

## Quality Measures and Health Assessment Group

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March 4, 2005

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

Dear Linda Krulish:

Thank you for your letter of February 8, 2004 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 our categorized OASIS Questions and Answers (August 2004) document available at: [www.qtso.com/hhdownload.html](http://www.qtso.com/hhdownload.html).

Sincerely,

/s/

Mary D. Weakland, RN, MS  
Health Insurance Specialist  
Quality Measures and Health Assessment Group  
Office of Clinical Standards and Quality  
Centers for Medicare & Medicaid Services

### Order of Services:

**Question 1:** If the RN is admitting and completing the initial and SOC comprehensive assessment for a Medicare case with orders for PT and home health aide (no nursing skill or orders), can the home health aide establish the SOC by making a visit on the same day as the RN admits. And if so, what time requirements would apply to when the PT must make his/her evaluation visit?

**Answer 1:** The case as described is a therapy-only case, thus the RN or the therapist can conduct the initial assessment to determine the immediate care and support needs of the patient and to determine eligibility for the Medicare home health benefit, including homebound status. Once patient eligibility has been confirmed, and the plan of care contains physician orders for the qualifying service as well as other Medicare covered home health services, the qualifying service does not have to be rendered prior to the other covered home health services ordered in the plan of care. If a covered service is provided, the SOC date is established and the visit is Medicare billable. A start of care comprehensive assessment cannot be performed prior to the SOC date. Thus, in the situation described, the RN or the PT can make the initial assessment. However this is not a billable visit and should not be included in the therapy visits. The home health aide who provides a covered service can be the first billable (SOC) visit. If it is the HHA's policy for the RN to conduct the SOC assessment, this would follow the home health aide visit. The RN's SOC assessment should be completed on or within five days after the SOC date (or according to agency policy). The timing of the PT evaluation visit is not specifically defined by the Conditions of Participation, except to say that the practice must comply with accepted professional standards and principles.

**Reference:** *Interpretive Guidelines G336*

**Question 2:** When initial orders exist for nursing and PT, can the PT make an evaluation visit and establish the start of care, with the RN subsequently visiting to conduct the initial assessment visit and to complete the SOC comprehensive assessment?

**Answer 2:** No. When initial orders exist for nursing and PT, the Conditions of Participation require that the RN conduct the initial assessment visit to determine the immediate care needs of the patient, and for Medicare patients, to establish program eligibility including homebound status. When nursing orders are present at the SOC, the RN is allowed up to five days after the SOC date to complete the SOC comprehensive assessment. The PT may conduct the PT evaluation visit after the initial visit by the RN and during the five-day period while the SOC comprehensive assessment is completed.

**Reference:** *Interpretive Guidelines G331*

**M0350:**

**Question 3:** Is Meals-on-Wheels considered assistance for M0350?

**Answer 3:** M0350 is asking the clinician to identify assisting person(s) other than home care agency staff. Response 3, paid help, includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family or a specific program. Meals-on-Wheels is a community-based service that assists the homebound by delivering meals and would be included in responding to M0350.

**M0440 & M0482:**

**Question 4:** Does a cataract surgery or a gynecological surgical procedure by vaginal approach result in a skin lesion for M0440, and a surgical wound for M0482?

**Answer 4:** No. Cataract surgery and gynecological surgical procedures are not included in M0440. M0440 captures skin lesions or an open wound to the integumentary system. Only certain types of wounds are described by OASIS. We would expect that any discharge, swelling, pain, etc. from either procedure would be reported in the agency's clinical documentation.

**M0520:**

**Question 5:** A patient is determined to be incontinent of urine at SOC. After implementing clinical interventions (e.g., Kegel exercises, biofeedback, and medication therapy) the episodes of incontinence stop. At the time of discharge, the patient has not experienced incontinence since the establishment of the incontinence program. At discharge, can the patient be considered continent of urine for scoring of M0520, to reflect improvement in status?

**Answer 5:** Assuming that there has been ongoing assessment of the patient's response to the incontinence program (implied in the question), this patient would be assessed as continent of urine. Therefore Response 0, no incontinence or catheter, is an appropriate response to M0520.

Timed-voiding was not specifically mentioned as an intervention utilized to defer incontinence. If, at discharge, the patient was dependent on a timed-voiding program to defer incontinence, the appropriate response to M0520 would be 1 (patient is incontinent), followed by response 0 to M0530 (timed-voiding defers incontinence).

**M0670:**

**Question 6:** A patient is unable to participate in the bathing tasks, and is totally bathed by a caregiver, but the caregiver bathes the patient in the shower (i.e., lifts the patient into a shower chair, rolls patient to the shower and bathes that otherwise passive patient). Response "5" states that the patient is unable to effectively participate in bathing and is totally bathed by another person. Please clarify if this patient would be scored a "5" because they are unable to effectively participate in bathing and are totally bathed by another person, or a "3" because the patient requires the presence and assistance of another person to bathe in the shower?

**Answer 6:** If the patient truly is unable to effectively participate in any part of the bathing tasks in the shower, response "5" is appropriate. If the patient is able to participate at all in the bathing tasks in the shower, then response "3" is appropriate.

**Question 7:** If the only reason why the patient can't bathe in the tub is because they can't perform the transfer safely, even with equipment and assistance, should they be scored a "4" or "5," Unable to use the shower or tub, even though the only reason is the transfer status, and transferring is not supposed to be considered in the scoring of M0670?

**Answer 7:** The tub transfer should not be considered when scoring M0670. However, the response for M0670 should differentiate patients who are able to bathe in the tub or shower (i.e., responses "0", "1", "2", or "3") from those who are unable to bathe in the tub or shower (e.g., response "4") regardless of the specific cause or barrier preventing the patient from bathing in the shower or tub.

**Reference:** CMS OCCB Q&As 10/2004

**Question 8:** Since the transfer into/out of the tub/shower should not be considered when scoring M0670, is it acceptable for assessing clinicians to ignore Response "2(b)" from the OASIS item wording?

**Answer 8:** The tub or shower transfer should not be considered when scoring M0670, and if the transfer is the only bathing task for which a patient requires help to bathe safely in the tub/shower, then the patient should be scored a "0" or "1", depending on their need for devices to safely perform all the included bathing tasks independently.

**Reference:** CMS OCCB Q&As 10/2004

**M0680:**

**Question 9:** If a patient is able to safely get to and from the toilet with assistance of another person, but they live alone and have no caregiver so they are using a bedside commode, how should M0680 be scored?

**Answer 9:** The OASIS item response should reflect the patient's ability to safely perform a task, regardless of the presence or absence of a caregiver. If the patient is able to safely get to and from the toilet with assistance, then response "1" should be selected, as this reflects their ability, regardless of the availability of a consistent caregiver in the home.

**Question 10:** Is the transfer on/off the toilet included in the scoring of M0680? What about the transfer on/off the BSC? What about the transfer on/off the bed pan?

**Answer 10:** M0680 does not include the transfer on and off the toilet (for response levels "0" and "1", or on/off the bedside commode (for response "2"); as both of these transfers are specifically addressed in the scoring of M0690 - Transferring. The transfer on and off the bedpan *is* considered for the scoring of M0680 response "3". If the patient requires assistance to get on/off the bedpan, then he/she would not be considered independent in using the bedpan and response "4" would be the best response.

**Reference:** CMS OCCB Q&As 8/2004 – Question 14

**Reference:** CMS OCCB Q&As 10/2004 - M0670

**Question 11:** If a patient uses a bedside commode over the toilet, would this be considered "getting to the toilet" for the purposes of scoring M0680?

**Answer 11:** Yes, a patient who is able to safely get to and from the toilet should be scored a "0" or "1", even if they require the use of a commode over the toilet. Note that the location of such a commode is not at the "bedside," and the commode is functioning much like a raised toilet seat.

**M0690:**

**Question 12:** Has CMS clarified Assistive Devices for the purposes of M0690? If not, can you provide an update on the progress or intended process of this clarification?

**Answer 12:** We don't have a response to this question at this time, as we are still investigating the suggestions.

**Reference:** CMS OCCB Q&As 8/2004

**M0830:**

**Question 13:** Is M0830 limited to the service sites specifically listed in the OASIS responses? What if a patient had an emergency and was a direct admit to the floor of the hospital, without passing through the emergency room?

**Answer 13:** M0830 identifies whether the patient received an unscheduled visit to any of the following services; hospital emergency room, doctor's office/house call, or outpatient department or emergency clinic. A direct admit to the floor of a hospital would not be reported as emergent care on M0830. This would, however, be considered a transfer to an inpatient facility, as long as the admission lasted 24 hours or longer for reasons other than diagnostic testing, and would be considered an "emergent" reason for hospital admission in responding to M0890.

**Revision of response to time point issue:**

CMS has been asked to review the response to an October 20, 2004 letter to the OASIS Certificate and Competency Board, Inc. letter concerning missed recertification assessments. CMS met with its contractor support staff and discussed the question and response. We are revising our response to reflect the need for maintaining the accuracy of the OASIS assessment by performing the assessment in actual time and not using a prior visit. The revised response follows:

**Time points:**

***Question 14:*** An agency misses the recertification window of day 56-60, yet continues to provide skilled services to the Medicare patient. Is the agency required to discharge and readmit the patient? Or, could the agency conduct the RFA 4 assessment late? And if so, how "late" is "too late"? And what transmission problems may be encountered?

***Answer 14:*** When an agency does not complete a recertification assessment within the required 5 day window at the end of the certification period, the agency should not discharge and readmit the patient. Rather, the agency should send a clinician to perform the recertification assessment as soon as the oversight is identified. The date assessment completed (M0090) should be reported as the actual date of the assessment, with documentation in the clinical record of the circumstances surrounding the late completion. A warning message will result from the non-compliant assessment date, but will not prevent assessment transmission. No time frame has been set after which it would be too late to complete this late assessment, but the agency is encouraged to make a correction or complete a missed assessment as soon as possible after the oversight is identified. Obviously, this situation should be avoided, and does demonstrate non-compliance with the comprehensive assessment update standard. For the Medicare PPS patient, payment implications may arise from this missed assessment. Any payment implications must be discussed with the agency's RHHI.