October 2011 Quarterly CMS OCCB Q&As

Category 2; Category 3; M0100

Question 1: A patient is seen monthly. On a monthly visit, which falls within the last five days of the certification period, the assessing clinician discovers the patient had a qualifying hospital admission since the last monthly visit that our agency was not aware of. Do we complete a Transfer, Resumption and Recert or just the Transfer and Resumption?

Answer 1: When the agency learns of a qualifying Transfer after the patient returned home, a Transfer and Resumption is required within 2 calendar days after learning of the inpatient stay. In this situation, a Transfer is required; and, since the time frame to complete the Resumption overlaps with the timeframe to complete the Recertification, the ROC assessment should be completed, fulfilling both the ROC and Recert requirements.

M0100

Question 2: If nursing performs a non-billable admit for a PT only case, the PT goes the same day completing an evaluation only, and there is no further need for therapy, are we required to complete the RFA 9 OASIS Discharge?

Answer 2: For skilled Medicare and skilled Medicaid patients, OASIS data collection is required if more than one visit was made in a quality episode. In your scenario, the nurse made one visit and the PT made one visit. Therefore both the SOC (RFA 1) and DC (RFA 9) comprehensive assessments are required. This is true even if one of the visits was non-billable.

Question 3: When we complete the RFA 6, Transfer; no discharge and the patient does not return to us, do we have to cancel the RFA 6 and resubmit the RFA 7, Transfer with Discharge?

Answer 3: If you complete and transmit the RFA 6, Transfer to 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. The patient will remain on your OASIS Patient Management Roster for 6 months and then drop off.

M0104

Question 4: 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?

Answer 4: M0104, Date of Referral, is the date stamped by your fax machine indicating when the referral was received.

M1308

Question 5: Should a pressure ulcer that has been “flapped” be reported in M1308 as a current pressure ulcer?

Answer 5: A muscle flap, skin advancement flap, or rotational 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 original blood supply) performed to surgically replace a pressure ulcer should be reported as a surgical wound. It should not be reported as a pressure ulcer in M1308.

M1308; M1340

Question 6: How do you answer the OASIS Integumentary items for a pressure ulcer that received a skin graft?

Answer 6: A pressure ulcer treated with a skin graft (defined as transplantation of skin to another site without retaining original blood supply) remains a pressure ulcer and should not be reported as a surgical wound in M1340. Until the graft edges completely heal, the grafted pressure ulcer should be reported in M1308 as d.1 (unstageable) pressure ulcer. The number of pressure ulcers meeting these definitions should be counted to determine the response to d.1. Once the graft edges heal, the closed Stage III or Stage IV pressure ulcer would continue to be regarded as a pressure ulcer at its worst stage.

M1320; M1324

Question 7: My patient has a Stage III pressure ulcer that is closing. How do I report the stage and status when the opening has shrunk to a pinpoint size and does not present a viewable base due to the small opening?

Answer 7: If you have a Stage III that is in the process of closing, it remains an observable Stage III unless the wound bed was covered with a dressing that could not be removed or the wound bed was obscured with avascular tissue. 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 III. The status could be either Early/partial granulation or Fully granulating, based on the descriptors in the WOCN Guidance on OASIS-C Integumentary Items, until the wound margins closed, at which time it would be considered a newly epithelialized Stage III pressure ulcer.

M1730

Question 8: I don't understand when I would ever select "NA - Unable to respond" in the PHQ-2 in M1730, Depression Screening. Please clarify.

Answer 8: The PHQ-2 is only used for patients that appear to be cognitively and physically able to answer the two included questions. After determining the PHQ-2 is an appropriate tool, the patient may decline or be unable to answer the questions, e.g. patient states the questions are too personal, or the patient may not be able to quantify how many days they have experienced the problems.

M1850

Question 9: 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?

Answer 9: The need for assistance with gait may impact the M1850, Transferring score if the closest sitting service 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 routine 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, the appropriate score would be a “2”.

M1860

Question 10: 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?

Answer 10: 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. This is true for blind patients utilizing a cane to ambulate safely, canes used for weight bearing, and a white cane used to detect objects in the path of the user.

M1870

Question 11: My patient was recently hospitalized for aspiration pneumonia. She can feed herself but needs to be closely observed/supervised during the entire meal because she tends to pocket food, forgets to swallow and then sometimes dozes while eating. How should I answer M1870, Feeding or Eating?

Answer 11: If a patient requires constant supervision throughout the meal in order to eat or feed self safely, the appropriate M1870 response is a “2-Unable to feed self and must be assisted or supervised throughout the meal/snack”.

M2030

Question 12: When answering M2030 at Discharge, are one-time injections and discontinued injectables included in this assessment? Consider the following scenarios:

> Scenario 1: The first two weeks of the episode, the patient had Lovenox SQ ordered. The patient is being discharged 4 weeks later with no injectable medications currently ordered. At discharge, is the answer NA - no injectable medications prescribed or do we assess their ability from earlier in the episode?
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> Scenario 2: Is the order to administer the flu vaccine at the beginning of the episode included when selecting a response for M2030 at the Discharge assessment?

Answer 12: If there are no current, ongoing orders for an injectable to be administered IM or SQ via needle and syringe in the home at the time of the assessment, the appropriate response to M2030 would be "NA."

The influenza vaccine is only included in M2030 if the patient was going to receive it in the home. An order for the patient to receive it outside the home after discharge would not be included.

Question 13: I understand from the CMS Q&A 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 his used needles and syringes into the trash. He stated he was never told how to properly dispose of them. Which M2030 response would be

appropriate? What if they were forgetful and sometimes disposed of the needles appropriately but at other times they didn't?

Answer 13: 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 a "2".

M2110

Question 14: Is M2110 asking how many days the patient receives help or how many times someone visits and provides help? My patient has two daughters. Daughter 1 visits and helps with laundry on Sunday morning, daughter 2 visits Sunday afternoon and Wednesday to help her mother in and out of the bathtub. Should I select "2-Three or more times a week" because 3 visits were made or "3-One to two times per week" because the patient received help on two days?

Answer 14: M2110, Frequency of ADL/IADL Assistance, reports how many times a week a caregiver provides some level of assistance with any ADL or IADL. In your scenario, the appropriate response would be "2-Three or more times a week" since there was 3 distinct times that someone provided assistance with an ADL/IADL.

M2400

Question 15: 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 previous assessment.

Can we respond "Yes" to M2400 (d) if pain mitigation orders were implemented but not completed prior to discharge?

Answer 15: If there are multiple interventions to address a specific problem included in M2400, 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.

M2250(g); M2400(f)

Question 16: A patient has two pressure ulcers for which wet-to-dry dressings are ordered. After the SOC assessment, the assessing clinician requests and receives an order for moist wound healing treatment for one of the pressure ulcers, without any discussion about appropriateness/inappropriateness of moist wound healing for the second ulcer. The moist wound healing treatment is provided and documented for the one pressure ulcer as ordered. How should 2400 be answered?

Answer 16: There is no requirement that every pressure ulcer be treated with moist wound healing in order to mark "Yes" for M2250 (g) or M2400 (f). If the agency has orders for and implements moist wound healing treatment for at least one pressure ulcer within the required time frames, then M2400 (f) should be "Yes".

M0903

Question 17: The patient died at home and we did the pronouncement. Is M0903, Date of Last (Most Recent) Home Visit, the date of the pronouncement or the date of the last visit by any discipline when the patient was alive?

Answer 17: M0903 reports the last (most recent) home visit made by agency staff to the live patient.