October 2012 CMS Quarterly Q&As

Category 3 – Follow-Up Assessments

**Question 1:** What OASIS is required when a patient returns home on day 61, in a situation where the patient was admitted to the hospital before or during day 56-60 recert window, is in an inpatient bed longer than 24 hours, but only for diagnostic testing; No Transfer OASIS had been completed?

**Answer 1:** Treat this situation as a missed Recertification and complete the Recertification as soon as possible after the patient's return home.

Category 4b – OASIS Data Items

**M0102 and M0104**

**Question 2:** Since there is no regulatory language allowing the ROC to be delayed by physician order beyond 2 calendar days of the facility discharge, what date if any is placed in M0102 on the Resumption of Care Assessment?

**Answer 2:** There is no regulatory allowance for a physician-ordered Resumption of Care date to extend beyond 2 calendar days of the facility discharge. If the physician orders the agency to resume care on a specific date that falls within 2 calendar days of the inpatient facility discharge, the specific ROC date ordered by the physician should be reported in M0102 Date of Physician-ordered SOC/ROC. If the physician orders the agency to resume care on a specific date that extends beyond 2 calendar days of the inpatient facility discharge, "NA" would be selected for M0102, Date of Physician-ordered SOC/ROC, and the date of the referral for resumption of home care services would be entered into M0104, Date of Referral. Clinical documentation would explain the timing of the patient's ROC visit.

**M1018**

**Question 3:** When answering M1018, if client has a nephrostomy tube do you mark indwelling/suprapubic catheter?

**Answer 3:** If the nephrostomy tube is utilized for urinary drainage, it is an indwelling catheter, therefore Response 2 – Indwelling/suprapubic catheter would be selected.
M1308

Question 4: Upon admission, our patient had 2 distinct pressure ulcers in close proximity. Over the course of the episode the ulcers deteriorate and no longer have any separating tissue. Do we now call this 1 pressure ulcer at the worst stage?

Answer 4: If the patient had one pressure ulcer and then later developed another pressure 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 the assessing clinician to determine the number of pressure ulcers in situations where multiple ulcers may have merged together.

M1710

Question 5: My patient was confused both when encountering a new situation and on awakening in the morning. Since M1710, When Confused, is not a “Mark All That Apply” item, please clarify when the response options should be selected.

Answer 5: 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.

M1800

Question 6: Please confirm that the assessment of the patient’s ability to perform the grooming tasks identified in M1800 also includes getting to where the grooming utensils are stored.

Answer 6: 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 him/her 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.

The OASIS-C Guidance Manual M1800 Item Intent states "These items address 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)."

**M1910**

**Question 7:** We see that a validation study has been published for the Missouri Alliance for Home Care’s Fall Risk Assessment Tool (MAHC-10). Does this mean that we can now use that tool as the single standardized, validated, multifactor tool to meet the “Yes” response for M1910? And if so, should the threshold of “4” or “6” be used to indicate fall risk?

**Answer 7:** Per existing guidance, if you want to report M1910 as “Yes” (that Fall Risk Assessment was conducted), you must use a multi-factor standardized tool that has been scientifically tested and validated, and the tool must be appropriately administered based on established instructions. CMS does not approve or disapprove individual tools. It is the agency’s responsibility to determine if the tool you are using includes these elements. If an agency has evidence (from published literature, the tool developer, or another authoritative source) that the tool they are using assesses multiple factors that contribute to the risk of falling, has been scientifically tested and validated on a population with characteristics similar to that of the patient being assessed, and shown to be effective in identifying people at risk for falls, and includes a standardized response scale, then the agency can consider the tool to meet the requirements for the OASIS-C best practice assessment.

In determining if a patient is at risk for falls, the standardized tool should have a standardized response scale, and/or established and validated threshold at which fall risk exists. A tool may have multiple thresholds identifying various levels of risk (i.e, “no risk”, “low risk”, “high risk”). Select Response 1 if the standardized response scale rates the patient as no-risk, low-risk, or minimal risk. Select Response 2 if the standardized response scale rates the patient as anything above low/minimal risk. If the tool does not provide various levels, but simply has a single threshold separating those “at risk” from those “not at risk”, then patients scoring “at risk” should be reported as Response 2.

**M2020**

**Question 8:** Are inhaled meds and sublingual meds considered in M2020, Management of Oral Medications?

**Answer 8:** No. Medications given per an inhaler or sublingually are not considered when answering M2020. 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.

**M2100c**

**Question 9:** A patient has B-12 injectables in the home that her physician administers when she visits monthly. The patient is not getting the medication on the SOC day. Is Response “3-Caregiver not likely to provide assistance” appropriate for this situation?

**Answer 9:** M2100c, Types and Sources of Assistance, determines the level of caregiver ability and willingness to provide needed assistance with medication administered in the home. If the patient does not require assistance with medications administered in the home, Response “0-No assistance needed in this area” would be the appropriate response.

**Question 10:** How is medication administration defined for M2100c? 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?

**Answer 10:** M2100c 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 Injectables 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-Caregiver(s) need training/supportive services to provide assistance" if the caregiver needs help to correctly fill a medication box.

**M2250d and M2400c**

**Question 11:** Should the diagnosis of bipolar disease be considered a diagnosis of depression for the M2250d/M2400c Plan of Care/Intervention Synopsis items?

**Answer 11:** M2250d and M2400c are applicable to all patients with a diagnosis of depression (clearly documented in their medical record and/or confirmed by a physician), including diagnoses with depression as a stated or intended component (e.g., bipolar disorder with depression, bipolar disorder - mixed depression and mania, Alzheimer’s with depression). The depression best practice is also applicable to all patients who have been screened for depression and exhibit symptoms that require further evaluation for depression, even if a formal diagnosis of depression has not been made.