

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

October 19, 2010
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 September 30, 2010 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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Nurse Consultant
Survey and Certification Group
Centers for Medicare & Medicaid Services

Cc: Robin Dowell, RN, BSN
Nurse Consultant
Office of Clinical Standards and Quality



October 2010 Quarterly CMS OCCB Q&As

Submission as Payment Condition & Single Visit in a Quality Episode

Question 1: We were told by our intermediary at an educational session that OASIS is now a requirement for payment by Medicare. Does this mean we must collect and submit OASIS data even when there has been just a single visit at the start of care? If submission is mandated for single visits, how does this impact the guidance on the Management of Single Visits from CMS, which stated we didn't have to collect or submit the OASIS for the single visit, nor perform a discharge OASIS assessment?

Answer 1: Per the new CMS payment regulations as of January 2010, you must submit an OASIS assessment in order to be paid for a final claim under the Medicare PPS system. If you choose NOT TO BE PAID, there is no requirement to collect and transmit OASIS data if there has been only one visit.

The Federal Register, November 2009 (<http://edocket.access.gpo.gov/2009/pdf/E9-26503.pdf>) explains: "Rather, we intend that in finalizing this policy, providers will ensure that prior to submitting a final HH PPS episode claim, a provider will have submitted an OASIS, and the HIPPS code on the final HH PPS episode claim will be consistent with the HIPPS on the OASIS validation report. As such, we are implementing the provision to require the submission of OASIS for final claims as a condition of payment, and revising § 484.210"

With these changes to the conditions for payment, the Single Visit Management document is being retired. At any time point where an OASIS assessment will impact the payment, even if that assessment visit is a single visit in a quality episode, completion and submission of OASIS data is mandated for payment. For agencies compliant with required data collection timeframes, the only time point where a single visit could impact payment is at the Start of Care (SOC). The discharge OASIS is never mandated in situations of single visits in a quality episode (SOC/ROC to TRF/DC).

M0100 – Use of RFA 7

Question 2: New text in the Medicare Claims Processing Manual, CMS Publication 100-4, Chapter 10, reads, "A beneficiary does not have to be discharged from home care because of an inpatient admission. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues. However, if an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same 60-day period, the discharge is not recognized for Medicare payment purposes. All the home health services provided in the complete 60-day episode, both before and after the inpatient stay, should be billed on one claim." Does this mean that providers should never do an RFA7 (Transfer with discharge)?

Answer 2: When a patient is transferred to the inpatient facility, it should be assessed if the agency anticipates the patient will be returning to service or not. If the HHA plans on the patient returning after their inpatient stay, the RFA6 should be completed. There will be times when the RFA7 is necessary to use, but only when the HHA does NOT anticipate the patient will be returning to care. There are several reasons why the RFA7 may be used, including these examples: the patient needs a higher level of care and no longer appropriate for home health care, the patient's family plans on moving the patient out of the service area, or the patient is no longer appropriate for the home health benefit.

The Claims Processing Manual clarified this issue in July 2010, and directs providers to not discharge a patient when goals are not met at the time of a transfer. If a provider does discharge and readmit within the same payment 60-day episode, a Partial Episodic Payment (PEP) adjustment will be automatically made.

M1012

Question 3: What is meant by "medical procedure" in the item intent for M1012? Would physical therapy and occupational therapy be considered as a "medical procedure" to be listed in this item if the assessing clinician considered it relevant to the POC?

Answer 3: The term "medical procedure" in M1012 can be defined as any procedure in Volume 3 of the ICD-9-CM coding manual, if it occurred during an inpatient stay with a discharge date within the past 14 days, and is relevant to the home health plan of care. The intent of this item is to provide a more comprehensive picture of the patient's condition prior to the initiation of home care. Typically, this would include recent surgical procedures, but any procedure that the clinician identifies as significantly impacting the patient's health status and care needs should be documented, based on the information that is available to the agency at the start (or resumption) of care. In some cases, this could include diagnostic or rehabilitative procedures.

M1030

Question 4: We have a patient that is having an infusion of Mucomist and Gentamycin into the bladder. Would this be reported as "Response 1 – Intravenous or infusion therapy" when answering M1030?

Answer 4: An irrigation or infusion of the bladder is not included when completing M1030, Therapies at Home.

M1055

Question 5: Has the CDC updated the recommended age/condition guidelines for PPV administration that should be considered for M1055 - Reason PPV not received?

Answer 5: In September 2010, the CDC and the Advisory Committee on Immunization Practices provided the most substantial update since 1997 for PPV administration. The important changes are that persons ages 18-64 with asthma or those who smoke are included in the groups for whom routine administration of PPV is recommended. Those removed from routine PPV administration include American Indians and Alaska Natives age < 65 unless they have a condition that qualifies them for PPV. The recommendations regarding those age 65

and older and re-vaccination were not changed.

More detailed information on the risk groups for whom vaccination is recommended is available from the CDC:

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5934a3.htm?s_cid=mm5934a3_e%0D%0A.

M1242

Question 6: When answering M1242, Frequency of Pain Interfering with Activity or Movement, does this refer only to physical activity like walking, dressing, bathing etc. or do you also look at nonphysical activity like sleeping (the pain is causing the patient to wake up during the night and not sleep well) or other activity they enjoy, like watching television or reading?

Answer 6: M1242, Pain Interfering with Activity or Movement, reports the frequency that pain interferes with the patient's activities or movement. It includes all activities, not just ADLs, e.g. sleeping, recreational activities, watching television.

M1340

Question 7: 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?

Answer 7: 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.

Question 8: Is the removal of a callus considered to be a surgical wound?

Answer 8: A callus that was removed is NOT considered a surgical wound when scoring the OASIS item M1340, although it may be reported in M1350 Wounds/Lesions if it is receiving intervention from the agency.

Question 9: 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?

Answer 9: The wound described should be considered a thoracostomy and is not considered a surgical wound when completing the OASIS data set item M1340.

M1350

Question 10: Are gastrostomies and jejunostomies considered bowel ostomies for the purposes of M1350, Skin Lesion or Open Wound?

Answer 10: M1350 excludes bowel ostomies for elimination, such as a colostomy or an ileostomy. A jejunostomy or gastrostomy utilized for enteral nutrition is not considered a bowel ostomy for the purposes of OASIS data collection.

M1400

Question 11: If the oxygen is ordered continuous but the client only wears it intermittently, do you assess the patient with or without the oxygen when answering M1400, Dyspnea.

Answer 11: If the patient "uses" oxygen intermittently, mark the response based on the patient's shortness of breath WITHOUT the use of oxygen. The response is not based on the order, but rather the patient's actual use of oxygen in the home.

M1510

Question 12: Our therapists do not feel qualified to educate patient's regarding the management of heart failure. If it is a therapy only case and the patient has chronic heart failure symptoms, would it be appropriate to answer M1510, Heart Failure Follow-up, as 4-Patient education or other clinical interventions, if the therapist only handed printed heart failure education materials to the patient?

Answer 12: Simply providing a patient printed materials regarding heart failure without assessment of their understanding of the material could not be considered an educational intervention.

M1845

Question 13: Is the patient's ability to cleanse around a colostomy stoma and a supra pubic catheter included when scoring M1845, Toileting Hygiene?

Answer 13: The wording of M1845 states that "if managing an ostomy, includes cleansing area around stoma,..." This would include all stomas that are used for urinary or bowel elimination, e.g. urostomies, colostomies, ileostomies.

M2250d

Question 14: A patient has depressive symptoms as identified by a PHQ-2 score of "4", but the patient has no diagnosis or current treatment for depression. If the clinician notifies the physician of the depressive symptoms and is instructed to continue to monitor the patient, with no orders for specific treatment, what response would be selected for M2250d?

Answer 14: After reporting the patient's status, a physician order to continue to assess for signs of depression could be considered an intervention for depression, and be reported as "Yes" for M2250d.

M2250e

Question 15: 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 (M2250e “no”), or would this be enough to answer “yes”, that we have an order to both monitor and mitigate pain?

Answer 15: 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, M2250e would be “Yes”.

M2300

Question 16: For M2300 is "since the last OASIS assessment" defined the same as M2400 - at the time of or since the last OASIS assessment?

Answer 16: The time frame under consideration for M2300, Emergent Care, is defined as "At or since the last time OASIS data were collected."

Note: For all OASIS items that include the phrase "since the previous OASIS assessment" (M1500, M1510, M2004, M2015, M2300 and M2400), the timeframe should be considered "at or since the previous OASIS assessment".

M2410

Question 17: When completing M2410 - To which Inpatient facility has the patient been admitted, is an admission to a chemical dependency inpatient program of a hospital considered to be a hospital admission or an admission to a Rehabilitation facility. What if a chemical dependency inpatient program is not part of a Hospital or SNF- how would M2410 be answered?

Answer 17: An inpatient drug rehabilitation admission is considered an inpatient admission. The appropriate M2410, Inpatient Facility Admission, response would be "1-Hospital" whether it was a free-standing drug rehabilitation unit or a distinct drug rehabilitation unit that is part of a short-stay acute hospital.

M2420

Question 18: If a patient is discharged and will be receiving outpatient therapy, is this considered a discharge to community with formal assistance when completing M2420, Discharge Disposition?

Answer 18: For M2420, “formal assistive service” does not refer to medical care and services received outside of the home. Therapy services provided in an outpatient setting would not be considered “formal assistance” for the purposes of answering M2420, Discharge Disposition. “Formal assistive services” refers to the types of services provided in the home that support a patient after discharge from your home care agency. Such services make it possible for them to remain safely in their home and are provided by organizations and helpers that are financially compensated for the services, e.g. community-based services like homemaking services under Medicaid waiver programs, home-delivered meals, home care or private duty care from another agency.