# CMS OCCB Q&As – July 2009

## CATEGORY 2 – Comprehensive Assessment

**Impact of cancelling orders for nursing before the initial assessment visit**

**Question 1: Both PT and RN evaluations are ordered by the referring physician. The patient's diagnosis by history and physical, discharge summary, and operative report indicate the primary reasons for home care are needs that can be met by the PT. Example: patient d/c from inpatient care status post uncomplicated hip replacement; patient with discharge diagnosis of L CVA with fractured tibia and fibula, and/or patient discharged status post ORIF. If the agency obtains an MD order stating PT may open, is it permissible for the PT to do the Initial Assessment?**

**Answer 1:** If orders for nursing exist at the SOC, the RN must perform the initial assessment visit and comprehensive assessment. If, upon review of the referral documentation, the agency calls the physician and the order for nursing is cancelled, it is no longer a PT and nursing referral and the PT could perform the initial assessment visit.

**Can comprehensive assessment be performed at adult day care center?**



**Question 2**: **We provide skilled services to a Medicaid patient during the day while they are at an adult day care center. Our state Medicaid program does not require that skilled services be provided in the patient's home. Can we perform the comprehensive assessment, including the OASIS, in the adult day care center or must it be completed in the patient's home?**

**Answer 2:** The comprehensive assessment, including the OASIS, involves collecting data on multiple aspects of the patient and their environment. The interrelated aspects of patient and environment all influence current and future health status. It is important that the clinician collects data on environmental characteristics (such as safety features) through first-hand observation rather than relying exclusively on report, therefore the assessment including the OASIS must be performed in the physical presence of the patient in their home or place of residence.

**Patient hospitalized after one visit**

**Question 3: If a patient was admitted to the hospital after the initial admission/SOC OASIS, but before another visit was completed, it is my understanding that we do not need to transmit that OASIS. When they are discharged from the hospital after more than a 24 hour stay, do we complete a new SOC assessment and use that as the SOC date and transmit that OASIS? If this is the case, what do we do with the initial OASIS?**

**Answer 3:** The OASIS data collection instrument was originally developed so that home health agencies could



calculate patient outcomes as part of their quality improvement initiatives. In order to produce end result outcomes, patient level data collected at SOC/ROC is compared to the data collected at discharge. When only one visit is made, it is impossible to calculate end result outcomes. Therefore, since the December 2002 OASIS burden reduction initiatives, home health agencies have not been required to collect and/or submit OASIS data for one-visit episodes. If you admit a patient to your home health agency and then become aware that for whatever reason no additional visits will be made after the first visit, you are not required to collect, or submit any already-collected, OASIS data to the State system for that patient episode. You may elect to submit the Home Health Resource Group (HHRG) to your fiscal intermediary/payer in order to obtain payment for the single visit, if eligibility and coverage criteria are met.

If the agency elected not to submit the OASIS data collected during the SOC assessment, discharging the patient upon admission to the inpatient facility (internal discharge, not OASIS DC), a new SOC would be completed upon return home. The agency would file the pre-hospitalization SOC assessment in the patient's record and may bill for the visit if the eligibility and coverage requirements of the payer were met (a billable service was provided).

If after completing the initial assessment visit and SOC comprehensive assessment (in conjunction with



a reimbursable visit), the patient was admitted to an inpatient facility before a 2nd visit was provided, the agency may select an alternative process involving transferring the patient upon eligible inpatient admission, and resuming care (ROC - RFA #3) upon the patient's return home. In this case, assuming the patient was a skilled Medicare/Medicaid patient, submission of the assessments to the State would be expected.

## CATEGORY 4b – Item-specific Questions

**M0090**

**Question 4: I am not sure how to complete M0090 when it is a therapy only case and the RN in the office performs the final review and checking off of the medication sheet for interactions or issues?**

**Answer 4:** M0090, Date Assessment Completed, is the date that the last piece of information necessary to complete the comprehensive assessment is gathered. The Condition of Participation, 484.55, the Comprehensive Assessment of Patients, requires that a drug regimen review be performed each time a comprehensive assessment is required. If your physical therapists rely on a nurse in the office to perform certain components of the drug regimen review (i.e., identifying drug-drug interactions), the date the RN in the office communicates her drug regimen review findings back to the PT becomes the M0090 date, the date the assessment was completed, assuming all other

comprehensive assessment data had been previously collected.

**M0246**

**Question 5: Is there any regulation that would prohibit the use of applying diagnostic codes to M0246 on our Non-MC or non-PPS OASIS patients when any V-code replaces a diagnostic code?**

**Answer 5:** M0246, Case Mix Diagnoses, is a payment item for use in the Prospective Payment System (PPS). It is intended to ensure appropriate assignment of the patient into a Home Health Resource Group (HHRG). OASIS rules and guidance for M0246 apply to patients that fall under the Medicare prospective payment system. M0246, Case Mix Diagnoses, is an optional item and there is no regulation that prohibits completing it for private pay patients when a V-code replaces a diagnostic code.

**M0250, M0780, M0810, M0820**

**Question 6**: **I have a patient who has just started chemotherapy with IV access present. She is unable to take oral medications or food and has a gastrostomy tube that is being flushed with water to maintain patency. The patient is scheduled to return to the physician in two weeks for further assessment and to obtain enteral nutrition orders. How do I score M0250, M0780, M0810, and M0820 at SOC?**

**Answer 6**: M0250, Therapies at Home - If the patient's IV access for the chemotherapy was ordered to be flushed in



the home, Response 1 would be appropriate, otherwise it would be 4-NA, as the patient is not receiving one of the listed therapies at home.
M0780, Management of Oral Medications, would be NA-no oral medications prescribed
M0810/820, Patient Management of Equipment - Even though the patient's g-tube is only being flushed with water to maintain patency until the feeding is ordered, the patient/cg must maintain the enteral nutrition equipment, so it would be appropriate to assess and report their ability to manage the equipment.

**M0290**

**Question 7: The guidance for OASIS item M0290 states: "Agencies are encouraged to develop written guidelines or policies that provide definitions or parameters, based on nationally accepted guidelines." I am having trouble finding the "nationally accepted guidelines" and would like some help in locating these guidelines to define "heavy smoking, Alcohol dependency and Drug dependency".**

**Answer 7**: Each agency should develop their own guidelines and policies based on literature and guidelines published by reputable national organizations. CMS is not prescriptive regarding the specific guidelines utilized, just that they are generally accepted by the healthcare community as national leaders in the areas of health promotion, disease prevention and evidence based medicine.



**M0482**

**Question 8**: **Our patient has a complicated wound involving a mid-line abdominal incision and 6 buttons holding retention sutures running under the skin. Would each button be considered a surgical wound for OASIS data collection?**

**Answer 8**: No, a retention suture that utilizes a button to prevent damage to the skin is not considered a surgical wound.

**M0482**

**Question 9: Is a Q ball used for pain management following a joint replacement considered a surgical wound if the Q ball remains in place? Is it considered a surgical wound after removal if the site is still observable?**

**Answer 9:** The ON-Q pump was developed to continuously infuse local anesthetic through 2 small catheters inserted at the wound site. If the catheters are inserted into the surgical incision, they are not considered separate surgical wounds. If the surgeon implanted the catheters at locations other than the surgical incision, the insertion sites would be considered separate surgical wounds, as the ON-Q pump catheters are implanted infusion devices. After discontinuation of the infusion, the insertion sites would be considered current surgical wounds until healed.

**M0482**



**Question 10: Is a VP shunt for hydrocephalus a current surgical wound, no matter how old it is?**

**Answer 10**: The incision created to implant the VP shunt is a surgical wound until it heals. After the incision heals, it is no longer considered a current surgical wound, as the VP shunt is neither venous access device nor an infusion device.

**M0770**

**Question 11: How do you answer M0770 for a man with a laryngectomy who is unable to speak but able to use the text function on his mobile telephone?**

**Answer 11:** M0770, Ability to Use Telephone, identifies the patient's ability to safely answer the phone, dial a number, and effectively use the telephone to communicate. If a speech-impaired patient can only communicate using a phone equipped with texting functionality, response "1-Able to use a specially adapted telephone…" would be selected.