

## Quality Measures and Health Assessment Group

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July 27, 2006

Linda Krulish, President  
The OASIS Certificate and Competency Board, Inc  
223 East Main Street  
New Iberia, LA. 70560

Dear Ms. Krulish:

Thank you for your letter of May 5, 2006 in which you ask a number of questions to determine accurate responses to Outcome and Assessment Information Set (OASIS) items. The responses were reviewed by CMS staff and CMS contractor, Kathryn Crisler, MS, RN, University of Colorado, Center for Health Services Research, and we have achieved consensus on the responses. You may use these responses in your educational program for the OASIS Certificate and Competency, Board, Inc. (OCCB). We will consider using these questions and answers when we revise the OASIS User Manual, Chapter 8, Item –by-item Tips available later this summer at:  
[http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp)

Sincerely,

//s//

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Quality Measures and Health Assessment Group  
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Cc: Pat Sevast, CMSO  
Kathryn Crisler, UCHSR

## CMS OCCB Q&As – July 2006

### Initial Assessment Visit:

**Question 1: One of the time requirements outlined in the CoPs for the initial assessment visit is that it must be conducted “within 48 hours of referral”. Does “referral” mean referral from a physician, or referral from anyone (e.g., the patient, family, assisted living facility)? Sometimes when we are contacted by the patient or family member, physician’s orders for home care may not exist. Does the “clock” for the 48 hours start when the patient/family contacts the agency requesting services, or when the physician provides orders?**

Answer 1: “Referral” refers to the referral from a physician (or designee) for home care evaluation and/or services. The referral may come in the form of initial contact by the physician’s office, a hospital discharge planner or even the patient or family member, who may be in possession of the written physician’s orders for home care.

If a patient or family member makes initial contact with the agency and has not discussed and/or received home care orders from the physician for a referral for home care, then this is not considered a “referral” for the purposes of determining compliance with conducting the initial assessment visit. In this case, the agency should contact the physician to obtain necessary orders, and then conduct the initial assessment visit within 48 hours of that referral, within 48 hours of the patient’s discharge from an inpatient facility, or on the physician’s ordered start of care date.

### M0090

**Question 2: The RN conducted the SOC assessment on Monday. The RN waited to complete the assessment until she could confer with agency therapists after they had completed their therapy evaluations. This communication occurred on Tuesday and included a discussion of the plan of care and the therapists’ input on the correct response for M0825. If the RN selects a response for M0825 based on the input from the therapists, does this violate the requirement that the assessment is to be completed by only one clinician? And what is the correct response for M0090, Date Assessment Completed?**

Answer 2: Tuesday would be the correct date for M0090. Tuesday was the date the assessing clinician gathered all the information needed to complete the assessment including M0825. In this case, the assessing clinician appeared to need to confer with internal agency staff to confirm the plan of care and the number of visits planned. M0825 is an item which is intended to be the agency’s prediction of the number of therapy visits expected to be delivered in the upcoming episode, therefore, an agency practice may include discussion and collaboration among the interdisciplinary team to determine the M0825 response and this would not violate the requirement that the assessment be completed by one clinician.

### M0100

**Question 3: I understand that when calculating the days you have to complete the comprehensive assessment, the SOC is Day “0”. At the other OASIS data collection time points, when you are calculating the number of days you have to complete an assessment, is the time point date, Day “0”, e.g. for RFA 9, Discharge from Agency, the assessment must be completed within 2 calendar days of M0906, Disch/trans/death date. Is M0906 Day “0”?**

Answer 3: Yes, when calculating the days you have to complete the comprehensive assessment, the SOC date is day "0". For the other time points the date of reference (e.g., transfer date, discharge date, death date) is day "0".

Note that for the purposes of calculating a 60 day episode, the SOC day is day "1".

**Question 4: A patient is admitted to the hospital for knee replacement surgery. During the pre-surgical workup, a test result caused the surgery to be canceled. The patient only received diagnostic testing while in the hospital but the stay was longer than 24 hours. Does this situation meet the criteria for RFA 6 or 7, Transfer to Inpatient Facility?**

Answer 4: No, under the circumstances described, the patient did not meet the OASIS transfer criteria of admission to an inpatient facility for reasons other than diagnostic testing, if the patient, indeed, did not have any other treatment other than diagnostic testing during their hospitalization. If the patient received treatment for the abnormal test result, then the situation, as described, would meet the criteria for RFA 6 or 7, Transfer to Inpatient Facility.

**Question 5: What do we do if the agency is not aware that the patient has been hospitalized and then discharged home, and the person completing the ROC visit (i.e., the first visit following the inpatient stay) is an aide, a therapist assistant, or an LPN?**

Answer 5: When the agency does not have knowledge that a patient has experienced a qualifying inpatient transfer and discharge home, and they become aware of this during a visit by an agency staff member who is not qualified to conduct an assessment, then the agency must send a qualified clinician (RN, PT, OT, or SLP) to conduct a visit and complete both the transfer (RFA 6) and the ROC (RFA 3). Both assessments should be completed within 2 calendar days of the agency's knowledge of the inpatient admission. The ROC date (M0032) will be the date of the first visit following an inpatient stay, conducted by any person providing a service under your home health plan of care, which, in your example would be the aide, therapist assistant, or LPN.

The home health agency should carefully monitor all patients and their use of emergent care and hospital services. The home health agency may reassess patient teaching protocols to improve in this area, so that the patient advises the agency before seeking additional services.

**Question 6: The CoPs require that the comprehensive assessment be updated within 48 hours of the patient's return home from the hospital. The OASIS Assessment Reference Sheet states that the Resumption of Care assessment be completed within 2 calendar days of the ROC date (M0032), which is defined as the first visit following an inpatient stay. Does this mean that the ROC assessment (RFA 3) must be at least started within 48 hours of the patient's return home, but can take an additional 2 days after the ROC visit to complete?**

Answer 6: No. When the agency has knowledge of a hospital discharge, then a visit to conduct the ROC assessment should be scheduled and completed within 48 hours of the patient's return home.

**Question 7: I accidentally completed the RFA 4 – Recertification assessment early (on day 54) for my Medicare patient. I did not realize this until I was into the next certification period. Should I do a new assessment or can the early assessment be used to establish the new case mix assignment for the upcoming episode?**

Answer 7: Whenever you discover that you have missed completing a recertification for a Medicare patient within the required time frame (days 56-60), you should not

discharge that patient and readmit, or use an assessment that was completed prior to the required assessment window. As soon as you realize that you missed the recert window, make a visit and complete the recertification assessment. You are out of compliance and will receive a warning from Haven or Haven-like software. Efforts should be made to avoid such noncompliance by implementing processes to support compliance with required data collection time frames.

### **M0150**

**Question 8: Do I mark response 1, Medicare (traditional fee-for-service) if the patient's payer is VA?**

Answer 8: If the patient has both VA and Medicare and both are expected payers, then you need to mark Response 1, Medicare (traditional fee-for-service) and Response 7, Other government (e.g. CHAMPUS, VA, etc.). But if the patient does not have Medicare, or Medicare is not an expected payer for provided services, then Response 7, Other government (e.g. CHAMPUS, VA, etc.) would be the correct response.

**Question 9: If a patient is receiving Meals-on-Wheels services, do you capture the payment for the service as a Response 10; Self Pay on M0150 Current Payment Sources for Home Care?**

Answer 9: No, food is not considered within the scope of M0150. Most patients pay for their food, whether they purchase it directly, a caregiver purchases and delivers it, or a service such as Meals-on-Wheels is utilized.

**Question 10: On M0150, since Response "10" – Self Pay should be marked for a patient who pays for their medications, should Response "1" Medicare (traditional fee-for-service) be marked for a patient whose medications are expected to be paid for in part by the Medicare drug benefit?**

Answer 10: No, M0150 is limited to identifying payers to which any services provided during this home care episode, and included on the home health plan of care will be billed by your home care agency. We are retracting a Q&A released in 06/05 which extended the scope of M0150 to include reporting of "self pay" as a pay source for non-services (i.e. DME or medications) that are paid in part or full to a DME vendor or drug store for equipment or medications essential or integral to the home care episode. M0150 does not include payment for equipment, medications or supplies, and is limited to only services provided and billed for by your Medicare certified agency.

### **M0175**

**Question 11: When a patient is discharged from an inpatient facility in the last 5 days of the certification period, should M0175 on the Resumption of Care (ROC) assessment report inpatient facilities that the patient was discharged from during the 14 days immediately preceding the ROC date or the 14 days immediately preceding the first day of the new certification period?**

Answer 11: When completing a Resumption of Care assessment which will also serve as a Recertification assessment, M0175 should reflect inpatient facility discharges that have occurred during the two-week period immediately preceding the first day of the new certification period.

### **M0200**

**Question 12: I was told that an exacerbation of a disease can be considered a change in medical or treatment regimen for M0200, Medical or Treatment Regimen Change Within Past 14 Days. Is this true?**

Answer 12: The exacerbation of a disease, in and of itself, would not be considered a change in medical or treatment regimen for M0200. The changes in medication, service,

or treatment that might result from a new diagnosis or the exacerbation of a disease would warrant in a “Yes” response on M0200.

**Question 13: If physical therapy (or any other discipline included under the home health plan of care) was ordered at Start of Care (SOC) and discontinued during the episode, does this qualify as a service change for M0200 at the Resumption of Care (ROC) or DC OASIS data collection time points? I understand that the referral and admission to home care does not qualify as a med/tx/service change for M0200.**

Answer 13: Physical therapy (or any other discipline) ordered at SOC and then discontinued during the episode, qualifies as a service change for M0200 at the ROC or DC OASIS data collection time points. You are correct that referral and admission to home care does not “count” as a medical or treatment regimen change. This means that all home care services or treatments ordered at SOC/ROC would not “count” for M0200, but would thereafter, if there was a change.

While a treatment change occurring on the same day as the assessment visit usually qualifies as occurring within the past 14 days, the discontinuation of home care services at DC, do NOT count as a “Yes” for M0200 (If it did, all episodes would include a “Yes” on M0200 at DC.)

#### **M0230/240**

**Question 14: During a supervisor’s audit of a SOC assessment, the auditor finds a manifestation code listed as primary without the required etiology code reported. Can this be considered a technical coding “error”, and can the agency follow their correction policy allowing the agency’s coding expert to correct the non-adherence to multiple coding requirements mandated by the ICD-9-CM coding guidelines, without conferring with the assessing clinician?**

Answer 14: The determination of the primary and secondary diagnoses must be completed by the assessing clinician, in conjunction with the physician. If the assessing clinician identifies the diagnosis that is the focus of the care and reports it in M0230, and ICD-9-CM coding guidelines required that the selected diagnosis is subject to mandatory multiple coding, the addition of the etiology code and related sequencing is not a technical correction because a diagnosis is being added. If any diagnosis is being added, in this case for manifestation coding requirements, the assessing clinician must be contacted and agree.

If, based on the review of the comprehensive assessment and plan of care, the auditor questions the accuracy of the primary diagnosis selected by the assessing clinician, this is not considered a “technical” error and the coding specialist may not automatically make the correction without consulting with the assessing clinician.

If after discussion of the manifestation coding situation between the assessing clinician and the coding specialist, the assessing clinician agrees with the coding specialist or auditor and that the sequence of the diagnosis codes should be modified to more accurately reflect the diagnosis that is most related to the current POC using current ICD-9-CM coding guidelines, agency policy will determine how (e.g., by whom) this change is made.

## **M0250**

**Question 15: When a patient has a G-tube (NG-tube, J-tube, and PEG-tube) and it is only utilized for medication administration, do you mark Response 3, Enteral nutrition for M0250, Therapies?**

Answer 15: No, M0250 Response 3 captures the administration of enteral nutrition. Medication administration alone is not considered nutrition.

**Question 16: When a patient has a feeding tube and it is only utilized for the administration of water for hydration (continuous or intermittent), do you mark Response 3, Enteral nutrition for M0250, Therapies?**

Answer 16: No, M0250 Response 3 captures the administration of enteral nutrition. Hydration alone is not considered nutrition.

**Question 17: I understand that if the patient is receiving infusion therapy in the home and the family or caregiver manages it completely that we should report the infusion therapy on M0250. Is this also true when the patient is receiving infusion therapy in the home from another provider?**

Answer 17: Only one question must be answered to determine whether the infusion “counts” as IV or infusion therapy – “Is the patient receiving such therapy at home?” regardless of who is managing it.

**Question 18: A patient has a Hickman catheter and is receiving TPN over 12 hours. At the beginning of the infusion, the line is flushed with saline and at the end of the infusion, it is flushed with saline and Heparin. For M0250, do you mark both 1 and 2?**

Answer 18: When the patient is receiving intermittent parenteral therapy at home and requires a pre- and post-infusion flush, it is not appropriate to mark Response 1, Intravenous or infusion therapy (excludes TPN), in addition to Response 2, Parenteral nutrition (TPN or lipids). The flushing of the line for intermittent parenteral therapy is considered a component of the parenteral therapy.

## **M0400**

**Question 19: My patient’s primary language is German, but he does speak English well enough for us to generally communicate without the use of an interpreter. Often I need to repeat my request, or reword my statements, but he eventually adequately understands what I’m asking or saying. When scoring M0400 Hearing and Comprehension of Spoken Language, I marked response “2” based on my assessment, but I wonder if the patient’s hearing/comprehension would be better (i.e., a Response “0” or “1”) if he were being spoken to in German, his primary language. Do I have to assess the patient with an interpreter in order to score M0400 in the patient’s primary language, even if I feel communication is generally adequate to allow evaluation of the patient’s healthcare needs and provision of care outlined in the Plan of Care?**

Answer 19: M0400 is an evaluation of the patient’s ability to hear and understand verbal (spoken) language in the patient’s primary language. If a patient is able to communicate in more than one language, then this item can be evaluated in any language in which the patient is fluent. If however, as you suggest, your patient’s ability to hear and understand is likely not as functional in a secondary language, you should make efforts necessary to access an interpreter to determine the patient’s ability to hear and comprehend in the patient’s primary language.

#### **M0430**

**Question 20: My patient has post-op pain which initially was well managed with pain medications. For the past few weeks the patient has been refusing to take her pain medications as prescribed due to fear of addiction. This has caused her to have pain that occurs at least daily and impacts her ability to sleep, get around her home, and carry out her home exercise program. The patient is being discharged to outpatient services. On my discharge assessment, I marked that the patient did NOT have intractable pain, because she could have “easily” relieved her pain if she took her pain medications as prescribed. Is this an appropriate application of the current guidance?**

Answer 20: The assessing clinician, with input from the patient, will determine if the pain is easily relieved. In your example, it appears that you believe the patient’s pain *could* easily be relieved, but in reality it is not relieved due to a fear of addiction. M0430 should be a reflection of the patient’s current pain and its current impact on the patient’s life, given the current parameters (e.g., pain level and characteristics, pharmacological and non-pharmacological treatments used). If the patient is not currently using adequate pain medication or non-drug pain management measures, even if they have been prescribed, and are present in the home, M0430 should still be a reflection of the patient’s current pain experience (is the pain easily relieved, does it occur at least daily, and does it affect one or more of the quality of life activities noted in the item.)

**Question 21: My patient reports he can not afford to buy his pain medications, and does have pain that occurs at least daily and interferes with quality of life issues. Can I say that the pain is not easily relieved because the patient does not have a means to relieve it?**

Answer 21: Knowledge that the patient is not currently taking medications as prescribed due to financial concerns is certainly an important finding that should be documented in the drug regimen review portion of the comprehensive assessment and addressed in the plan of care. If the patient is not currently using adequate pain medication, for any reason, including inability to afford medications prescribed, M0430 should still be a reflection of the patient’s current pain experience (is the pain easily relieved, does it occur at least daily, and does it affect one or more of the quality of life activities noted in the item.)

#### **M0440/482**

**Question 22: Is a peritoneal dialysis catheter considered a surgical wound? Isn't the opening in the abdominal wall a type of ostomy?**

Answer 22: The site of a peritoneal dialysis catheter is considered a surgical wound. The opening in the abdominal wall is referred to as the exit site and is not an ostomy.

#### **M0445**

**Question 23: If a pressure ulcer or a burn is covered with a skin graft, does it become a surgical wound?**

Answer 23: No, covering a pressure ulcer with a skin graft does not change it to a surgical wound. It remains a pressure ulcer. Applying a skin graft to a burn does not become a surgical wound. The burn remains a skin lesion, with details captured in the comprehensive assessment. In either case, a donor site, until healed, would be considered a surgical wound.

#### **M0450–M0464**

**Question 24: If a pressure ulcer has any eschar or slough AT ALL, is it considered nonobservable and therefore unable to be staged, even if another portion of the ulcer reveals bone, indicating a stage 4 ulcer? The current guidance suggests that a pressure ulcer is not able to be staged until the wound bed can be visualized, since any necrotic tissue may be covering a deeper wound depth than can be observed. But when bone is visible, isn't it clearly a stage 4 pressure ulcer, regardless of what might be under any necrotic tissue present?**

Answer 24: Based on guidance from the NPUAP and the WOCN Society, a pressure ulcer can only be staged when necrotic tissue is not present. Since CMS relies on the expert guidance from these organizations to support data collection for the pressure ulcer OASIS items, any pressure ulcer with any amount of eschar or slough present, even an ulcer with bone visible, would be considered non-observable and therefore could not be staged.

#### **M0464**

**Question 25: According to the WOCN Guidance on OASIS Skin and Wound Status M0 Items, a “non-healing” status applies to a pressure ulcer with greater than or equal to 25% avascular tissue and Early/Partial Granulation status applies to a pressure ulcer with minimal avascular tissue (i.e., less than 25% of the wound bed is covered with avascular tissue). Does this guidance supersede the Chapter 8 M0464 guidance that states “If part of the ulcer is covered by necrotic tissue then it is not healing (Response 3)?” What if only 5% of the wound bed is covered with eschar?**

Answer 25: Follow the WOCN guidance. If only 5% of the wound bed is covered with eschar, according to the WOCN guidance, the status would be Early/Partial Granulation, as long as the other criteria are met. To meet the criteria for “Non-healing”, the portion of the wound bed coverage must be equal to or greater than 25% avascular tissue.

#### **M0482**

**Question 26: If a patient has a venous access device that no longer provides venous access, (e.g. no bruit, no thrill, unable to be utilized for dialysis), is it considered a venous access device that would be “counted” as a surgical wound for M0482, Surgical Wound and the subsequent surgical wound questions?**

Answer 26: Yes, as long as the venous access device is in place, it is considered to be a surgical wound whether or not it is functional or currently being accessed.

**Question 27: Does the presence of sutures equate to a surgical wound? For example, IV access that is sutured in place, a pressure ulcer that is sutured closed or the sutured incision around a fresh ostomy.**

Answer 27: No, the presence of sutures does not automatically equate to a surgical wound. In the examples given, if the IV was peripheral, it would be excluded from M0440 and M0482, and a pressure ulcer does not become a surgical wound by being sutured closed, and the ostomy would be excluded from M0440 and M0482.

**Question 28: Since an implanted venous access device is considered a surgical wound for M0482, when it is initially implanted, is the surgical incision through which it was implanted a second surgical wound (separate from the venous access device?).**

Answer 28: No. The surgical incision is considered a surgical wound until it is healed, becoming a scar. The site of the venous access device is initially considered a surgical wound, as long as it is in place.

**Question 29: If an abscess is incised and drained, does it become a surgical wound?**

Answer 29: No, an abscess that has been incised and drained is an abscess, not a surgical wound.

**M0488**

**Question 30: A venous access device is routinely accessed and upon assessment has a scab at the puncture site. Assuming there are no signs or symptoms of infection, is the wound status early/partial granulation or fully granulating?**

Answer 30: To answer M0488, the healing status of a wound can only be determined by a skilled assessment (in person). Follow the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document*) found at <http://www.wocn.org/> to determine the status. Based on the WOCN guidelines, a wound with  $\geq 25\%$  avascular tissue is considered "non-healing"; therefore a venous access puncture site which is covered by a scab (avascular tissue) would be classified as Response 3 - non-healing.

**M0490**

**Question 31: What is the correct response for the patient who is only short of breath when supine and requires the use of oxygen only at night, due to this positional dyspnea? The patient is not short of breath when walking more than 20 feet or climbing stairs.**

Answer 31: Since the patient's supplemental oxygen use is not continuous, M0490 should reflect the level of exertion that results in dyspnea without the use of the oxygen. The correct response would be "4 – At rest (during day or night)". It would be important to include further clinical documentation to explain the patient's specific condition.

**M0530**

**Question 32: If a patient is utilizing timed-voiding to defer incontinence and they have an "accident" once-in-a-while, can you still mark M0530 "0 – Timed-voiding defers incontinence"?**

Answer 32: If the patient utilizes timed-voiding but still has an "occasional" accident, determine when the accidents occur and mark either Response 1 "during the day and night" or 2 "during the night only". CMS does not offer specific timeframes to define the term "occasionally". Clinical judgment will be required to determine if the last urinary accident is in the relevant past or if the patient's current use of timed-voiding is 100% effective and therefore should be marked as "timed-voiding defers incontinence".

**M0570 & M0580**

**Question 33: What does unresponsive mean?**

Answer 33: It means the patient is unconscious, or is unable to voluntarily respond. A patient who only demonstrates reflexive or otherwise involuntary responses may be considered unresponsive. A patient with language or cognitive deficits is not automatically considered "unresponsive". A patient who is unable to verbally communicate may respond by blinking eyes or raising a finger. A patient with dementia may respond by turning toward a pleasant, familiar voice, or by turning away from bright lights, or by attempting to remove an uncomfortable clothing item or bandage. A patient who simply refuses to answer questions should not automatically be considered "unresponsive". In these situations, the clinician should complete the comprehensive assessment and select the correct response based on observation and caregiver interview.

## **M0640 & M0670**

**Question 34: Is hair washing/shampooing considered a grooming task, a bathing task, or neither?**

Answer 34: The task of shampooing hair is not considered a grooming task for M0640. Hair care for M0640 includes combing, brushing, and/or styling the hair. Shampooing is also specifically excluded from the bathing tasks for M0670, therefore the specific task of shampooing the hair is not included in the scoring of either of these ADL items.

## **M0660**

**Question 35: If the patient has a physician's order to wear elastic compression stockings and they are integral to their medical treatment, (e.g. patient at risk for DVT), but the patient is unable to apply them, what is the correct response for M0660?**

Answer 35: M0660 identifies the patient's ability to obtain, put on, and remove their lower body clothing, including lower extremity supportive or protective devices. A prescribed treatment that is integral to the patient's prognosis and recovery from the episode of illness, such as elastic compression stockings, air casts, etc., should be considered when scoring M0660. The patient in this situation would be scored based on their ability to obtain, put on and remove the majority of their lower body dressing items, as the elastic compression stockings are a required, prescribed treatment.

## **M0670**

**Question 36: Based on my SOC comprehensive assessment, I determine that my patient requires assistance to wash his back and feet safely in the tub. At the time of the assessment, I believe the patient *could* wash his back and feet safely *if* he had adaptive devices, like a long-handled sponge. Should the initial score be "1" able to bathe in the tub/shower with equipment or "2" requires the assistance of another person to wash difficult to reach areas?**

Answer 36: Since at the time of the assessment the patient requires intermittent assist of another person to wash difficult to reach areas, then response "2" should be selected. If the clinician determined that the patient could become more independent (i.e., require less assistance) with the use of adaptive equipment, then such equipment could be obtained or recommended as part of the home health plan of care. If at discharge the patient is able to wash his entire body using the equipment provided, then response "1" should be reported. If the patient is financially unable or otherwise refuses to obtain the recommended equipment, then the clinician would not have the opportunity to instruct or evaluate the patient's ability to determine if the equipment improves independence. If the patient does not get the equipment, or if even with the equipment the patient continues to require intermittent assistance, then response "2" would apply.

**Question 37: I understand that recent clarification reveals that the transfer in/out of the tub/shower should not be included in the scoring of M0670. Previous guidance stated that in order for the patient to be able to bathe in the tub/shower they had to be able to get there (e.g., if a patient is restricted from stair climbing and their only tub/shower is upstairs, then they are unable to bathe in the tub/shower) Is this still true or is M0670 now limited to just the patient's ability to wash their entire body once in the tub/shower? It seems strange that walking up the stairs *would* impact the bathing item score, but getting into the tub/shower *wouldn't*.**

Answer 37: Guidance for this item has evolved over time and additional clarification has been provided, allowing objective measurement of improvement in a specific portion of the bathing process; the patient's ability to wash their entire body. If a patient can get to the tub/shower and in/out of the tub/shower (by any safe means), then their ability to wash their entire body while in the tub/shower should be assessed, and the score

reported as “0” if they need no human assistance or equipment, “1” if they need no human assistance but require equipment, “2” if they require intermittent assistance, “3” if they require constant supervision/assistance, “4” if they are unable to use the shower or tub and is bathed in bed or bedside chair, or “5” if they are unable to participate at all in washing their body. If medical restrictions prohibit the patient from activities which would be required for the patient to get to/from the tub/shower (e.g., restricted stair climbing), in/out of the tub/shower (e.g., some joint precautions), or from bathing or showering in the tub or shower (e.g., some cast or incision precautions), then the patient should be considered “unable to bath in the tub or shower” and would be scored a “4” or “5”, depending on their ability to participate in washing their body at any location outside of the tub/shower.

#### **M0690**

**Question 38: If a patient requires a little help from the caregiver to transfer (e.g., verbal cueing, stand by assist, contact guard), would the score for M0690 Transferring be “1” (requires “minimal human assistance”) or a “2” (“unable to transfer self”)? Both seem to apply.**

Answer 38: If the patient is able to transfer self but requires standby assistance or verbal cueing to safely transfer, response “1” would apply. If the patient is unable to transfer self but is able to bear weight and pivot when assisted during the transfer process, then response “2” would apply.

#### **M0700**

**Question 39: My patient does not have a walking device but is clearly not safe walking alone. I evaluate him with a trial walker that I have brought with me to the assessment visit and while he still requires assistance and cueing, I believe he could eventually be safe using it with little to no human assistance. Currently his balance is so poor that ideally someone should be with him whenever he walks, even though he usually is just up stumbling around on his own. What score should I select for M0700?**

Answer 39: The score should reflect the patient’s usual status more than 50% of the time during the day of the assessment, to safely walk, once in a standing position. It sounds as though your assessment findings cause you to believe the patient should have someone with them at all times when walking (Response “2”). When scoring M0700, clinicians should be careful not to assume that a patient, who is unsafe walking without a device, will suddenly (or ever) become able to safely walk *with* a device. Observation is the preferred method of data collection for the functional OASIS items, and the most accurate assessment will include observation of the patient using the device. Often safe use will require not only obtaining the device, but also appropriate selection of specific features, fitting of the device to the patient/environment and patient instruction in its use.

#### **M0710**

**Question 40: For Feeding or Eating, what is the definition of meal set-up?**

Answer 40: Meal set-up is included in Response 1 of M0710, Feeding or Eating. When reviewing Response 1, you will see that it is identifying patients who are able to feed self independently but need some special assistance to do so. With this in mind, meal set-up would include any special assistance that is required for the patient that others do not require in order to feed themselves once the food is placed in front of them. Examples of meal set-up activities that a patient may require assistance with include cutting the food into manageable pieces, buttering bread, or placing a straw in a cup. (Note: Chopping or cutting of food is not considered meal set-up in homes where the culture dictates that the food be chopped or cut before being served, such as in some Asian cultures.)

### **M0780, M0790, M0800**

**Question 41: If a patient was in the hospital 14 days prior to the OASIS data collection time point and hospital policy prevents the patient from managing their own medications, how do you respond to the patient's prior ability to manage their oral, injectable and inhalant/mist medications?**

Answer 41: To answer the prior status items correctly, interview the patient/caregiver and determine what the patient's ability was on that particular day, despite the facility's policies or restrictions. The patient's cognitive, mental and physical condition on that particular day must be considered when determining the accurate response. Assessments of the patient's vision, strength and manual dexterity in the hands and fingers, as well as mental status will provide the necessary information to evaluate his/her ability.

### **M0810 and M0820**

**Question 42: Is C-PAP *without* oxygen or a nebulizer included as equipment for M0810 and M0820?**

Answer 42: No. If the patient's only equipment was C-PAP without oxygen or a nebulizer, the correct M0810 response would be NA – No equipment of this type used in care and M0820 would be skipped.

### **M0825**

**Question 43: Our agency is continuing with voluntary OASIS data collection for skilled private insurance patients. Some of our private insurance payers are using a reimbursement model similar to the Medicare PPS, which requires a response for M0825 of "0" or "1". Although the assessment strategies in Chapter 8 instruct us to mark "NA" for non-Medicare patients, would we be non-compliant to mark "0" or "1" for non-Medicare patients instead of "NA"?**

Answer 43: No, the response to M0825 only affects the Medicare PPS when M0150 is marked "1 – Medicare (traditional fee for service), therefore marking "0" or "1" for non-Medicare patients is an acceptable agency practice.

Some payment sources that are not Medicare-fee-for-service (i.e., other than Response 1 to M0150) will use this information in setting an episode payment rate. If your patient needs an HIPPS code for billing purposes a "Yes" or "NO" response to this item is required to generate the case mix weight rate code.

**Question 44: If nursing and therapy are ordered, is there any requirement that the completion of the comprehensive assessment be delayed until the therapy evaluation(s) are completed in order to determine a response for M0825 Therapy Need, and the primary or secondary diagnoses?**

Answer 44: The CoPs require the SOC comprehensive assessment be completed on or within 5 days after the SOC date. Evaluations by other disciplines (e.g., therapies) are required to occur in a timely manner consistent with patient needs and professional standards of practice. For multidisciplinary cases, there is no explicit requirement that the therapy evaluation(s) be conducted prior to completion of the SOC assessment by the RN, although agencies should realize that the additional information gained from the completion of the therapists' evaluations may contribute to a greater accuracy for therapy need for M0825 and may influence the selection of the primary diagnosis.

## **M0830**

**Question 45: We have a rather large physician's practice in our area where no appointments are scheduled in advanced. The patients needing to be seen simply are instructed to show up and are seen by the physician's on a first-come, first-served basis. Since all these appointments are "unscheduled", would all of these doctor's visits need to be reported as emergent care by the MD on M0830?**

Answer 45: Since the determination of an MD emergent care visits is defined as a visit to/from the MD scheduled less than 24 hours in advance, then the patient's visits to the MD scheduled and provided as you describe would all meet the definition of being scheduled less than 24 hours in advance, and should be reported as emergent care Response 2 for M0830 – Emergent Care.

**Question 46: My patient had a fall at home. The family called 911. The ambulance arrived and the patient was evaluated by the EMTs but not transported from the home. Is this considered emergent care for M0830, and if so what response should be marked?**

Answer 46: M0830 reports the patient's use of emergent care by/from 3 distinct settings/providers, the hospital emergency department, the physician's office, and the outpatient clinic/urgicenter. Services from the ambulance staff are not included in the providers reported in M0830.

**Question 47: An RN completes a SOC assessment and establishes the plan of care. After the admission visit, subsequent care is provided by the LPN and home health aide for a period of 2 weeks, during which time the patient is seen in the ER. The physician contacts the agency to discontinue home care without an opportunity to complete a discharge assessment visit. Based on current guidance, in this case of an unexpected discharge, the discharge comprehensive assessment would be based on the last visit by a qualified clinician (which was the SOC assessment by the RN.) Since it should reflect the patient's status on that SOC visit, should the emergent care use be captured, since it occurred after the SOC visit?**

Answer 47: No, in the case of an unexpected discharge, the agency must go back to the last visit that was completed by a qualified clinician, and report the patient's health status at that actual visit, and would not capture events or changes in patient status/function (improvements or declines) that occurred after the last visit conducted by a qualified clinician. Agencies should recognize that the practice of allowing long periods of time where the patient's care is provided by those unable to conduct a comprehensive assessment may negatively impact the patient's care and outcomes, and in fact, in a situation as the one described, may be the reason that the patient required emergent care.

The home health agency should carefully monitor all patients and their use of emergent care and hospital services. The home health agency may reassess patient teaching protocols to improve in this area, so that the patient advises the agency before seeking additional services.