C1310B - Inattention as Code 1 - Behavior continuously present, does not fluctuate.

C1310C - Disorganized Thinking as Code 0 - Behavior not present.

C1310D - Altered level of consciousness as Code 1 - Behavior continuously present, does not fluctuate.

Q676.500. D0150 & D0160. Can you provide additional information on the rationale for having to use multipliers in D0160 - Total Severity Score? When reviewing the Pfizer version of the PHQ-9 scoring, Pfizer does not indicate the following computing scores for missed questions. [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 01/23 Q6]

A676.500. D0160 - Total Severity Score identifies the severity score calculated from responses to the PHQ-2 to 9. The Total Severity Score is a summary of the frequency scores on the PHQ-2 to 9 that indicates the extent of potential depression symptoms.

Item D0160 is used to report the total severity score for the Patient Mood Interview. The score in item D0160 is based upon the sum of the values that are contained in the following nine items: D0150A2, D0150B2, D0150C2, D0150D2, D0150E2, D0150F2, D0150G2, D0150H2, and D0150I2.

The Scoring Rules explain how to compute the score that is placed in item D0160. These rules consider the "number of missing items in Column 2" which is the number of items in Column 2 that are skipped.

- If all of the items in Column 2 have a value of 0, 1, 2, or 3 (i.e., they all contain non-missing values), then item D0160 is equal to the simple sum of those values.
- If the number of missing items in Column 2 is equal to one, multiply the sum of the 8 items in Column 2 by 9/8 (1.125).
- If the number of missing items in Column 2 is equal to two, multiply the sum of the 7 items in Column 2 by 9/7 (1.286).
- If items D0150A through D0150I were asked and if Column 2 is equal to three or more, the interview is deemed NOT complete. Total Severity Score should be coded as "99".

CMS obtained permission from Pfizer to modify the PHQ-2 to 9 for use in CMS's data collection instruments.

Q683. K0520. If a patient is placed on a full liquid diet for a bowel cleanse should this be considered a mechanically altered diet when coding K0520 - Nutritional Approaches? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 01/23 Q8]

A683. The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge. K0520C - Nutritional Approaches; Mechanically altered diet reports if the patient requires a mechanically altered diet.

Mechanically altered diet is defined as a diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids for patients having trouble chewing and/or swallowing foods or thin liquids.

If, in your scenario, the diet texture is altered for a reason other than to facilitate oral intake, it would not be considered a mechanically altered diet when coding K0520C.

Q683.1. K0520. If a patient has an order to be NPO in anticipation of a procedure/surgery is this considered either a mechanically altered diet or a therapeutic diet when coding K0520 - Nutritional Approaches? [Q&A ADDED 10/23, Previously CMS Qtrly Q&A 07/23 Q5]

A683.1. No. The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge.

NPO related to a procedure/surgery is not considered a nutritional approach for the purposes of coding K0520C - Nutritional Approaches; Mechanically altered diet and/or K0520D - Nutritional Approaches; Therapeutic diet.

Q683.500. K0520, N0415, & O0110. Please provide guidance as to the accurate response for K0520Z - Nutritional Approaches; None of the Above in the following scenario:

K0520A - Parenteral/IV Feeding = checked

K0520B - Feeding Tube = not checked

K0520C - Mechanically altered diet = Dash to indicate there was no available information

K0520D - Therapeutic diet = not checked

Should K0520Z - None be unchecked because K0520A is checked, or dashed because K0520C is dashed? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 04/23 Q7]

A683.500. When one or more items for K0520A - K0520D is checked, to indicate that the specified nutritional approach applies to the patient, then K0520Z should be left unchecked. This is true even if one of the other items K0520A - K0520D is dashed.

This same concept applies to N0415 - High Risk Drug Classes: Use and Indication and O0110 - Special Treatments, Procedures, and Programs.

Q683.501. K0520, N0415, & O0110. What is the look back or time period under consideration for the new OASIS items K0520 - Nutritional Approaches, N0415 - High-Risk Drug Classes: Use and Indication, and O0110 - Special Treatments, Procedures, and Programs? Is it the day of assessment, which may include medications, nutritional approaches, and/or treatments, procedures, or programs the patient may have taken/received in an inpatient facility before they were discharged home, or is coding just based on what is part of the current reconciled drug regimen and/or current

care/treatment plan at the time of the assessment? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 04/23 Q8]

A683.501. The general OASIS convention “Day of Assessment” which is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home does not apply to K0520 - Nutritional Approaches, N0415 - High-Risk Drug Classes: Use and Indication, and O0110 - Special Treatments, Procedures, Programs.

These items are coded based on what is part of the patient’s current reconciled drug regimen and/or care/treatment plan during the SOC/ROC (or discharge) assessment.

Q685. O0110. For O0110C - Special Treatments, Procedures, and Programs; Oxygen therapy: If the oxygen is ordered PRN, is that considered intermittent because it is ordered PRN or only if the patient uses it PRN on the day of assessment? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 10/22 Q10]

A685. The intent of O0110 - Special treatments, Procedures, and Programs identifies if any of the listed special treatments, procedures, and programs apply to the patient.

O0110 should be completed based on a comprehensive assessment that occurs at SOC/ROC or discharge.

Regardless of how the oxygen is ordered (i.e., continuously or intermittently), apply the OASIS specific definitions in determining whether oxygen is coded as continuous (delivered for ≥ 14 hours per day) or intermittent (oxygen was not delivered continuously for at least 14 hours per day).

Q685.1. O0110. For Special Treatments, Procedures, and Programs: Non-invasive Mechanical Ventilator O0110G2 - BiPAP and O0110G3 - CPAP, are these only selected if the BiPAP/CPAP was used during the assessment window? Sometimes a treatment may be ordered and available but the patient will refuse to wear it. [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 10/22 Q11]

A685.1. If the BiPAP or CPAP is part of the patient’s current care/treatment plan, then mark O0110G1 - Non-Invasive Mechanical Ventilator and O0110G2 - BiPAP or O0110G3 - CPAP.

Q685.2. O0110. Would an AV fistula be reported in O0110O1 - IV Access? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 01/23 Q12]

A685.2. An AV fistula does not meet the definition of IV Access for O0110O1.

If there is not a current IV access in place at the time of assessment, and no other treatments, programs, or procedures listed in O0110 apply to the patient then code O0110Z - None of the above.

Q685.3. O0110. We know that we code O0110 - Special Treatments, Procedures, and Programs based on what is part of the current care/treatment plan at the time of the assessment. Can CMS provide further clarification on how to code O0110O1 - IV Access and O0110O4 - IV Access; Central if a PICC line is being pulled during the discharge assessment? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 04/23 Q14]

A685.3. The intent of O0110 - Special Treatments, Procedures, and Programs is to identify any special treatments, procedures, and programs that apply to the patient.

Check all treatments, programs and procedures that are part of the patient's current care/treatment plan at the time of assessment, even if not used during the time of assessment for SOC/ROC (or discharge).

This includes a PICC line that is being discontinued at the time of the assessment.