

## **Survey & Certification Group**

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October 20, 2004

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 October 5, 2004 in which you ask a number of questions to determine accurate responses to Outcome and Assessment Information Set (OASIS) items. Kathryn Crisler, MS, RN, University of Colorado, Center for Health Services Research and I reviewed the questions and agreed 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, MS RN  
Nurse Consultant  
Centers for Medicare & Medicaid Services

### **Time points:**

**Question:** 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:**

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 complete the recertification as soon as the oversight is identified, using the last visit date in the previous certification period by a qualifying clinician as the basis for the assessment completion and OASIS scoring. The date assessment

completed (M0090) should be reported as the actual date the assessment is being “created”, with notation in the clinical record of the actual visit date on which the assessment is being based, and 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.

**(OCCB NOTE: CMS revised the answer to this question in March 2005. See CMS OCCB Q&As – March 2005 Question 14 for latest CMS guidance)**

### **M0150**

**Question:** A patient with traditional Medicare is referred for skilled services, and upon evaluation, is determined to *not* be homebound, and therefore *not* eligible for the home health benefit. The patient agrees to pay privately for the skilled services. Should M0150 include reporting of response 1 – Medicare (traditional fee-for-service)?

**Answer:** The purpose of M0150 is to identify any and all payers to which any services provided during this home care episode are being billed. Although the patient described is a Medicare beneficiary, response 1 of M0150, Medicare (traditional fee-for-service), would not be marked, since the current situation described does not meet the home health benefit coverage criteria. In fact, since Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 temporarily suspended OASIS data collection for non-Medicare and non-Medicaid patients, if the services will not be billed to Medicare or Medicaid, then no OASIS collection would be required for this patient; although, if desired, the agency may voluntarily collect it as part of the still-required comprehensive assessment. If at some point during the care, a change in patient condition results in the patient becoming homebound, and otherwise meeting the home health benefit coverage criteria, then a new SOC assessment would be required, on which response 1 – Medicare (traditional fee-for-service) would be indicated as a payer for the care.

### **M0420/M0430**

**Question:** A patient is taking narcotic pain medications continuously and is currently pain free. Medication side effects, including constipation, nausea and drowsiness affect the patient’s interest and ability to eat, walk, and socialize. How should M0420 be reported? Is pain interfering with the patient’s activity? And based on the information provided, would this patient be considered to have intractable pain for M0430?

**Answer:** M0420 identifies the frequency with which pain interferes with a patient’s activities, with treatment if prescribed. Since M0420 reports the frequency that pain interferes with activity and not the presence of pain itself, then even if a patient is pain-free as a result of the treatment, M0420 should be scored to reflect the frequency that the patient’s activities are affected or limited by pain. In this scenario, the patient is described as being pain-free, so pain apparently is not interfering with the patient’s activity. Medication side effects are not addressed in responding to M0420.

M0430, Intractable Pain, refers to pain that is not easily relieved, occurs at least daily and, affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, or ability or desire to perform activity. Intractable pain is ever present. The clinician making the assessment will determine if the patient's pain meets the components of the definition of intractable pain. If the pain is well controlled by round-the-clock pharmacologic interventions, then the pain may not occur daily, and therefore would not be considered intractable. The assessing clinician, with input from the patient, will determine if the pain is easily relieved, and will identify the affects of the pain or related treatment approaches on the patient's activities and life.

M0420 and M0430 are separate items and should be assessed and considered separately. There is not an "If response ... on M0420, then response ... on M0430" algorithm that is appropriate to follow in responding to these items.

### **M0430**

**Question:** For M0430 – Intractable pain, must the pain meet all three criteria listed in the item (i.e. (1) be not easily relieved, (2) occur at least daily, and (3) affect the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity) in order to be considered “intractable pain”?

**Answer:** Yes, the pain must be not easily relieved, be present at least daily, and affect the patient's quality of life as outlined in the item wording.

### **M0430**

**Question:** The Chapter 8 assessment strategies describe intractable pain as “ever present”. Does this mean that if pain occurs daily, but not constantly, that it could not be considered “intractable”?

**Answer:** Intractable Pain, refers to pain that is not easily relieved, occurs at least daily and, affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, or ability or desire to perform activity. While the pain does not need to be constant to be considered intractable, the combination of the pain, its effects on the patient's quality of life and activities, and the effort to manage the pain must be involved, or “ever present”.

### **M0670**

**Question:** Please clarify how the patient's ability to access the tub/shower applies to M0670.

**Answer:** M0670 defines the bathing item to identify the patient's ability to wash the entire body. This item also provides guidance when medical restrictions prevent the patient from accessing the tub/shower, his/her bathing ability will be 'scored' at a lower level. Tasks related to transferring in and out of the tub or shower are evaluated and scored when responding to M0690 - Transferring, and are not considered part of the bathing tasks for M0670.

### **M0700**

**Question:** When scoring M0700 – Ambulation/Locomotion, how would I score a patient who does not use an assistive device, but does sometimes need help on level/even surfaces?

**Answer:**

A patient who needs intermittent assistance (including any combination of hands-on assistance, supervision, and/or verbal cueing) to ambulate safely would be scored as a “1” on M0700. A patient who needs continuous assistance (including any combination of hands-on assistance, supervision, and/or verbal cueing) to ambulate safely would be score as a “2” – “able to walk only with the supervision or assistance of another person at all times”.

### **M0720**

**Question:** Should a therapeutic diet prescription be considered when assessing the patient’s ability to plan and prepare light meals for M0720? For example, if a patient is able to heat a frozen dinner in the microwave or make a sandwich – but is NOT able to plan and prepare a simple meal within the currently prescribed diet (until teaching has been accomplished for THAT diet, or until physical or cognitive deficits have been resolved), would the patient be considered *able* or *unable* to plan and prepare light meals?

**Answer:** M0720 identifies the patient’s cognitive and physical ability to plan and prepare light meals or reheat delivered meals. While the nutritional appropriateness of the patient’s food selections is not the focus of this item, any prescribed diet requirements (and related planning/preparation) should be considered when scoring M0720. Therefore a patient who is able to carry out mobility and cognitive tasks that would be required to heat a frozen dinner in the microwave or make a sandwich, but who is currently physically or cognitively *unable* plan and prepare a simple meal that complies with a medically prescribed diet should be scored as a “1- unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations”, until adequate teaching/learning has occurred for the special diet, or until related physical or cognitive barriers are addressed. This is a critical assessment strategy when considering the important relationship between this IADL and nutritional status. A poorly nourished patient with limited ability to prepare meals is at greater risk for further physical decline.

### **M0830**

**Question:** The CMS 8/2004 Q&As state that if a patient dies after receiving care from an emergency department that the patient is under the care of the facility and would not be considered as a death at home RFA 8 for M0100. The guidance goes on to advise the clinician to complete a transfer OASIS to close out the patient’s record. Since admission to an Emergent Room does not meet the OASIS definition of “transfer” for the purposes of RFA 6 of 7, which RFA should be selected to close out this patient episode?

**Answer:**

A patient who dies in the emergency room is NOT considered to have died while under the care of the agency, and therefore is NOT considered a death at home. The agency should complete a transfer assessment, RFA 7 – “Transferred to an inpatient facility – patient

discharged from agency”; even though the patient never actually was admitted as to an inpatient facility. Clarifying documentation within the clinical record should outline the details of the emergent care and death in the emergency room.

### **M0100 RFA 8**

***Question:*** If a patient is transported to the emergency room, and is pronounced dead by the ER physician, is this considered a “death at home” for the purposes of selecting an RFA for M0100?

***Answer:*** If the patient is pronounced “dead on arrival”, then the patient is presumed to have passed away while under the care of the agency, and would be considered a death at home. If the patient is not pronounced “dead on arrival”, is taken under care by the emergency department, and subsequently dies, the patient is considered to have died while under the care of the emergency facility, and not under the care of the home health agency, and would not be considered a “death at home”.

### **M0830**

***Question:*** If a patient is admitted to an inpatient facility subsequent to initial access in the emergency room, is there ever a situation in which that emergent care would NOT be reported on M0830, (i.e., patient is only briefly triaged in ER with immediate and direct admit to the hospital)?

***Answer:*** The item-by-item response specific instructions in Chapter 8 of the Implementation Manual clarify that response to M0830 – Emergent Care, include the entire period since the last time OASIS data were collected, including current events. Any access of emergent care, regardless of how brief the encounter, should be reported on M0830 if it occurred since the last time OASIS data were collected.