

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

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January 20, 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 January 10, 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.qtso.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,  
Patricia M. Sevast, BSN, RN  
Nurse Consultant  
Survey and Certification Group  
Centers for Medicare & Medicaid Services

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



## CMS OCCB Q&As – January 2010

### CMS Guidance Manual – Chapter 3 Update

**Question 1:** The item page for M0100 (page B-3 in the OASIS-C Guidance Manual) directs the clinician to “Go to M0906” for an RFA 8 – Death at Home. The “Go to” instruction in the OASIS data set is to “Go to M0903”. Which is correct?

**Answer 1:** The OASIS data set, indicating a “Go to M0903” is correct.

#### CATEGORY 4a – General

##### Referring back to previous documentation to complete OASIS

**Question 2:** How should we complete M2400 Intervention Synopsis at the SOC/ROC if we are not allowed to refer back to previous assessment time points?

**Answer 2:** When completing items in the OASIS-C data set at Transfer and Discharge, there are a number of items that will require the clinician to complete a record review in order to answer the item correctly, including:

##### At Transfer and DC

Immunization Items: M1040- Influenza Vaccine, M1045-Reason Influenza Vaccine not received, M1050-PPV, M1055-Reason PPV not received

Heart Failure Items: M1500-Symptoms in Heart Failure, M1510-Heart Failure Follow-up

Medication Items: M2004-Medication Intervention, M2015-Patient/Caregiver Drug Education Intervention  
Emergent Care Items: M2300-Emergent Care, M2310-Reason for Emergent Care

##### At DC

M1307-Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge

M1308-Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

M2400-Intervention Synopsis

M0906-Date of Last (Most Recent) Home Visit

Note, this is not an all inclusive list, as clinicians may need to refer back to prior documentation to determine the answer to other OASIS items such as how frequently pain interferes with activity or movement. In situations when a clinician is discharging a patient who is unknown to them, they may not have the knowledge of how often pain interfered with activity or movement. If the patient is a poor historian, it may require referencing prior clinical notes to answer the item accurately.

##### Process measures reporting communication w/physician

**Question 3:** Regarding CMS OASIS OCCB 10/09 Q&A #32, what is meant by “communication can be directly to/from the physician, or indirectly through physician’s office staff on behalf of the physician, in accordance with the legal scope of practice.”? Can the physician’s secretary be considered Office staff if she/he speaks directly to the physician with the clinician’s questions and then gives the information directly back to the clinician?

**Answer 3:** The reference to “in accordance with the legal scope of practice” refers to the State requirements defining who can take orders from physicians. Each HHA should have a policy and procedure consistent with State law that describes who can take orders from the physician. In most States it is going to be a clinician. It is important to understand that all orders must come from the physician and eventually be signed by the physician.

## CATEGORY 4b

### **M0102**

**Question 4: If the physician provides a range of dates in which home care should begin (for example, “begin care 3/1/2010 or 3/2/2010”), what date should be reported for M0102?**

**Answer 4:** In order to be considered a physician-ordered SOC date the physician must give a specific date to initiate care, not a range of dates. If a single date to initiate services is not provided, the initial contact (via the initial assessment visit) must be conducted within 48 hours of the referral or within 48 hours of the patient's return home from the inpatient facility.

### **M1040/M1050**

**Question 5: Due to state law and/or agency policies, some home health staff may not be allowed to transport meds (including vaccines)? Patient and/or the family members might need to pick the vaccine up for the agency to administer. How would the agency get credit for these outcome measures?**

**Answer 5:** The process measures describing the best practice gives credit not only when the agency provides the immunization(s) (regardless of who transports the vaccine to the patient's home), but the agency also may get credit by facilitating the patient's receipt of the immunization through other health care providers. This facilitation will be represented in M1045 and M1055, and computation of these related process measures will rely on both M1040 and M1045 (for influenza) and M1050 and M1055 (for pneumonia).

### **M1100**

**Question 6: Does the rule that the availability of a call bell equates to “around the clock care” apply only to the ALF setting, or if one is available in congregate housing would the availability of assistance in that situation also be reported as around the clock availability of assistance as well?**

**Answer 6:** If, in a congregate housing situation, the patient has available in-person assistance in response to a call bell 24 hours a day, the correct answer would be "around the clock."

### **M1100**

**Question 7: Is there a designated block of time that would define “regular daytime” or “regular nighttime” for M1100? For example is “regular daytime” 12 hours or during daylight hours?**

**Answer 7:** When completing M1100, clinical judgment must be used to determine which hours constitute "regular daytime" and "regular nighttime" for each patient based on their specific activities and routines. No hours are specifically designated as daytime or nighttime.

### **M1100**

**Question 8: How do you answer M1100, Patient Living Situation, when the patient lives with their family member and the family member is being paid to care for the patient, either by the patient or by a state funded program?**

**Answer 8:** When answering M1100, Patient Living Situation, if a patient lives with their family, Row b., Patient lives with other person(s) in the home, would appropriately depict their living arrangement, even if the patient pays their family member to provide care or the family member is being paid through another source, e.g. another family member or state funded program.

### **M1510**

**Question 9: In M1510 where we are reporting the actions taken in response to heart failure symptoms, are we allowed to consider interventions that take place over the phone when answering this item or must we only consider the interventions that occur face to face during a home visit? Many agencies use telehealth and may not be making face-to-face visits but adequately intervening in cases of increased weight gain etc.**

**Answer 9:** Interventions provided via the telephone or other telehealth methods utilized to address heart failure symptoms could be reported on M1510, Heart Failure Follow-up.

### **M1800 Series**

**Question 10: OASIS-C excluded shampooing of hair from bathing and grooming...Do you see this as being captured any other place?**

**Answer 10:** Shampooing of the hair is excluded from both the Bathing and Grooming items in OASIS B-1 and OASIS-C. Shampooing may be included as one of the ADLs in M2100, Types and Sources of Assistance, as this question is concerned broadly with types of assistance, not just the ones specified in other OASIS items.

### **M1810/M1820**

**Question 11: OASIS guidance is clear that if a patient adapts/modifies their environment (e.g. where items are stored, location of bedroom etc.) that if that change is intended to be permanent then it becomes their usual storage area when answering ADL questions. Would the same guidance apply if the patient has changed the type of clothing they wear? If the type of clothing they wear has been changed due to their condition, is there a time frame at which point this “new” clothing becomes “permanent /usual”?**

**Answer 11:** If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the "routine" clothing.

The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.

### **M1830**

**Question 12: How do you answer M1830, Bathing, if the patient has no tub and only needs help washing hard to reach areas? Are they a “4” – independent in bathing outside of tub/shower or “5” – requires supervision/assist throughout the bath outside of tub/shower? Neither response seems to exactly apply.**

**Answer 12:** If there is a barrier preventing the patient from bathing safely in a tub/shower and the patient needs intermittent assistance to wash their entire body safely at a sink, in a chair or on a commode, the appropriate score would be a 5, even though response option 5 refers to the patient using assistance or supervision of another person *throughout the bath*. In order to score a 4, the patient must be able to safely bathe without any human assistance at some site outside the tub/shower (e.g., at the sink, in a chair, on the commode).

### **M1850**

**Question 13: Is M1850 Transferring assessed for the patient who has slept for years in a recliner?**

**Answer 13:** M1850, Transferring, must be assessed for all patients requiring OASIS data collection. The item includes assessment of the bed to chair/chair to bed transfers. If your patient no longer sleeps in a bed (e.g. sleeps in a recliner or on a couch), you will assess the patient's ability to move from the supine position on their usual sleeping surface to a sitting position and then transfer to another sitting surface, like a bedside commode, bench, or chair.

### **M1910**

**Question 14: Which falls risk assessments meet the OASIS-C criteria for “multi-factor” and “validated?”**

**Answer 14:** CMS does not endorse the use of any specific falls risk assessment tool. To meet the OASIS-C criteria for best practice assessment, the multi-factor falls risk assessment must consist of or include a standardized tool that 1) has been scientifically tested on a population of community dwelling elders and shown to be effective in identifying people at risk for falls; and 2) includes a standard response scale. It is the agency's responsibility to determine if the tools they are considering for the OASIS-C M item best practice assessments meet the requirements as detailed in Chapter 3 of the OASIS-C Guidance Manual and the CMS OASIS OCCB Q&As. An agency may use a standardized falls risk tool

from any organization able to effectively develop, test and validate the tool for use on a population of community dwelling elders.

#### **M1910**

**Question 15: We are having some difficulty in verifying the need for a standardized fall risk assessment tool to answer question M1910. In the guidance section, it is stating there is NOT a mandate for the use of standardized tools. However, in the question and answer, Question 14 it is stating YES under Standardized Assessment Required. We are using a multi-factor risk assessment screening with six questions, consisting of the six areas noted in question M1910. Is this okay to do and then answer yes to this question?**

**Answer 15:** When the guidance states standardized tools are not mandated, it means CMS does not mandate their use as a condition of participation. However, if you want to answer the OASIS Process Measure items "Yes" or "NA", you must use a standardized tool for M1240, Pain Assessment, M1730, Depression Screening, and M1910, Fall Risk Assessment, as specified in the item.

A standardized tool is one that has been scientifically tested and validated as effective in identifying a specified condition or risk in population with characteristics similar to the patient being evaluated. A standardized tool includes a standard response scale, and must be appropriately administered based on established instructions. To meet the need of the pain assessment, the depression screen or the multi-factor fall risk assessment referenced in the OASIS, an agency may use a standardized tool from any organization able to effectively develop, test, and validate the tool for use on a population similar to that of the patient(s) being assessed. Without the validation process, an agency may not simply create an assessment by combining clinical assessment factors, unless the OASIS item indicates that the assessment can be based on clinical judgment, such as M1300, Pressure Ulcer Risk.

For M1910, the agency can use a multi-factor, standardized, validated fall risk assessment tool, or alternatively, a standardized, validated performance assessment, like the TUG (Timed Up and Go) or Functional Reach Assessment, combined with at least one other factor, e.g. fall history, polypharmacy, impaired vision, incontinence, etc. to meet the requirements of the multifactor, standardized validated fall risk assessment. It is the agency's responsibility to determine if your tool includes these elements. If an agency has evidence (from published literature, the tool developer, or another authoritative source) that the tool they are using assesses multiple factors that contribute to the risk of falling, has been scientifically tested and validated on a population of community dwelling elders, has been shown to be effective in identifying people at risk for falls, and includes a standardized response scale, then the agency can consider the tool to meet the requirements for the OASIS-C best practice assessment.

#### **M2002**

**Question 16: If a clinically significant medication issue is identified on a weekend, and the agency phones the physician on-call, who does respond but because he doesn't really know the patient directs the agency to contact the primary care physician on Monday, can the clinician select Response 1 Yes – Physician or physician-designee was contacted within one calendar day to resolve clinically significant medication issues?**

**Answer 16:** When completing M2002, Medication Follow-up, if the physician or physician designee responds within one calendar day and there is a resolution to the clinically significant medication issue or a plan to resolve the issue, Response "1-Yes" should be selected. In your scenario, you describe a situation where the physician was contacted and informed of the medication issue, but the due to the contacted physician's unfamiliarity with the patient, you were directed to contact the primary care practitioner on Monday. Therefore no one reconciled, or formulated a plan to reconcile the specific medication issue identified within one calendar day, so "0-No" should be selected.

#### **M2002**

**Question 17: I am aware that in order to mark response "1 - Yes", the two-way communication AND plan for reconciliation must be completed by the end of the next calendar day after the problem was identified. Does that "next calendar day" have to be within the 5 days after the SOC? That is if the nurse finds a problem with the patient's meds while completing the comprehensive assessment on day 5 after the SOC, and the physician is notified and the problems are reconciled but not until day 6 after the SOC, (although it is within the one calendar day), can "1 - Yes" be marked?**

**Answer 17:** M2002, Medication Follow-up, is only collected at the SOC and ROC. The item must be answered within the timeframe allowed at the SOC/ROC to ensure compliance with the Condition of Participation regarding the completion of the comprehensive assessment. If a problem is identified, the communication and reconciliation (or plan to resolve the problem) must occur within one calendar day of identification and before the end of the allowed timeframe in order to answer "1 - Yes."

If a medication issue is identified on day 5 after the SOC, the physician is contacted within one calendar day and responds back with a plan for reconciliation on day 6 after the SOC, this 2-way communication could not be captured at the SOC, but M2002 could be marked "1 -Yes" at a ROC time point, reflecting that the identification and 2-way communication w/plan for reconciliation had occurred as required by the item.

#### **M2004**

**Question 18: M2004 relates to clinically significant medication issues arising “since the previous OASIS assessment”. If no other OASIS assessments were done between the SOC/ROC and the transfer/discharge (when M2004 is being collected), should the response at transfer/discharge include the medication issues reported at the SOC/ROC OASIS, if no other clinically significant medication issues occurred after the SOC/ROC?**

**Answer 18:** M2004, Medication Intervention, should report if there were any clinically significant medication issues identified at the time of or since the previous OASIS assessment and is collected only at Transfer and Discharge. If the last OASIS assessment completed was the SOC or ROC, and a clinically significant problem was identified at that SOC or ROC visit, the problem (and/or related physician communication) would be reported at both the SOC/ROC (on M2002), and again at Transfer or Discharge (on M2004), since the time frame under consideration for M2004 is since OR AT the previous OASIS assessment.

#### **M2010/M2015**

**Question 19: How would Patient/Caregiver Drug Education for M2010 and M2015 be impacted for patients living in assisted living where the medications are managed by facility staff?**

**Answer 19:** When completing the OASIS process measures that address patient/caregiver education, M2010, Patient/Caregiver High Risk Drug Education and M2015, Patient/Caregiver Drug Education, for patient's residing in an assisted living facility, it may be appropriate to educate the patient and/or the staff administering the medication on the topics included in each item. As with patients who live at home, the decision to direct the teaching to the patient, caregiver, or both should be made by the assessing clinician, based on the specific circumstances. For the purposes of selecting a response, the facility staff would be considered caregivers.

#### **M2010/M2015**

**Question 20: It states in Chapter 3 for M2010 and M2015 “If agency staff other than the clinician responsible for completing the SOC/ROC OASIS provided education to the patient/caregiver on high-risk medications, ...this collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and ultimately must be completed by one clinician.” Could this education include an office nurse giving the education over the phone to the patient?**

**Answer 20:** A clinician other than the assessing nurse or therapist may provide drug education in person or by phone to the patient and/or caregiver. If the assessing clinician has knowledge this has been done, he/she may take credit for the education by selecting “Yes” in M2010 – High Risk Drug Education, or M2015 – Drug Education, whichever applies.

#### **M2020**

**Question 21: How would we score M2020 Management of Oral Medications when a client needs reminders to take a medication on an as needed basis such as pain medication or extra dose of Lasix if weight increases by 5 lbs?**

**Answer 21:** In M2020, Management of Oral Medications, you are reporting the level of assistance the patient needs on the day of the assessment to be safe when managing ALL oral medications; therefore you report the level of assistance for the most dependent medication. If the medication is ordered

prn, and on the day of assessment the patient needed a reminder for this prn, then the patient would be a "2". If on the day of assessment, the patient did not need any prn medications, therefore no reminders, then assess the patient's ability on all of the medications taken on the day of assessment.

### **M2100**

**Question 22: Which category of assistance would taking care of a wound VAC fall under...Row (d) Medical Procedures or would it be considered Row (e) Management of Equipment?**

**Answer 22:** The application/changing/removal of the wound dressing, including the foam and drape used with a wound VAC would constitute a "Medical procedure" as other dressing changes do. This would be considered and reported under Row d, Medical procedures. The emptying of the VAC canister or the disconnection/reconnection to the VAC for short times to allow certain activities would be considered management of the equipment and would be included under Row e, Management of equipment.

### **M2250 - Depression**

**Question 23: M2250 - If the patient has a diagnosis of depression but no symptoms per the standardized tool, can the clinician choose "NA".**

**Answer 23:** No. NA is only appropriate if the patient has NO diagnosis of depression AND the clinician completed an assessment that indicated the patient has no symptoms of depression (or does not meet criteria for further evaluation or treatment if a standardized depression screening tool was used).

### **M2250**

**Question 24: Many of the areas related to M2250 - Plan of Care Synopsis follow evidence-based practice. Use of fall prevention interventions, instruction in proper foot care for diabetic patients, pressure ulcer prevention education, and ongoing pain assessment/monitoring are all good clinical practices that routinely implement without specific physician's orders. Are we now required to obtain physician's orders for these general care practices?**

**Answer 24:** It is understood that some of the best practices captured in M2250 includes care that might be routinely provided to a patient without a specific order. For instance, you may be admitting a patient for wound care, and in the process of your assessment, encounter a fall risk, like clutter on the floor. You might resolve the issue through intervention or education, all without obtaining a physician's order. However, if your agency wants to "get credit" for conducting this fall prevention intervention (by marking "yes" on M2250 (c)), you must have an order for fall prevention interventions.

### **M2250**

**Question 25: For M2250 - Plan of Care Synopsis.**

**Item Intent** states that this identifies if the physician-ordered home health plan of care incorporates specific best practices. The "physician ordered plan of care" means that the patient condition has been discussed and there is agreement as to the plan of care between the home health agency staff and the physician.

**Response - Specific Instructions** states that the question can be answered "Yes" prior to the receipt of signed ordered *if* the clinical record reflects evidence of communication with the physician to include specified best practice interventions in the plan of care.

In order to report on M2250 that physician orders exist, does that initial verbal/faxed communication need to include details of the specified best practice interventions (e.g. fall prevention interventions, pain monitoring, specific clinical parameters requiring physician notification, etc.)?

Could it be determined that all these specific best practice orders were present if the communication with the physician were more general (like the patient's clinical findings are discussed with the physician and there is an agreement as to the general POC between the admitting clinician and the physician. Then the formal detailed POC is sent to the physician for signature, outlining the specific parameters and interventions)?

**Answer 25:** The OASIS-C process measures are not changing the expectations and requirements for communicating with the physician to obtain verbal orders prior to providing services.

The Medicare Benefit Policy Manual, defines clearly how orders can be obtained verbally if complete orders were not provided in the referral. Chapter 7, Section 30.2.5 states:

"Services which are provided from the beginning of the 60-day episode certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care."

All orders would be under the same instruction from CMS, including those which are reported in M2250 and M2400.

#### **M2250/M2400**

**Question 26: Does the inclusion of existing ordered antidepressant medications on the medication profile equate to a "Yes" response to Depression Interventions on M2250 and/or M2400?**

**Answer 26:** M2250, Plan of Care Synopsis and M2400, Intervention Synopsis, report whether the physician ordered plan of care includes depression interventions. The presence of an existing antidepressant medication in the medication profile/plan of care is considered a depression intervention.

#### **M2310**

**Question 27: If a patient goes to the hospital emergency department for a suspected DVT and scans/tests rule out DVT, is the correct response for M2310 #18 (Deep Vein Thrombosis, pulmonary embolus) or #19 (Other than above reasons)?**

**Answer 27:** M2310, Reason for Emergent Care, reports the reason the patient sought emergent care. In the situation you described, the patient sought care for a suspected DVT, even though the result of the evaluation was negative for a DVT, it was the reason they sought care and Response 18, Deep Vein Thrombosis, would be appropriate.

#### **M2250 – Patient Specific Parameters**

**Question 28: A clinician assesses the patient at SOC and calls the physician with a report and to discuss the POC. The clinician asks if the physician would like a report of abnormal vital signs during the episode and recites the parameters found in the agency's standardized guidelines. The physician says "Yes" and the order with the parameters are printed on the POC for his signature.**

**Is this considered "patient specific parameters" resulting in a YES response for row a?**

**Answer 28:** If the physician agrees that the agency's standardized parameters would meet the needs of this specific patient, they would become patient specific parameters.

#### **M2400**

**Question 29: The "NA" column of M2400 refers to use of a "formal" assessment tool". Does formal mean standardized? Is the clinician allowed to respond "yes" (interventions on the POC and implemented) if a formal/standardized tool was not used in the assessment of b through e?**

**Answer 29:** Chapter 3 Item Intent states "The formal assessment that is referred to in the last column for rows b-e refers to the assessment defined in OASIS items for M1240 – Formal Pain Assessment, M1300 – Pressure Ulcer Assessment, M1730 – Depression Screening, and M1910 – Fall Risk Assessment." For M1240, M1730, and M1910 this means a standardized assessment. For M1300 – Pressure Ulcer Assessment, the use of a standardized assessment tool is optional.

You may say "Yes" to M2400 b - e, if the specified clinical interventions were included in the physician ordered plan of care and implemented at the time of or since the previous assessment whether or not a formal assessment was performed. However, the Response Specific Instructions state that for Rows b-e, in order to select "NA-Not applicable", a formal assessment must have been performed as defined in the relevant OASIS items.