



DEPARTMENT OF HEALTH & HUMAN SERVICES
Survey and Certification Group
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Survey and Certification Group

April 19, 2011
Linda Krulish, PT, MHS, COS-C
President
OASIS Certificate and Competency Board, Inc
850 Kaliste Saloom Road, Suite 123
Lafayette, LA 70508

Dear Ms. Krulish:

Thank you for your letter of April 4, 2011 in which you requested review of a number of questions and scenarios related to data collection and accurate scoring of Outcome and Assessment Information Set (OASIS) items. The accompanying questions and answers have been reviewed by CMS staff, selected content experts and contractors, and consensus on the responses has been achieved.

As deemed valuable for providers, OASIS Education Coordinators and others, CMS will consider incorporating these questions and answers into current OASIS-C preparation and education activities, and may include them in future updates to the CMS Q&As posted at <https://www.gtso.com/hhdownload.html>, and/or in future releases of item-by-item tips.

In the meantime, you are free and encouraged to distribute these responses through educational offerings sponsored by the OASIS Certificate and Competency Board, Inc. (OCCB) or general posting for access by all interested parties. Thank you for your interest in and support for enhancing OASIS accuracy.

Sincerely,
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Cc: Robin Dowell, RN, BSN
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April 2011 Quarterly CMS OCCB Q&As

Category 1 – Applicability

Face-to-Face

Question 1: We admit a patient for service, understanding that the patient will have their F2F on day 25. We complete the SOC comprehensive assessment; send the OASIS to the state and it is accepted. Potentially other OASIS assessments may be submitted, depending on the patient situation, e.g. other F/U, transfer/ ROC. Now, by day 30 after the SOC, the patient does not have their F2F with the physician and we discharge the patient, due to not meeting coverage criteria.

1. What do we do with the OASIS submitted to the state?
2. Is another OASIS now required at discharge?

Answer 1: If the individual was determined to not be eligible for services, no OASIS data collection would be required. No data would be transmitted to the State agency. Since, in this case the OASIS had already been submitted to the state, the OASIS assessment should be deleted, not inactivated. You may reference the “New Outcome and Assessment Information Set (OASIS) Correction Policy for Home Health Agencies” (April 2001) for guidance related to deleting assessments. It is located at www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter01-12.pdf and in Appendix B of the OASIS-C Guidance Manual at www.cms.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp. Since the patient was determined not eligible for services, no discharge OASIS is required. The HHA should be advised to maintain good clinical record documentation of care provided and reason for discharge.

Category 4b – M Item-Specific

M1012

Question 2: On an April 13, 2011 CMS Open Door Call, it was announced that the response to M1012 was insignificant. Please explain.

Answer 2: CMS has determined that the data from M1012 is not currently used for payment, quality measure development, or risk adjustment. Therefore, effective immediately, any response reported for M1012 ("UK", "NA", or the reporting of procedures and codes) is acceptable to report, and the impact of the response is insignificant. **Note that at this time, the item cannot be left blank.**

Agency policy or software vendors may dictate specific reporting guidelines for M1012 data, but effective April 13, 2011, until further notice, any response reported is acceptable for CMS purposes.

M1030

Question 3: How do I score M1030, Therapies at home, if the patient has a multi-lumen central line and is receiving continuous TPN through one lumen and the other two lumens are flushed daily to maintain patency of the line?

Answer 3: If there had only been one lumen, you would have followed the guidance in the CMS OASIS Category 4b Q&A 53.4 and reported “Response 2 – Parenteral nutrition” only.

Since there are two additional lumens that are ordered to be flushed to maintain patency, you would mark both “Response 1 - IV or infusion therapy” and “Response 2 - Parenteral nutrition.”

M1342

Question 4: Related to M1342, Status of Most Problematic (Observable) Surgical Wound, CMS OASIS Q&A 108.1 states, “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 wound could not possibly have been fully epithelialized for at least 30 days, Response 1 – Fully granulating should be reported.” Should it state “Response 0 – Newly epithelialized” instead of Response 1 – Fully granulating?

Answer 4: It is correct to state that response “0-Newly epithelialized” is now appropriate for the scenario you describe. CMS OASIS Q&A 108.1 was added in September 2009 (pre-OASIS-C) and at that time the correct response was “1-Fully granulating”. With the implementation of OASIS-C, the addition “0-Newly epithelialized” was added as an available response for M1342, therefore “0-Newly epithelialized” should now be considered the correct response to select for a wound that is currently completely epithelialized but could not possibly have been fully epithelialized for at least 30 days.

M1350

Question 5: Our patient had a burn with orders for the nurse to assess and change the dressing twice weekly. The patient is leaving the geographical area. The PT is making the last visit and completing the Discharge comprehensive assessment. She will not be changing the burn dressing on the discharge visit. How do we answer M1350? Is M1350 asking whether or not the agency provided intervention to the wound on the day of discharge or is it asking whether or not the patient had a wound on the day of assessment that required intervention from the agency, even though they didn't receive a specific intervention on the day of the discharge?

Answer 5: M1350, Skin Lesion or Open Wound, is asking if the patient has a skin lesion or open wound, on the day of the assessment that is receiving intervention by the home health agency. It is not necessary that the intervention be provided on the day of the assessment, just that ongoing assessment and/or clinical intervention by the home health agency is part of the planned/provided care.

If, at the discharge assessment, there are wounds or lesions that still require intervention from the agency, the answer to M1350 would be “Yes”. This is true even if the intervention was not provided that day, (e.g. burn requires ongoing dressing changes and assessment, PT does not perform dressing change or assessment on the day of the discharge).

If, at the discharge assessment, there are no wounds or lesions that still require intervention from the agency, the answer to M1350 is “No”, (e.g. burn had healed and no longer needed assessment or dressing changes).

M1510

Question 6: Can I mark M1510, Heart Failure Follow-up, Response “1-Patient's physician contacted the same day”, if the physician calls the patient back, not the agency, on the same day heart failure symptoms were identified with instructions regarding heart failure symptoms? (The agency identified the symptoms and left a message with the physician's office staff on the same day, but the physician called the patient back, not the agency, on the same day with instructions.)

Answer 6: No, you may not select Response 1 if instructions were communicated by the physician directly to the patient/caregiver. In order to select Response 1, the agency must have communicated the heart failure symptoms to the physician or their designee and received

instructions or further advice from the physician or their designee by the end of the same day the symptoms were identified. If it was communicated by the physician to the patient or their caregiver, the agency must confirm the accuracy of the information with the physician on the same day to select Response 1.

M1610

Question 7: 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?

Answer 7: No. M1610 Response 2-Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) remains the appropriate response if a patient requires intermittent catheterization. The statement from the 12/2010 Chapter 3 "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.

M1740

Question 8: 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.

Answer 8: The time frame 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.

M1750

Question 9: If there are no orders on the referral for psych nursing services, should the skilled nurse answer M1750 "Yes" if she identifies a psych issue on her initial assessment and plans to obtain physician's orders for the agency's Mental Health Nurse? Can she answer "Yes" even if the visit by the Mental Health Nurse will not be completed in the 5 day assessment window?

Answer 9: In order to select "Yes" for M1750, Psychiatric Nursing Services, you must have a physician order for psychiatric nursing services on the Start of Care/Resumption of Care plan of treatment. It is not required that the clinician completing the comprehensive assessment be a qualified psychiatric nurse. The first visit by the qualified psychiatric nurse does not have to occur in the time frame allowed for completing the comprehensive assessment, but you must have an order for the psychiatric nursing services to answer "Yes."

M1850; M1860

Question 10: How is "bedfast" defined for M1850, Transferring and M1860, Ambulation/Locomotion? Do I only count what my patient could do during the visit?

Answer 10: M1850, Transferring and M1860, Ambulation/Locomotion report the patient's ability on the day of the assessment. Day of assessment is the 24 hours before the clinician arrives in the patient's home and the time spent in the home performing the comprehensive assessment. Ch. 3 of the OASIS-C 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 her/his 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 she/he is 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 him from tolerating the sitting position.

M1860

Question 11: 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?

Answer 11: 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 response in this case is "5-Chairfast, unable to ambulate and is unable to wheel self".

M2015

Question 12: For M2015, Patient/Caregiver Drug Education Intervention----Does "other healthcare provider" include a pharmacist?

Answer 12: Yes. If assessment of the patient/caregiver's baseline knowledge reveals the patient received the education specified in M2015, Patient/Caregiver Drug Education Intervention, from the pharmacist, you can include this education in M2015. This would require that the pharmacist educated the patient/caregiver to monitor the effectiveness of all drug therapy (prescribed, as well as all OTC), drug reactions, and side effects, and how and when to report problems that may occur to the appropriate care provider. Note that just including written materials in the bag with the medications at the time the medication is dispensed may not provide the specified education. The education of the patient may also be a collaborative effort, in which the pharmacist may provide part of the education, with other healthcare providers.

M2020

Question 13: 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)?

Answer 13: M2020 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. Someone prepares the medi-planner and sets it within the patient's reach with the water they need to take the meds, the appropriate score is a "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 a "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 a "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 a "0" at the next OASIS data collection time point.

M2100

Question 14: When answering M2100 - Types and Sources of Assistance, do we include the assistance provided to the patient at an Adult Day Care center?

Answer 14: M2100, 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.

M2100

Question 15: How is "Assistance needed, but no Caregiver(s) available" defined? Would it apply to a son who is managing equipment and assists with ADLs safely and independently, but is unwilling to assist with medication administration and is unable to take the patient to doctor's appointments?

Answer 15: "Response 5 - Assistance needed, but no Caregiver(s) available" means the patient has no one involved in providing any level of care to them at all. In your example, the patient has a son who is providing some level of caregiver assistance; therefore, Response 5 would not be an appropriate response.

If the son was willing and able to manage equipment and assist with ADLs, the appropriate responses for Row a and Row e would be "1-Caregiver currently provides assistance." If the son was unwilling to assist with medication administration and unable to take the patient to doctor's appointments, the appropriate responses for Row c, Medication administration and Row g, Advocacy or facilitation would be "3-Caregiver not likely to provide assistance" because

this response is defined as including situations where the caregiver is unwilling or unable to provide the needed care.

M2250a

Question 16: If our patient's physician agrees that the American Heart Association (AHA) guidelines for physician notification would be appropriate for his patient, is it sufficient for the order on the plan of care to read "Follow AHA guidelines for physician notification"?

Answer 16: In order to select "Yes" for M2250a, Patient-Specific Parameters, the physician-ordered plan of care must include specific parameters, e.g. notify physician if INR <2.0 or >3.0. Just including the name of a set of guidelines, e.g. AHA guidelines, ABC Agency guidelines, ADA guidelines, etc. would not meet the requirements of this best practice.

M2250a

Question 17: There is a discrepancy between previous Q&A guidance and the December 2010 errata/updated manual related to how to respond to M2250a when an agency uses standardized parameters which have not been approved by the physician. Was this an intentional change?

Answer 17: No, this was not an intentional change and reflects an error which will be updated in a future manual update.

Errors:

OASIS-C Guidance Manual (December 2010)

Chapter 3, Page N-4

8th Bullet on the page; last word should be "NA" instead of "No"

OASIS-C Guidance Manual Errata (January 2011)

Page 17

1st Bullet on the page; last word should be "NA" instead of "No"

The previous guidance related to M2250a stands unchanged. If the agency uses their own agency standardized guidance, which the physician has NOT agreed to include in the plan of care for this particular patient, select "NA".

M2310

Question 18: Are responses for M2310, Reason for Emergent Care, selected because of the reasons the patient sought and/or received treatment in the ER? For example, a patient went to the ER because of flu symptoms, nausea, vomiting and chills and was given a prescription. Response 19 is selected. The patient is also a diabetic, and lab work showed the patient was hyperglycemic. He was instructed to continue to check his blood sugars and consult his PCP if they continued to be elevated. Would Response 10 also be marked even though it was not the reason responsible for the ER visit?

Answer 18: M2310, Reason for Emergent Care, reports all the reasons the patient both sought and received care in the hospital's emergency department. Chapter 3, Response-Specific Instructions state "If more than one reason contributed to the hospital emergency department visit, mark all appropriate responses." Other Response-Specific instructions use the phrase "...patient sought care..." "...if a patient seeks care..."

In your scenario above, both Response 19 and 10 would be appropriate for M2310 because the patient sought care for GI flu symptoms (19-Other than above reasons) and received care for hyperglycemia (10-Hypo/Hyperglycemia, diabetes out of control).

M2420

Question 19: Is the dialysis center which maintains a patient's dialysis catheter considered formal assistive services?

Answer 19: Formal assistive services are supportive community-based services provided through organizations or by paid helpers and do not include medical or rehabilitative services provided outside the home, e.g. outpatient therapy, physician office visits, dialysis, wound care clinic visits.

M2430

Question 20: When answering M2430, Reason for Hospitalization, can I select Response 19 - Scheduled treatment or procedure, when my patient's health is deteriorating and the physician instructed us to monitor the patient's condition for 2 days and then call 911 if the patient does not improve?

Answer 20: Response 19 - Scheduled treatment or procedure refers to a treatment or procedure that is scheduled in advance and is not related to an urgent or emergent condition or dependent upon an acute change in condition. Examples of a scheduled treatment or procedure include joint replacement surgery, non-emergency procedures to improve blood flow or heart function, such as angioplasty or pacemaker insertion, or cataract surgery.

The scenario you provided is not an example of a situation where the patient is being admitted for a scheduled treatment or procedure.