



CATEGORY 1 – Applicability

Question 1: We are a pediatric Medicaid certified home healthcare agency. We are currently collecting OASIS data on several clients over the age of 18. If we were not Medicare certified, would we need to continue to collect OASIS on these clients?

Answer 1: First, if you are solely a Medicaid home health provider and not a Medicare certified provider, you would only be required to collect OASIS if your state requires you to meet the Medicare Conditions of Participation. If, as an organization, you are required to collect and submit OASIS because your state requires you to meet the Medicare Conditions of Participation, you must do so on all skilled Medicare and Medicaid patients except those under the age of 18, maternity patients, personal care only patients and patients receiving only a single visit in a quality episode.

CATEGORY 2 – Comprehensive Assessment

Comprehensive assessment not completed within 5 days after SOC date

Question 2: We know that for a PT only case where the RN is doing the SOC Comprehensive Assessment that

Question 3: When a PT only patient comes home from the hospital, can the PT go out within 24 hours of the patient's return from the hospital and then the RN complete the OASIS ROC the next day. This would keep the RN within the 2 day window. Our administrative policy requires that an RN make a non-bill visit to perform the comprehensive assessment and OASIS. The ROC date and the date on the OASIS would differ as the ROC would reflect the date of PT visit and the OASIS M0090, Date Assessment Completed, would reflect the following day when the RN completed the visit.

Answer 3: The ROC comprehensive assessment must be completed within 2 calendar days after the facility discharge date or knowledge of the patient's return home. Any clinician qualified to perform comprehensive assessments (RN, PT, OT, SLP) may complete the comprehensive assessment, following the agency's policy.

In a PT only ROC, there is no requirement that the PT complete the comprehensive assessment on the first visit. It would be compliant with the Condition of Participation, 484.55, Comprehensive Assessment of Patients, for the PT to perform a discipline-specific re-evaluation and then an RN complete the comprehensive assessment on a non-billable visit as long as the comprehensive assessment is completed within 2 calendar days of the facility discharge (or knowledge of the patient's return home). In this case, the ROC date, M0032, will be the date of the PT's visit (the first visit after the patient's return home) and the ROC

it has to be done on or within 5 days after SOC date. If it is done prior to the SOC date, we understand that it is not valid and the RN will have to go back out and redo the assessment. This recently happened but it was not discovered until way after the fact (the 5 days had lapsed). Is there anything we can do? Can the PT derive the OASIS item answers from the PT evaluation? This would be out of compliance with our policies and procedures.

Answer 2: There would be no way of resolving this situation compliantly as the SOC comprehensive assessment was not done on or within 5 days after the SOC date. The situation was discovered too late to send an RN out to the home to perform a SOC comprehensive during the allowed timeframe and since the agency policy does not allow PTs to perform the comprehensive assessment at the SOC, their assessment findings cannot be utilized by the therapist to "create" a SOC comprehensive assessment.

The agency could send out an RN to perform a SOC comprehensive assessment as soon as the situation is discovered. The M0090 date, Date Assessment Completed, will be the actual date the clinician visited the home and then completed the assessment. A warning message will result from the non-compliant assessment date, but this will not prevent assessment transmission.

Timing of first visit and comprehensive assessment at ROC

comprehensive assessment's M0090, Date Assessment Completed, will be the date the RN completed the comprehensive assessment. The dates would not be the same if the RN visited and completed the comprehensive assessment the day after the PT visited and performed the evaluation. This still represents compliance with the regulations.

Discharge to in-home hospice

Question 4: How do I handle a discharge on a Medicare patient who decides they are going to receive hospice in their home? M0100 only gives the option to transfer if it is to an inpatient facility not if the patient is opting to receive Hospice in the home which is not an inpatient facility.

Answer 4: If you need to discharge a patient from Medicare home health when they move to the Medicare Home Hospice benefit, you are required to complete the RFA 9, Discharge comprehensive assessment. M0870, Discharge Disposition will be Response "2-patient transferred to a noninstitutional hospice."

Is Discharge necessary when only one RN/Therapy and one MSW visit were made?

Question 5: What do we do when the patient refuses more visits after just one nursing or therapy visit at the SOC/ROC and one MSW visit? Would a Discharge OASIS need to be completed? The information would match what was in the original SOC

or ROC visit since MSWs cannot complete OASIS Assessments. What if the RN visits once and the HHA visits once.

Answer 5: You have described a situation where more than one visit was made - RN or therapist performs SOC comprehensive visit and then a MSW (or HHA) visits. Two visits were made. In this situation a Discharge comprehensive assessment is required.

CATEGORY 4b – Item-specific Questions

M0100 – RFA 6/7 Transfer

Question 6: 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 and “something goes wrong”, does it become a Transfer?

Answer 6: An RFA 6 or 7, Transfer to the 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, if they are admitted

Question 8: Should a blood-filled blister be reported as a Stage II pressure ulcer on M0450 of the current OASIS-B1 document, which includes the word “blister” as part of the definition of a Stage II ulcer?

Answer 8: No, a blood-filled blister should not be reported as a Stage II pressure ulcer, as the current OASIS-B1 definition of a Stage II is limited to partial thickness skin loss involving the epidermis and dermis. Under current OASIS-B1 wording, such a lesion would be reported as a skin lesion in M0440 and not reported as a pressure ulcer in M0450. The patient’s medical record should include the specific history of the blister, (i.e. blister is the result of pressure). It is also important to note the following: if a blister worsens resulting in an ulcer with a partial thickness skin loss involving the epidermis and dermis which, as stated above, is the definition of a Stage II pressure ulcer then the agency must ensure that the patient’s home health plan of care reflects the necessary diagnosis and skilled service change.

M0620

Question 9: Are the behaviors listed in M0620 exclusive to M0620 or are they linked also to behaviors listed in M0610?

Answer 9: The definition of M0620, Frequency of Behavior Problems, in Chapter 8 of the *OASIS User’s Manual* is “Identifies frequency of behavior problems which may reflect alterations in a patient’s cognitive or neuro/emotional status...Any behavior of concern for the patient’s safety or

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, 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 they stay in the inpatient bed is for 24 hours or longer.

M0175

Question 7: 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 M0175 in this case?

Answer 7: M0175, Inpatient Facility Discharge, 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 and was placed under observation, it is considered a hospital discharge. If the patient was 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 M0175.

M0450

social environment can be regarded as a problem behavior.” M0610, Behaviors Demonstrated at Least Once a Week, “identifies specific behaviors which may reflect alterations in a patient’s cognitive or neuro/emotional status.” The OASIS Web-Based Training further clarifies “Behaviors represent actions that are more severe manifestations of alterations in cognitive or neuro/emotional status and have serious implications for care and care planning.” M0610 asks if these types of behaviors occur at least once a week. In responding to M0620, the clinician must determine whether any existing behavior problems are severe enough to cause “concern for the patient’s safety or social environment.” Because M0610 addresses behavior and M0620 asks about the frequency of behavior problems, they are related. However, it is important (and correct) to say that the answer to one item does not “dictate” the answer to the other. There is no “formula” for answering these items (if ‘x’ on M0xx, then ‘y’ on M0620). The items need to be assessed, considered, and answered separately.

M0650/660

Question 10: The guidance in M0650/M0660 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.

Answer 10: M0650/660, Upper/Lower Body Dressing, 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 M0650/660.

M0650/660

Question 11: At my agency, we are asked to score M0650 and M0660 as "2 - Someone must help the patient put on upper 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?

Answer 11: 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.

Answer 13: When you are completing a discharge from agency (RFA-9), the only valid response for M0855 is 'NA'. There are some agencies that have only one discharge form (used for multiple discharge time points such as RFAs 7- Transfer with discharge, RFA 8 – Death at home, or RFA 9 – Discharge from agency), requiring M0855 to be included in the Discharge assessment time point. If you use separate forms for Transfer, Death, and Discharge, inclusion of M0855 on the Discharge may appear unnecessary. Just remember, that at discharge, the only valid response for M0855 is NA.

CATEGORY 6 – Data Submission

Data Transmission

Question 14: Do all Medicare and Medicaid HMOs require OASIS data collection. Are they also required to transmit the OASIS data?

Answer 14: OASIS data collection and submission is required on skilled Medicare and skilled Medicaid patients (traditional fee-for-service and HMOs). Maternity, personal care, pediatric and single visit quality episode patients are excluded from the OASIS data collection requirement. When OASIS data collection is required by regulation, then submission is also required

M0840

Question 12: What do you report in M0840, Emergent Care Reason, if a patient has sought emergent care multiple times since the last time OASIS data were collected? Do you include the reason for each visit or just the most recent visit?

Answer 12: M0830, Any Emergent Care, asks "Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care?" The clinician is instructed to mark all that apply during the entire period since the last time the OASIS data were collected. M0840, Emergent Care Reason, is a mark all that applies item. It is asking "For what reason(s) did the patient/family seek emergent care?" If the patient sought emergent care multiple times in any of the three specified care provider settings since the last time OASIS data were collected, M0840 should report the reason for each visit, not just the most recent visit.

M0855

Question 13: At the time of the Transfer, the inpatient admission is reported in M0855, To which Inpatient Facility has the patient been admitted? When you complete M0855 at discharge, doesn't it count the same inpatient admission again? Should M0855 be answered "since the last time OASIS information was collected", like emergent care?