



**Category 1 - Applicability**

**Face-to-Face**

**Question 1:** If the F2F does not occur within 30 days, but it does occur, for example, on the 35th day, does the agency have to adjust the SOC until then or does the original SOC stand?

**Answer 1:** If the F2F encounter does not occur within the 90 days prior to the SOC, or within 30 days after the SOC, then the Medicare HH payment coverage conditions have not been met and the episode is not covered or billable as a Medicare HH episode.

Assuming all other coverage conditions are met, the F2F encounter (occurring on day 35 in the given scenario) would represent a pay source change to the Medicare HH benefit.

As always, Medicare payment episodes require a new SOC and SOC OASIS. The HHA may establish the

**Category 2 – Comprehensive Assessment**

**OASIS Corrections**

**Question 2:** Our clinician reported an ostomy as a surgical wound in the OASIS M1340, Surgical Wound item. The clinician no longer works for the agency, so we cannot contact her about the error. Can this OASIS change be made by the DON without speaking to the clinician?

**Answer 2:** You have described a situation where a true OASIS scoring error was discovered during the audit process. The assessment was complete. The patient had an ostomy, a clear, non-disputable fact based on the entire clinical record. The assessing clinician responsible for completing the assessment misunderstood, wasn't aware, or made an error based on the OASIS scoring guidance, which states all ostomies are excluded as surgical wounds in M1340.

HHAs should have a policy and procedure for correcting errors that involves the assessing clinician. The policy should follow established clinical record professional practice standards and guidance found in relevant CMS regulations and guidance. Normally, if an error is identified through audit or review, the

Medicare SOC on the next covered visit after the F2F encounter occurred. This would require completion of a new SOC comprehensive assessment on or within 5 days after this new SOC date, including collection of SOC OASIS data as stated in 42 CFR 484.55.

Assuming the new SOC occurred on the day of the F2F, the previous 34 days of skilled care are not reimbursable by a Medicare payer which means OASIS data collection/submission for that previous episode of care was not required. The SOC is the first billable visit date in an episode, outlined in Chapter 7, Section 10.4 of the Home Health Benefit Policy Manual. The previously collected SOC OASIS assessment (along with any subsequent OASIS data collected/submitted prior to the F2F encounter) would need to be deleted from the repository, following established processes.

All documentation related to both the Medicare episode and the potentially uncompensated episode (including copies of the deleted OASIS assessments) should be maintained by the agency as a record of the clinical care, communications and actions relevant to the patient's care.

individual who made the original entry into the patient's record would, whenever possible, make the necessary correction by following agency policy. A correction policy may allow the auditor who found the error to contact the clinician, discuss the discrepancy in the medical record and make the correction following your policy including information such as who discovered the error, and the date and time of communication with the assessing clinician who agrees that it was an error. Correction of an error will not impact the M0090, Date Assessment Completed.

In a case where, as you have described, the original documenter is not available, the clinical supervisor or quality staff may make the correction to the documentation following the correction policy. The supervisor must document why the original assessing clinician is not available to make the correction and how the error was identified and validated as a true error. When corrections are made to assessments submitted to state, you must determine the impact of the correction on the POC, HHRG, the Plan of Treatment, RAP and make corrections to those documents and billing, as applicable.

When the comprehensive assessment is corrected, the HHA must maintain the original as well as subsequent corrected assessments in the patient's clinical record per requirements at 42 CFR 484.48. CMS urges HHAs to make corrections and/or submit inactivations as quickly as possible after errors are identified so the state system will be as current and accurate as possible, as the data is used to generate OBQM, OBQI, PBQI, Patient-Related Characteristics Report and HHRG.

Follow the guidance found in CMS Survey & Cert Letter 01-12 New Outcome and Assessment Information Set (OASIS) Correction Policy for Home Health Agencies (HHAs)—ACTION and INFORMATION at [www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/scletter01-12.pdf](http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/scletter01-12.pdf)

### **Category 4b – M Item-Specific**

#### **M0100**

**Question 3:** The CMS OASIS Q&A 21.1 located in Category 4b instructs us not to discharge a patient if we anticipate the patient will be returning to our service. Do I have to follow this guidance for Medicaid patients? In my state, our Medicaid program instructs

Discharge comprehensive assessment is also required. The discharge is the endpoint of the quality episode, which is not captured with a recertification assessment.

#### **M1242**

**Question 5:** Could you clarify the time period under consideration when answering M1242 Frequency of Pain Interfering with Activity or Movement?

If a patient reports they have no pain currently because they have modified their activity level several weeks or months ago to exclude an activity they know will cause pain, do we answer M1242 based on the fact that they have modified their activity level (e.g., aren't even attempting to perform that activity due to the possibility of the pain returning), or do we not even consider that activity when answering the question because the patient has excluded it from their activities a "long" time ago. And if that is true, what would be the time frame for a "long" time ago?

**Answer 5:** The timeframe under consideration when answering M1242, Frequency that Pain interferes with Activity or Movement is the day of assessment and recent pertinent past. If the patient has stopped

us to discharge when a patient is transferred into the inpatient setting.

**Answer 3:** The instructions in Q21.1 only apply to Medicare Traditional fee-for-service patients. Follow your payer's guidance.

**Question 4:** If there was a need for continuing services into the next certification period, but the clinician missed completing the recertification assessment between day 56-60 and on the first visit in the new episode it was determined the patient had reached goals and needed to be discharged, do I have to complete both the Recert and the Discharge OASIS?

**Answer 4:** Yes. When a Recertification assessment is missed it should be completed as soon as possible. In the situation described, you needed to recertify for the visit that was needed and justified by the patient's condition in the new episode of care. The recertification comprehensive assessment supports the patient's need for services, and the recertification OASIS drives the payment for that episode. If the clinician determined the patient was ready for discharge on the first visit in the new episode, the

performing an activity in order to be free of pain, the patient HAS pain that is interfering with activity.

If a patient at some point stopped performing activity because of pain and there is no reasonable expectation that they could or would ever perform the activity again, an assessing clinician's judgment may determine that the activity is not considered to be in the pertinent past. Examples: stopped skiing after a knee injury 20 years ago.

#### **M1330; M1332; M1334; M1350**

**Question 6:** How do we answer the OASIS stasis ulcer questions when the patient diagnoses include Peripheral Arterial Disease and Venous Stasis Insufficiency? The nurse spoke with the physician who stated the patient had "mixed arterial and venous disease."

**Answer 6:** In a situation where the clinician visually assessed ulcers on the lower legs that the physician diagnosed as a mixture of venous stasis and arterial ulcers, the OASIS stasis ulcer items would be answered as follows: (Utilization of the WOCN's "Quick Assessment of Leg Ulcers" located at

www.wocn.org may be helpful when distinguishing the ulcers that have a venous disease etiology versus the arterial disease.)

M1330, Does this patient have a Stasis Ulcer = Yes.

M1332, Number of Observable Stasis Ulcers would be answered reflecting only those ulcers that were a result of venous insufficiency, not arterial. Utilize WOCN Quick Assessment of Leg Ulcers to help distinguish venous from arterial.

M1334, Status of Most Problematic (Observable) Stasis Ulcer would be based on the one observable ulcer resulting from venous insufficiency that is the most problematic.

M1350, Wounds/Lesions would report the ulcers that were purely a result of arterial disease, if they are receiving intervention from the agency.

### **M1332**

**Question 7:** My patient has a venous stasis wound of the lower extremity that covers the entire lower leg, but in the midst of the wound there are two dark areas. Do we count this as one ulcer or two?

**Answer 7:** If areas of venous stasis ulceration are contiguous and developed at the same time, the entire area would be counted as one stasis ulcer. If the patient had a venous stasis ulcer and then later developed another venous stasis ulcer, and eventually the wound margins met, it would be counted as two ulcers, as long as it remains possible to differentiate one ulcer from another based on wound margins. Depending on the timing and progression, it may be difficult for the clinician to know that a current ulcer was once two ulcers, and/or where one ulcer ends and another begins for assessment/reporting purposes. It would be up to the assessing clinician to determine the number of stasis ulcers in situations where multiple ulcers may have merged together.

### **M1340**

**Question 8:** Are toenail removals by a MD considered a surgical wound with or without sutures?

**Answer 8:** Removal or excision of a toenail is not considered a surgical wound. If a surgical procedure was performed that goes beyond simple excision, it would be considered a surgical wound.

**Question 9:** Are insulin and morphine pumps captured in M1030, Therapies at Home and M1340, Surgical Wounds?

**Answer 9:** A pump infusing medication while the patient is at home is reported as Response 1 in M1030, Therapies at home. This is true whether it is an infusion via an implanted device or an infusion via an external pump. If the infusion device is implanted, it would also qualify as a surgical wound under M1340. An external device infusing medication via a SQ needle is not counted as a surgical wound.

### **M1342; M1350**

**Question 10:** Where in the OASIS do I report staple insertion sites and the related edema and bruising that result after surgery?

**Answer 10:** The staple sites are expressly excluded from consideration as a surgical wound. Since they are not a surgical wound, they may be reported in M1350, Wounds/Lesions if they are receiving intervention from the agency.

Edema or bruising that result secondary to a surgical insult that is integral to the surgical wound and requires no additional interventions would not be

considered separately. If the assessing clinician determines the bruising or edema requires additional intervention, separate from the surgical wound interventions, it would be reported in M1350.

### **M1800-1900**

**Question 11:** When the M item response states "assisted or supervised by another person" is that referring to a single person?

**Answer 11:** The response related to "assistance of another person" includes those patients, actively participating in performing a task, but needing assistance of one or more person(s) to safely complete included tasks.

### **M1820**

**Question 12:** M1820, Ability to Dress Lower Body. The patient has an order for ace wraps to their lower extremity. Should the ace wraps to the lower body be considered lower body dressing items like Ted hose are?

**Answer 12:** Chapter 3 of the OASIS-C Guidance Manual, M1820 Response-Specific Instructions state

"Prosthetic, orthotic or other support devices to the lower body...should be considered as lower body dressing items." Elastic bandages, including ACE Wrap brand, worn for support and compression should be considered as a lower body dressing item.

### **M1840**

**Question 13:** My male patient is bedfast and can place and remove the urinal, but not the bedpan. What response should be selected for M1840, Toilet Transferring?

**Answer 13:** If the bedfast patient needs assistance to get on/off the bedpan, the appropriate M1840 Response is "4-Is totally dependent in toileting" even if they can place and remove the urinal.

### **M1870**

**Question 14:** If a patient is receiving TPN and is also taking in nutrients orally, is the correct answer for M1870 Feeding or Eating - 0, 1 or 2? They do not have a tube in place.

**Answer 14:** M1870, Feeding or Eating, identifies the patient's ability to feed him/herself food and does not

qualified to perform comprehensive assessments may collaborate on the Drug Regimen Review. On therapy only cases, can the therapist collaborate with a pharmacist when completing the Drug Regimen Review?

**Answer 16:** In a therapy only case, it would be acceptable for the therapist to collaborate with a pharmacist when performing the drug regimen review. Agency policy and practice will determine how the pharmacist participates in the drug regimen review process and how it is documented.

### **M2310**

**Question 17:** When answering M2310 (Reason for emergent care) how is the term "injury" defined in Response 2-Injury caused by fall? I understand a fractured bone is an injury, but what about ecchymosis, increased edema, neurological changes (no confirmed neurological diagnosis as far as a bleed, etc.), lacerations, abrasions, etc.?

**Answer 17:** Injury means that hurt, damage or loss is sustained by the patient. The assessing clinician may use this definition and clinical judgment to determine

include total parenteral nutrition (TPN). If the patient is receiving TPN and is also taking in nutrients orally, the answer will be 0, 1, or 2. Response 5 would apply if the patient is not able to take in nutrients orally or by tube feeding and is receiving all nutrition intravenously or for patients who are only receiving IV hydration.

### **M1910**

**Question 15:** Does the Tinetti test by itself meet the requirement of using a standardized, validated, multifactor fall risk assessment? My understanding was that it does since the Tinetti has a separate gait and balance score (2 or more factors).

**Answer 15:** The Timed Up and Go, Tinetti, etc. are standardized assessments validated for use with community dwelling elders and may have multiple components such as gait, balance, etc., but they only assess one factor, mobility. You must assess at least one other non-mobility factor to make the fall risk assessment *multi-factorial*, such as vision, polypharmacy, environment, etc.

### **M2000**

**Question 16:** Current guidance in the Jan 2011 CMS OCCB Question #16 states that only clinicians

whether or not the patient was "injured" when they fell.

### **M2400d**

**Question 18:** At the time of a visit, the patient reports mild pain and the nurse observes that the patient's functioning is not limited by the mild pain. The POC includes prn analgesic for pain management, which is offered, however the patient feels the pain is tolerable and elects no intervention at this time.

Can I select "Yes" for M2400d, Pain Interventions, because the intervention was ordered, offered to patient, but not felt by the patient to be needed?

**Answer 18:** In order to answer "Yes" for M2400d, the record review at Transfer/Discharge must reveal that at or since the previous OASIS assessment, there were orders to assess for pain and mitigate pain, as well as evidence that both were implemented. If both were not implemented, you may not answer M2400d "Yes".

If there were orders to assess pain and relieve pain (prn analgesic), and record review revealed that since the previous OASIS assessment, the clinician assessed pain, and offered the analgesic, but it was

never taken because of documented lack of need, as evidenced by patient's subjective comments that the pain did not warrant the medication, then M2400d may be answered "Yes". The intervention was implemented when the attempt to provide it was made, and the lack of need identified.