

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

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July 15, 2008  
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 June 30, 2008 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 future updates to the CMS Q&As posted at <https://www.qtso.com/hhdownload.html>, and/or in future revisions to the OASIS User Manual, Chapter 8, 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,  
Patricia M. Sevest, BSN, RN  
Nurse Consultant  
Survey and Certification Group  
Centers for Medicare & Medicaid Services

Cc: Debora A Terkay, RN, MS  
Office of Clinical Standards and Quality



## CATEGORY 2 – Comprehensive Assessment

### **RN performing ROC for PT only case**

**Question 1:** When a nurse completes a Resumption of Care (ROC) assessment for a PT only case, can the nurse do the ROC on one day and the therapist re-eval the following day? I know this can't be done at SOC, but not sure for ROC since episode has already been established.

**Answer 1:** The Comprehensive Assessment of Patients Condition of Participation (484.55) (d) states the comprehensive assessment must be completed within 48 hours of the patient's return home from the inpatient facility stay of 24 hours or longer for reasons other than diagnostic testing. It is acceptable for the RN to make a non-billable visit in a PT only case and complete the ROC assessment within 48 hours of discharge and the PT to visit to evaluate either before or after the RN's assessment visit, as long as the PT visit timing meets federal and state requirements, physician's orders, and is deemed reasonable by professional practice standards. The resumption of care date (reported in M0032) is the first visit following an inpatient stay, regardless of who provides it, whether or not the visit is billable, and whether or not the ROC assessment is completed on that first visit.

## CATEGORY 4a – OASIS Forms

### **Integrating the OASIS items into the Comprehensive Assessment**

**Question 2:** Our agency has been using a typical OASIS form that integrated the comprehensive assessment information with OASIS (as required by the Conditions of Participation) within one single form. We recently decided to use two separate forms. One form is the Comprehensive Assessment as stated above and the second is CMS OASIS -B1. Someone told us that this was unacceptable and a single, physically integrated form is required. Is this true?

**Answer 2:** In order to be compliant with the Medicare Condition of Participation, 484.55, Comprehensive Assessment of Patients, the OASIS Assessment Items must be integrated into the agency's comprehensive assessment forms and arranged in a clinically meaningful manner. The M0 Items may not be kept on a separate form and attached as a separate document to the comprehensive assessment.

## CATEGORY 4b – OASIS Data Items

### **M0110**

**Question 3:** We had a Medicare patient who received 2 contiguous episodes of service which did not meet the home health benefit. In order to receive payment from a secondary insurer, we submitted demand bills to our intermediary, fully expecting, and receiving denials. One month after being discharged from care, the patient now needs services which do meet Medicare eligibility and we are completing a new SOC to initiate a new episode under Medicare PPS. When answering M0110, should the previous 2 episodes, which were billed to, but denied by the intermediary, be considered when counting adjacent episodes or should they be ignored, since payment under Medicare PPS was denied? For the purposes of defining Medicare PPS episodes for M0110, does it mean the episode was BILLED AND PAID by Medicare PPS, or just that it was BILLED to the Medicare via the RHHI?

**Answer 3:** At this time, when an agency bills Medicare via the RHHI, an episode is created in the Common Working File (CWF), even if the claim is denied. This payment system problem is in the process of being resolved. Denied episodes should not be counted when determining the correct response to M0110 episode timing.

#### **M0350**

**Question 4:** Guidance related to M0350 Assisting Persons Other than Home Care Agency Staff suggests that we are to consider using response #3 when a patient receives Meals-on-Wheels. In some of our rural areas the individuals who deliver the meals are volunteers. Since they are volunteers, it seems that “*Response 3 – Paid help*”, would be inappropriate. Would “*Response 1 – Relatives, friends, or neighbors living outside the home*” be more appropriate since in this situation the one who delivers the meal could very well be a neighbor?

**Answer 4:** While the actual individual who delivers the meals may be volunteering as a community service, if the patient (or family or non-agency community program) is providing funding for the Meals-on-Wheels service, or a similar community organization, to deliver meals, “*Response 3 - Paid help*” would be appropriate for M0350. If a neighbor is providing meals to the patient and is not working on behalf of a service organization that is reimbursed by the patient or any entity, then the appropriate response would be “*1-Relatives, friends, or neighbors living outside the home*”.

#### **M0390**

**Question 5:** Our patient has dementia and is unable to answer questions related to his vision appropriately or read a medication bottle out loud. He has no obvious visual problems as outlined in M0390 response 1 or 2. How does a clinician correctly answer this question given this level of verbal impairment?

**Answer 5:** When a patient is cognitively impaired, the clinician will need to observe the patient functioning within their environment and assess their ability to see functionally. Does it appear the patient can see adequately in most situations? Can they see eating and grooming utensils? Do they appear to see the buttons on their shirt/blouse? If so, the patient would be reported as a “*0-Normal vision*” even though the constraints of the dementia may not allow the patient to communicate whether they can see newsprint or medication labels.

#### **M0445**

**Question 6:** When answering M0445, how is a pressure ulcer that has been sutured closed categorized?

**Answer 6:** Since it is relatively uncommon to encounter direct suture closure of a pressure ulcer, it is important to make sure that the pressure ulcer was not closed by a surgical procedure (such as skin advancement flap, rotation flap, or muscle flap). A pressure ulcer that is sutured closed (without a flap procedure) would still be reported as a pressure ulcer.

While this approach (direct suture closure) may rarely be attempted due to a low success rate, home care providers are reporting occurrence. Appropriate guidance for answering the M0450, M0460 and M0464 items would still be found in the WOCN OASIS Guidance Document. While the wound bed of a pressure ulcer sutured shut may not be obscured by necrotic tissue or a non-removable dressing, responses to questions relative to staging (e.g., M0450/460) will need to be reported as no observable pressure ulcer. The response to the question relative to status (e.g., M0464) would suggest early/partial granulation, unless specific signs of non-healing are present.

### **M0482**

**Question 7:** Is an implanted mechanical left ventricle device (LVAD) that has an air vent exiting through lower right abdomen a surgical wound?

**Answer 7:** The Left Ventricular Assist Device's (LVAD/HeartMate) cannula exit site would be considered a surgical wound until the LVAD is discontinued and the wound heals and becomes a lesion.

### **M0482**

**Question 8:** An I&D is not considered a surgery - but a drain inserted during this procedure makes the wound a surgical wound. Dilemma: This makes the OASIS answer for surgical wound a yes but we cannot code aftercare because we don't code the I&D as a surgery - but we do have surgical wound care. This is quite confusing.

**Answer 8:** The OASIS M0 item response will not always mirror diagnoses and ICD-9 codes found in M0230 and M0240. Continue to score the OASIS following current CMS guidance, and follow ICD-9 CM coding guidance for code selection for M0230 and M0240.

**Question 9:** If staples remain in a surgical wound, would it be considered as not healing?

**Answer 9:** A surgical wound with staples in place would only be considered not healing if it meets the WOCN Guidance on OASIS Skin and Wound Status M0 Items' definition of not healing. The WOCN guidance can be found at [www.wocn.org](http://www.wocn.org). Presence of staples, in and of themselves, do not meet the WOCN criteria for non-healing.

**Question 10:** Is a chest tube site a surgical wound?

**Answer 10:** A chest tube site is a thoracostomy. All ostomies are excluded from consideration as a wound or lesion at M0440, Open Wounds or Lesions and therefore should not be considered in any of the subsequent OASIS wound items. A chest tube site is not a surgical wound even if a chest tube or drain is present.

### **M0482; M0488**

**Question 11:** When does a surgical wound become "healed" or no longer reportable as a surgical wound on M0482?

**Answer 11:** For the purposes of determining the healing status for this OASIS item, a surgical wound can be considered fully healed and not reportable as a current surgical wound 4 weeks after complete epithelialization. The incision must be clean, dry and completely closed with no signs or symptoms of infection. The resulting scar continues to be reported as a wound/lesion (M0440) and not a surgical wound (M0482-M0488).

### **M0488**

**Question 12:** Does the presence of a "scab" indicate a non-healing wound?

**Answer 12:** A scab is a crust of dried blood and serum and should not be equated to either avascular or necrotic tissue when applying the WOCN guidelines. Therefore while the presence of a scab does indicate that full epithelialization has not occurred in the scabbed area, the presence of a scab does not meet the WOCN criteria for reporting the wound status as "not healing".

This represents a retraction of previous guidance that indicated a scab was considered avascular or necrotic tissue, and therefore an indicator of a non-healing surgical wound.

*(Note: This new CMS guidance will supersede prior guidance found in CMS OASIS Q&As; Category 4, Questions 112.1, 112.2, and 112.3)*

### **M0520**

**Question 13:** If a patient that has a history of UTI and incontinence, had a urinary catheter in place at the Start of Care (SOC), but the orders are to remove the catheter during the SOC visit, how should we respond to M0520?

**Answer 13:** When a patient's status varies on the day of the assessment, the clinician reports what is true greater than 50% of the time. If the catheter was pulled during the visit, "*Response 2 – Patient requires a urinary catheter*" would be selected since the catheter was present greater than 50% of the day under consideration.

Don't let this guidance related to the majority of the time confuse you when considering whether or not the patient is incontinent. M0520 is asking what's true on the day of the assessment. Does the patient have a condition on the day of assessment that requires a catheter or causes episodes of incontinence as evidenced by involuntary leakage of urine? The incontinence does not have to occur on the day of assessment, it may only occur occasionally, only once-in-a-while or when coughing, but the condition resulting in the incontinence must be present on the day of the assessment, e.g. weakened pelvic floor or bladder muscles, overactive bladder, neurological conditions, inflammation, prolapsed organs, limited mobility, etc.

### **M0590**

**Question: 14** If a patient is on an antidepressant and symptoms are fairly well controlled, how would M0590 be answered?

**Answer 14:** M0590 reports whether or not the patient has symptoms of depression, either observed or reported. The time period under consideration is the day of assessment and the recent pertinent past (as determined by the assessing clinician). If the patient does not have symptoms of depression as a result of an antidepressant drug regimen, then the appropriate response would be "*6 - None of the above feelings observed or reported*". If the patient is taking an antidepressant medication and still demonstrates or reports depressive symptoms, then one or more M0590 responses may be reported, dependent on the specific symptom(s) observed/reported.

### **M0690**

**Question 15:** For M0690, Transferring, does the transfer from bed to chair include evaluation from a seated position in bed to a seated position in a chair or from supine in bed to seated in a chair? How does the location of a chair affect the assessment? For example, is the transfer from bed to chair assessed when the environment does not allow for placement of a chair next to the bed and the patient must walk to the next room to reach one?

**Answer 15:** M0690 assesses the patient's ability in safe performance of three specified transfers: bed to chair, on and off the toilet or commode and into and out of the tub/shower. The bed to chair transfer includes the patient's ability to get from the bed to a chair. For most patients, this will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair.

If the patient is unable to perform one of the specified transfers due to an environmental barrier (e.g. there is no toilet or commode in the home, no tub/shower or chair in which to transfer from the bed), then M0690 would report the patient's ability in the performed transfers. If the patient's ability varies among the performed transfers, the clinician should select a response that reflects the patient's ability in a majority of the most frequently performed transfers.

### **M0790**

**Question 16:** Is prescription nasal spray considered an inhalant medication (e.g., Flonase) for M0790? What about over the counter nasal spray (e.g., saline nasal mist)?

**Answer 16:** M0790 includes all prescribed and over-the-counter inhalant/mist medications included on the plan of care. Management of both the prescription Flonase and the OTC saline spray would be considered when responding to M0790.

### **M0800**

**Question 17:** Our patient has orders for Vitamin B12 to be injected by the RN once a month and SQ Insulin to be injected by the patient 3 times a day. How would M0800 be reported in this situation?

**Answer 17:** When completing M0800, Management of Injectable Medications, the clinician must consider all prescribed injectable medications that the patient is receiving in the home. In situations where the patient's ability to inject their various medications varies on the day of assessment, the clinician must report what is true in a majority of the scheduled injectable doses of medication.

In the situation described, the patient self injects insulin 3 times a day and the Vitamin B12 injection is administered by the RN only once a month. Since the order requires the nurse to administer the Vitamin B12, the patient would be considered unable to administer that medication. But, since the insulin is administered more frequently (3 times a day), the clinician should report what the patient's ability is to administer the insulin and not consider the ability to administer the once a month injection.

### **M0810, M0820**

**Question 18:** When completing M0810 and M0820, Patient/Caregiver Management of Equipment, is there a consideration for people who use the larger portable oxygen tanks versus the smaller tanks? Some of our patients use liquid oxygen and have the equipment available in the home to refill their tanks. Other patients get the larger oxygen tanks from the DME company. A person may have the ability to fill a larger tank but it is not feasible to have this equipment available in the home. The same question could apply to the various types of IV bags, equipment or solutions used for IV/infusion therapy.

**Answer 18:** M0810/820, Patient/Caregiver Management of Equipment, reports the patient/caregiver's ability to set up, monitor and change the equipment that is in the home on the day of the assessment. You do not report what the patient would be able to do if different size tanks or different IV bags or solutions were available. Report the patient's ability on the day of assessment with the equipment they currently have.

### **M0840**

**Question 19:** A patient went to an urgent care center (M0830) because of worsening oral thrush symptoms with increased (new) oral lesions. Would M0840 – Emergent Care Reason be marked as “5 - *Wound infection, deteriorating wound status, new lesion/ulcer*”? M0440 - refers only to lesions to the integumentary system; is that also true for M0840?

**Answer 19:** M0840, Response 5, would report emergent care of any wound infection, deteriorating wound status or new lesion or ulcer, (e.g. skin, eyes, oral cavity, nasal, vaginal, rectal).