



**Reference Manual**

Tab 7:  
OASIS Questions  
and Answers



## CATEGORY 1 – APPLICABILITY

[Q&A EDITED 09/09]

### **Q1. To whom do the OASIS requirements apply?**

A1. The comprehensive assessment and OASIS data collection requirements apply to Medicare certified home health agencies (HHAs) and to Medicaid home health providers in States where those agencies are required to meet the Medicare Conditions of Participation. The comprehensive assessment requirement currently applies to all patients regardless of pay source, including Medicare, Medicaid, Medicare managed care (now known as Medicare Advantage), Medicaid managed care, and private pay/including commercial insurance. The comprehensive assessment must include OASIS items for all skilled Medicare, Medicaid, and Medicare or Medicaid managed care patients with the following exceptions: patients under the age of 18, patients receiving maternity services, patients receiving only chore or housekeeping services, and patients receiving only a single visit in a quality episode. 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. OASIS requirements for patients receiving only personal care (non-skilled) services have been delayed since 1999. The transmission requirement currently applies to Medicare and Medicaid patients receiving skilled care only. **Note:** The Medicare PPS reimbursement system requires a PPS (HHRG/HIPPS) code to be submitted on the claim of any Medicare PPS patient under 18 or receiving maternity services. While the OASIS data set was not designed for these population types, and is not required by regulation to be collected, in these rare instances, HHAs desiring to receive payment under Medicare PPS would need to collect the data necessary to generate a HHRG/ HIPPS code. The HHA is not required to transmit these data to the State. (You can read or download the December 2003 notice from <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage>. Search for 04-12)

[Q&A ADDED 09/09; Previously CMS OCCB Q&A 04/09 Q&A #1]

### **Q1.1. We are a pediatric Medicaid certified home healthcare agency. We are currently collecting OASIS data on several clients over the age of 18. If we were not Medicare certified, would we need to continue to collect OASIS on these clients?**

A1.1. First, if you are solely a Medicaid home health provider and not a Medicare certified provider, you would only be required to collect OASIS if your state requires you to meet the Medicare Conditions of Participation. If, as an organization, you are required to collect and submit OASIS because your state requires you to meet the Medicare Conditions of Participation, you must do so on all skilled Medicare and Medicaid patients except those under the age of 18, maternity patients, personal care only patients and patients receiving only a single visit in a quality episode.

[Formerly Q&A #8; EDITED 08/07]

### **Q1.2. A patient turns 18 while in the care of an HHA -when do we do the first OASIS assessment?**

A1.2. If the patient is under age 18 and the home care is covered under Medicare PPS, the HHA must complete the comprehensive assessment, including the OASIS, to obtain a Medicare PPS (HHRG/HIPPS) code. The HHRG/HIPPS code is submitted on the request for advance payment (RAP). The OASIS data would not be submitted to the State OASIS system. For a skilled Medicare/Medicaid patient who turns 18 while under the care of an HHA, the comprehensive assessment with OASIS data collection and submission to the State OASIS system would occur the first time one of the following events takes place: 1-When patient returns home from a qualifying inpatient stay - Resumption of Care, i.e., RFA#3; 2-When patient is transferred to an inpatient facility for 24 hours or longer (for a reason other than diagnostic tests) -Transfer to an Inpatient Facility -RFA#6 if not discharged from the HHA or RFA#7 if discharged from the HHA; 3-When the 60 day recertification is due, i.e., the last five days of the certification period -Follow-up, i.e., RFA#4; 4-When there is a major decline or major improvement in the patient's condition to update the care plan -Other follow-up, i.e., RFA#5; or 5-On death of the patient at home, or when the patient is discharged from the agency i.e., RFA#8 - death or RFA#9 -normal discharge.

If the patient is not a Medicare or Medicaid patient, other regulations apply. Effective December 8, 2003, OASIS data collection for non-Medicare/non-Medicaid patients was temporarily suspended under Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Note that the Conditions of Participation (CoP) at 42 CFR sections 484.20 and 484.55 require that agencies must provide **each** agency patient, regardless of payment source, with a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward the achievement of desired outcomes. The comprehensive assessment must also identify the patient's continuing need for home care, medical, nursing, rehabilitative, social, and discharge planning needs. If they choose, agencies may continue to collect OASIS data on their non-Medicare/non-Medicaid patients for their own use. To access the CoP, go to <http://www.cms.hhs.gov/center/hha.asp>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

A memo was sent to surveyors on 12/11/03, "The Collection and Transmission of the Outcome and Assessment Information Set (OASIS) for Private Pay Patients," which you can access by going to the CMS OASIS web site at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage>, scroll down and click on "Survey and Certification Policy Memoranda," it is memo 04-12 on the list for 2004.

[Q&A ADDED 09/09; Previously CMS OCCB Q&A 10/07 Q&A #1]

**Q1.3. It is my understanding that OASIS collection is not required for Medicare patients under the age of 18. How do you submit a claim with the appropriate HIPPS/HHRG if you do not complete the OASIS assessment? If you do complete an OASIS assessment, can it be submitted to the state? Where would I search on the website for this type of information?**

A1.3. The Conditions of Participation do not require OASIS data collection on pediatric patients. However, if Medicare is the payer, at least the payment OASIS items would have to be collected in order to generate the payer requirement of a HHRG/HIPPS code. This code would be submitted to the Regional Home Health Intermediary (RHII) for billing purposes only. The data should not be submitted to the State System. The OASIS State System will reject any incomplete assessments or any data submitted for patients younger than 18 years of age.

For further information regarding data submission, contact your OASIS Automation Coordinator (OAC). Contact information is available at [http://www.cms.hhs.gov/OASIS/07\\_AutomationCoord.asp#TopOfPage](http://www.cms.hhs.gov/OASIS/07_AutomationCoord.asp#TopOfPage). For further information about coverage or billing, contact your RHHI.

**2. [Q&A RETIRED 09/09; REDUNDANT TO GUIDANCE FOUND IN Q&A #2.1]**

[Formerly Q&A 11; EDITED 09/09; ADDED 08/07; Originally CMS OCCB Q&A 05/07 Q&A #1]

**Q2.1. Do we need to collect OASIS on a patient admitted to home health with post-partum complications? If we open a patient 2-3 months after a C-section for infection of the wound, do we collect OASIS, or do we consider this "maternity"? What is the definition of "maternity" and when do we collect OASIS on these patients?**

A2.1. The Conditions of Participation do not require OASIS data collection for patients receiving only maternity-related services. If the patient was a Medicare PPS patient, the OASIS data would be required in order to generate an HHRG/HIPPS code for payment under PPS.

Post-partum complications and a wound infection in the C-section incision are only possible in maternity patients. Maternity patients are patients who are currently or were recently pregnant and are receiving treatment as a direct result of the pregnancy.

[Q&A EDITED 09/09]

**Q3. How do the OASIS regulations apply to Medicaid HHA programs? Do the OASIS regulations apply to HHAs operating under Medicaid waiver programs?**

A3. The OASIS regulations apply to HHAs that must meet the home health Medicare Conditions of Participation (CoP). An agency that currently must meet the Medicare CoP under Federal and/or State law will need to meet the CoP related to OASIS and the comprehensive assessment. If an HHA operates under a Medicaid waiver, and if that State's law requires HHAs to meet the Medicare CoP in order to operate under the Medicaid waiver, then OASIS applies. If an HHA operates under a Medicaid waiver, and if that State's law does not require that the HHA meet the Medicare CoP in order to operate under the Medicaid waiver, then OASIS does not apply. HHAs should be aware of the rules governing HHAs in their State. Currently, OASIS requirements apply to all patients receiving skilled care reimbursed by Medicare, Medicaid, and Medicare or Medicaid managed care patients with the following exceptions: patients under the age of 18, patients receiving maternity services, patients receiving only chore or housekeeping services, and patients receiving only one visit in a quality episode. OASIS requirements have been delayed for patients receiving only personal care (non-skilled) services.

[Q&A EDITED 08/07]

**Q4. We are an HHA that also provides hospice services. Do the OASIS requirements apply to our hospice patient population? What if they are receiving 'hospice service' under the home care agency (not the Medicare hospice benefit)? Would OASIS apply?**

A4. Medicare Conditions of Participation (CoP) for home health are separate from the rules governing the Medicare hospice program. Care delivered to a patient under the Medicare home health benefit needs to meet the Federal requirements put forth for home health agencies, which include OASIS data collection and reporting for skilled Medicare and Medicaid patients. Care delivered to a patient under the Medicare hospice benefit needs to meet the Federal requirements put forth for hospice care, which do not include OASIS data collection or reporting. However, if a Medicare patient is receiving skilled terminal care services through the home health benefit, OASIS applies.

**Q5. We have a branch of our agency that serves non-Medicare patients. Can you elaborate on whether we need to do the comprehensive assessment with OASIS for these patients? We do serve Medicaid patients from this branch --does this make a difference?**

A5. If an HHA is required to meet the Medicare Conditions of Participation (CoP), then all of the CoP apply to all branches of that agency including the comprehensive assessment and OASIS data collection. Whether the agency has different branches operating under a single provider agreement/number serving different patient populations does not matter. Some States, as a part of State licensure or certification, allow HHAs to establish completely separate entities for serving other than Medicare/Medicaid patients. If the separate entity does not have to comply with the Medicare CoP for any reason (e.g., they do not have to meet the Medicare CoP to compete for managed care contracts, etc.) and the individual State does not require Medicare compliance, then none of the CoP applies. To be considered a separate entity, several requirements must be met, including separate incorporation for tax and business purposes, separate employer IDs, separate staff, separate billing and cost reporting systems, etc. If this separate entity is not meeting the Medicare CoP, then it cannot be using Medicare certification for any reason, including payment or competing for contracts.

[Q&A EDITED 08/07]

**Q6. Does the patient's payer source matter? Should we collect OASIS data on private pay patients who are only paying for aide service? What about a patient receiving therapy services under Medicare Part B?**

A6. Effective December 8, 2003, OASIS data collection for non-Medicare/non-Medicaid patients was temporarily suspended under Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. Note that the Conditions of Participation (CoP) at 42 CFR sections 484.20 and 484.55 require that agencies must provide **each** agency patient, regardless of payment source, with a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward the achievement of desired outcomes. The comprehensive assessment must also identify the patient's continuing need for home care, medical, nursing, rehabilitative, social, and discharge planning needs. If they choose, agencies may continue to collect OASIS data on their non-Medicare/non-Medicaid patients for their own use. A Survey and Certification Memo (#04-12) sent to surveyors on 12/11/03, further explains the requirement change. It is accessible at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage> (Search for 04-12 in fiscal year 2004)

If the agency provides services to a private pay patient paying for personal care services only, e.g. aide services the agency would be required to conduct a comprehensive assessment, excluding OASIS, of the patient. A comprehensive assessment is not required if only chore or housekeeping services are provided.

The Medicare home health benefit exists under both Medicare Part A and Medicare Part B. Patients receiving skilled therapy services under the Medicare home health benefit that are billed to Medicare Part B would receive the comprehensive assessment (including OASIS items) at the specified time points if care is delivered in the patient's home. If a Medicare patient receives therapy services at a SNF, hospital, or rehab center as part of the home health benefit simply because the required equipment cannot be made available at the patient's home, the Medicare Conditions of Participation apply, including the comprehensive assessment and collection and reporting of OASIS data. However, if the services are provided to a patient RESIDING in an inpatient facility, then these are not considered home care services, and the comprehensive assessment would not need to be conducted.

If a Medicare beneficiary receives outpatient therapy services from an approved provider of outpatient physical therapy, occupational therapy, or speech-language pathology services under the Medicare outpatient therapy benefit (as opposed to the Medicare home health benefit), then OASIS requirements would not apply. Bear in mind that under PPS, if the patient is under a home health plan of care, the outpatient therapy is bundled into the prospective payment rate and is not a separate billable service. See our February 12, 2001 Survey and Certification memorandum (#3 for 2001) at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage>, "The Application of OASIS Requirements to Medicare Beneficiaries..." for more information on the applicability of OASIS to Medicare beneficiaries.

**Q7. When a nurse visits a patient's home and determines that the patient does not meet the criteria for home care (e.g., not homebound, refuses services, etc.), is the comprehensive assessment required? What about OASIS data collection?**

A7. If the individual was determined to not be eligible for services, the patient would not be admitted for care by the agency, and no comprehensive assessment or OASIS data collection would be required. No data would be transmitted to the State agency.

**Q8** [Q&A RENUMBERED; now Q#1.2]

[Q&A EDITED 08/07]

**Q9. Can you explain the term 'skilled service?'**

A9. Skilled services covered by the Medicare home health benefit are discussed in the Medicare Benefit Policy Manual. This publication can be found on our website at: <http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf>.

**Q10. What is the current status of OASIS applicability to patients receiving only personal care services?**

A10. The applicability of OASIS to patients receiving only personal care services is delayed and will remain so until a new Federal Register notice is published that announces otherwise.

**Q11** [Q&A RENUMBERED; now Q#2.1]





## CATEGORY 2 - COMPREHENSIVE ASSESSMENT

[Q&A EDITED 09/09]

**Q1. Are OASIS data collected on patients that are recertified or only on patients that are transferred or discharged?**

A1. The Condition of Participation (CoP) published in January 1999 requires a comprehensive patient assessment (with OASIS data collection) be conducted for all adult, nonmaternity patients receiving skilled care at start of care, at resumption of care following an inpatient facility stay of 24 hours or longer for reasons other than diagnostic testing, every 60 days or when there is a major decline or improvement in patient's health status, and at discharge. OASIS data collection is also required for a Transfer to an Inpatient Facility (a stay in an inpatient facility bed of 24 hours or longer for reasons other than diagnostic testing) and at Death at Home.

OASIS data collection, effective December 8, 2003, is required for skilled Medicare and skilled Medicaid patients only. Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (<http://www.treas.gov/offices/public-affairs/hsa/pdf/pl108-173.pdf>) temporarily suspends the requirement that Medicare-certified home health agencies collect OASIS data on non-Medicare/non-Medicaid patients. Note that the CoP at 42 CFR sections 484.20 and 484.55 require that agencies must provide **each** agency patient, regardless of payment source, with a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward the achievement of desired outcomes. The comprehensive assessment must also identify the patient's continuing need for home care, medical, nursing, rehabilitative, social, and discharge planning needs. If they choose, agencies may continue to collect OASIS data on their non-Medicare/non-Medicaid patients for their own use.

A Survey and Certification Memo (#04-12) sent to surveyors on 12/11/03, further explains the requirement change. It is accessible at <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopofPage> (Search for 04-12)

Note that a private pay patient is defined as any patient for whom M0150 Current Payment Source for Home Care does **NOT** include responses 1, 2, 3, or 4. If a patient has private pay insurance in conjunction with M0150 response 1, 2, 3, or 4 covering the care the agency is providing, then OASIS data must be collected (this includes patients for whom Medicare may be a secondary payer).

[Q&A EDITED 09/09]

**Q2. In my agency, we have 'maintenance' type patients. For example, in one case a monthly visit was made on March 20, 2000, and we found that a patient had been hospitalized March 2, 2000. We were not notified of that hospitalization. The patient had returned home, and no problems were noted. What would I need to do to comply with the OASIS collection requirements?**

A2. In most cases, a hospitalization of 24 hours or more, which occurs for reasons other than diagnostic testing, is a significant event that can trigger changes in the patient and may alter the plan of care. When you learn of a hospitalization, you need to determine if the hospital stay was 24 hours or longer and occurred for reasons other than diagnostic testing. If the hospitalization was for less than 24 hours (or was more than 24 hours but for diagnostic purposes only), no special action is required. If the hospitalization did

meet the criteria for an assessment update, complete an assessment that includes the Transfer to Inpatient Facility OASIS data items using response 6 in M0100 - Reason Assessment is Being Completed. Enter March 20, 2000, as the response to M0090 (if that was the date you completed the data collection after learning of the hospitalization) and March 2, 2000, in M0906 (the actual date of the transfer). You have 2 days from the point you have knowledge of a patient's return home from an inpatient stay to complete the Resumption of Care assessment, selecting response 3 for M0100. M0090 will be the date the assessment is actually completed. The Resumption of Care Date (M0032) would be the first visit after return from the hospital, i.e., March 20, 2000 in this example. When completing the Resumption of Care (ROC) assessment, follow all instructions for specific OASIS items. For example, in responding to M1000, when the inpatient facility discharge date was more than 14 days prior to the ROC date, NA is the appropriate response. M1005 and M1010 thus will not be answered.

[Q&A EDITED 08/07]

**Q3. Do we have to complete an OASIS discharge on a patient who has been hospitalized over a specific time period?**

A3. The agency will choose one of two responses to OASIS item M0100 when a patient is transferred to an inpatient facility for a 24-hour (or longer) stay for any reason other than for diagnostic testing:

M0100=6 - Transfer to an Inpatient Facility--patient not discharged from agency; or

M0100=7 - Transfer to an Inpatient Facility--patient discharged from agency.

The agency's internal policies should guide the decision whether or not to discharge a patient. For additional guidance on transferring Medicare PPS patients with or without discharge, see the OASIS Considerations for Medicare PPS Patients document found at the QIES Technical Support website

<https://www.qtso.com/download/OASISConsidForMedicarePPSPatRev.pdf>

**Q4. May an LPN, OTA, or PTA perform the comprehensive assessment?**

A4. No. An LPN, OTA, and PTA are clinicians that are not qualified to establish the Medicare home health benefit for Medicare beneficiaries or perform comprehensive assessments.

[EDITED 09/09]

**Q5. What comprehensive assessments do I need to complete on my Medicare PPS patients?**

A5. You must conduct a comprehensive assessment including OASIS data items at start of care, at resumption of care following an inpatient facility stay of 24 hours or longer, every 60 days, and at discharge. When a patient is transferred to an inpatient facility for 24 hours or longer for reasons other than diagnostic testing or dies at home, a brief number of OASIS data items must be collected, but no Discharge comprehensive assessment is required.

[EDITED 09/09]

**Q6. Does information documented in OASIS have to be backed up with documentation elsewhere in the patient's records?**

A6. There is no regulatory requirement that OASIS assessment data be duplicated elsewhere in the patient record. However, we expect patient needs that have been assessed in the agency comprehensive assessment would be reflected in the patient's medical record or plan of care. This is in accordance with Condition of Participation (CoP) 42 CFR 484.48, Clinical Records, requiring a clinical record containing pertinent past and current findings in accordance with accepted professional standards be maintained for every patient receiving home health services. (The CoPs can be read or downloaded from [http://www.access.gpo.gov/nara/cfr/waisidx\\_99/42cfr484\\_99.html](http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html)). For example, if the response for OASIS item M1030 - Therapies the patient receives at home, were 1, 2, or 3, then the medical record should reflect appropriate interventions and physician orders to provide the required intravenous or infusion therapy, parenteral, or enteral nutrition. The clinical record would also have appropriate documentation of the implementation and evaluation of the interventions. The medical record and the plan of care should reflect the aspects of care for which the HHA has responsibility, including the therapy(ies) provided at home. Documentation in the clinical record, for example, may indicate that the patient and caregiver are learning all aspects of administering the therapy, with an outline of the focus of education and assessment provided by the agency. Another patient/caregiver may be independent with providing the therapy, but the HHA is periodically re-evaluating the patient's nutritional and fluid status during this episode.

Another example would be OASIS item M1200, Vision, with a response of 1 or 2. This would mean that for response 1, the patient has partially impaired vision, i.e., the patient cannot see medication labels. Therefore, the plan of care would need to document the plan for ensuring that the patient receives the correct medications at the correct times, and the clinical record would contain documentation of the education provided and evaluation of the interventions implemented.

[Q&A EDITED 09/09]

**Q7. At Recertification, our agency collects only the Reduced Burden OASIS items. Is this sufficient to meet the CoP for the follow-up assessment?**

A7. The OASIS items alone are not a complete comprehensive assessment and must also have the agency-determined components of the Follow-Up comprehensive assessment.

**Q8.** [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat 4b, Q15]

**Q9. Who can perform the comprehensive assessment when RN and PT are both ordered at SOC?**

A9. According to the comprehensive assessment regulation, when both disciplines are ordered at SOC, the RN would perform the SOC comprehensive assessment. Either discipline may perform subsequent assessments.

**Q10. Who can perform the comprehensive assessment when PT is ordered at SOC and the RN will enter 7-10 days after SOC?**

A10. If the RN's entry into the case is known at SOC (i.e., nursing is scheduled, even if only for one visit), then the case is NOT therapy-only, and the RN should conduct the SOC comprehensive assessment. If the order for the RN is not known at SOC and originates from a verbal order after SOC, then the case is therapy-only at SOC, and the

therapist can perform the SOC comprehensive assessment. Either discipline may perform subsequent assessments.

[Q&A EDITED 08/07]

**Q11. Who can perform the comprehensive assessment for a Medicare PPS patient when PT (or ST) is ordered along with an aide?**

A11. Because no nursing orders exist, the PT (or ST) could perform the comprehensive assessment at the SOC and all subsequent assessments.

[Q&A EDITED 09/09]

**Q12. Who can perform the comprehensive assessment for a therapy-only case when agency policy is for the RN to perform an assessment before the therapist's SOC visit?**

A12. A comprehensive assessment performed on a date BEFORE the SOC date cannot be entered into HAVEN (or HAVEN-like software) and does not meet the requirements of the regulations. Since the regulations allow for the comprehensive assessment to be conducted by the therapist in a therapy-only case, the agency may consider changing its policies so that the therapist could perform the SOC comprehensive assessment. If the agency chooses to have an RN conduct the comprehensive assessment, the RN should perform an assessment on or after the therapist's SOC date (within 5 days to be compliant with the regulation).

[Q&A ADDED 09/09; Previously CMS OCCB 04/08 Q&A #1]

**Q12.1. If an agency sends an RN out on Sunday to provide a non-billable initial assessment visit for a PT only case and the PT establishes the Start of Care on Monday by providing a billable service, is the 60-day payment episode (485 "From" Date) Sunday or Monday?**

A12.1. The Medicare Benefit Policy Manual explains: "10.4 - Counting 60-Day Episodes (Rev. 1, 10-01-03) HH-201.4 A. Initial Episodes The "From" date for the initial certification must match the start of care (SOC) date, which is the first billable visit date for the 60-day episode. The "To" date is up to and including the last day of the episode which is not the first day of the subsequent episode. The "To" date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days."

The "To" date (the 60<sup>th</sup> day of the payment episode) marks the end of the payment episode for the purposes of determining if a subsequent episode is adjacent or not for M0110 Episode Timing.

The Start of Care is established when a service is provided that is considered reimbursable by the payer. If an agency sends a clinician to the patient's home to provide a non-billable service, it does not establish the Start of Care. The Medicare PPS 60 day payment episode (485 From Date) begins on the date the first billable service is provided. In your scenario, the episode begins on Monday when the PT provides a billable service.

This guidance can be found in the Medicare Benefit Policy Manual  
<http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf>

[Q&A EDITED 08/07]

**Q13. Who can perform the comprehensive assessment when OT services are the only ones ordered for a non-Medicare patient?**

A13. The Occupational Therapist (OT) can perform the assessment if OT services establish program eligibility for the non-Medicare payer. While OT cannot establish program eligibility for Medicare patients, that may not be applicable to other payers. The OT may conduct subsequent assessments of Medicare patients.

**Q14. Who can perform the comprehensive assessment when both RN and PT will conduct discharge visits on the same day?**

A14. When both the RN and Physical Therapist (PT) are scheduled to conduct discharge visits on the same day, the last qualified clinician to see the patient is responsible for conducting the discharge comprehensive assessment.

[Q&A EDITED 09/09]

**Q15. Can the MSW or an LPN ever perform a comprehensive assessment? What about therapy assistants?**

A15. According to the comprehensive assessment regulation, a MSW or LPN is not able to perform the comprehensive assessment. Only RN, PT, SLP (ST), or OT is able to perform the assessment. Therapy assistants are also not able to perform the comprehensive assessment. This is no different from the previously existing Medicare Conditions of Participation (CoP) that set forth the qualification standards for those conducting patient assessments. The CoP can be read or downloaded from [http://www.access.gpo.gov/nara/cfr/waisidx\\_99/42cfr484\\_99.html](http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html), click on "Conditions of Participation 484.55, Comprehensive Assessment of Patients"

[Q&A ADDED & EDITED 9/09; Previously CMS OCCB 01/09 Q&A #5]

**Q15.1. My patient was released from the hospital and needed an injection that evening. The case manager was unavailable and planned to resume care the following day. Could the on call nurse visit and give the injection before the resumption of care assessment is done? Is there a time frame in which care (by an LPN or others) can be provided prior to the completion of the ROC assessment?**

A15.1. There are no federal regulatory requirements that prevent an LPN from making the first visit to the patient when resuming care after an inpatient facility stay, but there must be physician orders for the services/treatments provided during that visit. It is not required that the ROC comprehensive assessment be completed on the first visit following the patient's return home. OASIS guidance states that the Resumption of Care comprehensive assessment must be completed within 2 calendar days after the patient's return from the inpatient facility. The clinician that completes the ROC comprehensive assessment must be an RN, PT, OT or SLP.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/09 Q&A #4]

**Q15.2. Who can complete the OASIS data collection that occurs at the Transfer and Death at Home time points? Can someone in the office who has never seen the patient complete them? Does it have to be an RN, PT, OT or SLP?**

A15.2. Since the Transfer and Death at Home OASIS time points require data collection and not actual patient assessment findings, any RN, PT, OT or SLP may collect the data, as directed by agency policy. The OASIS-C Guidance Manual, under M0100, explains that a home visit is not required at these time points. As these time points are not assessments and do not require the clinician to be in the physical presence of the patient, it is not required that the clinician completing the data collection must have previously visited the patient. The information can be obtained over the telephone by any RN, PT, OT or SLP familiar with OASIS data collection practices. This guidance applies only to the Transfer and Death time points, as a visit is required to complete the comprehensive assessments and OASIS data collection at the Start of Care, Resumption of Care, Recertification, Other Follow-up and Discharge.

[Q&A EDITED 08/07]

**Q16. How does the agency develop a SOC comprehensive assessment that is appropriate for therapy-only cases?**

A16. Discipline-specific comprehensive assessments are expected to include: the OASIS items appropriate for the specific assessment (i.e., SOC, follow-up, etc.); agency-determined 'core' assessment items (appropriate for use by any discipline performing a comprehensive assessment); and discipline-specific assessment items. The combination of these components in an integrated form would constitute a discipline-specific comprehensive assessment for the appropriate time point. Discipline-specific assessment forms are available from commercial vendors and may be available through some professional associations. This subject is discussed more fully in Appendix A of the *OASIS-C Guidance Manual* located at [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage)

[Q&A EDITED 09/09]

**Q17. Are we required to discharge patients from the agency when they are admitted to an inpatient facility?**

A17. The agency may develop its own policies and procedures regarding discharging patients at the time of admission to inpatient facilities, but must be cognizant of the billing implications for Medicare PPS patients. Questions about billing must be directed to the agency's Medicare Administrative Contractor (MAC). For guidance on transferring patients with or without discharge, refer to the OASIS Considerations for Medicare PPS Patients located at the QIES Technical Support website <https://www.qtso.com/download/OASISConsidForMedicarePPSPatRev.pdf>.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 10/07 Q&A #2]

**Q17.1. During the SOC visit, the nurse completed all consents, OASIS, etc and was nearing the end of her visit. The patient developed symptoms which required transport to the ER. The patient was kept overnight for observation and then sent home. Do we have a Start of Care? Can we bill for the visit? If we don't bill, do we still have to do the SOC OASIS?**

A17.1. In the scenario presented, you describe a case in which an initial assessment was conducted, it was determined the patient met the payer's eligibility and your agency's admission criteria and a comprehensive assessment was begun, if not completed. If a reimbursable service was provided, it would have established the Start of Care. If the OASIS assessment was not completely finished and the criteria for a



Transfer to Inpatient was not met, the same clinician would have up to 5 days after the SOC date to complete the RFA 1, SOC comprehensive assessment. If the same clinician was unable to complete the SOC comprehensive assessment, a second clinician could visit the patient and start and complete a new SOC assessment within 5 days after the SOC date. The SOC date was established when the first reimbursable service was provided.

If no billable service was provided before the patient was transported to the ER, the Start of Care was not established and a new SOC would be completed upon return home from the inpatient facility.

If the patient was admitted to the HHA, the SOC was established, the clinician was unable to complete the SOC comprehensive assessment, and the patient's stay in the hospital was for 24 hours or longer for reasons other than diagnostic testing, the incomplete SOC assessment (and the transfer assessment) would not be able to be submitted. These documents should be maintained in the clinical record, with documentation explaining the unique circumstances. The agency may complete internal agency discharge paperwork and complete a new SOC when the patient returns home.

If the clinician was able to assess the 24 PPS payment items before the patient was hospitalized, you may contact your Medicare Administrative Contractor (MAC) to determine if they would allow you to bill for the visit.

Whether you decide to bill or not for this visit does not impact the OASIS data collection requirements. You are not required to collect and submit data on a one-visit only episode. If you do collect the OASIS data voluntarily, submission of the optional data to the state is not required.

Questions related to coverage and billing are addressed in the *Medicare Policy Benefit Manual* which is located at: <http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf> and the *Claims Processing Manual* located at: <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf>.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 04/09 Q&A #4]

**Q17.2. How do I handle a discharge on a Medicare patient who decides they are going to receive hospice in their home? M0100 only gives the option to transfer if it is to an inpatient facility not if the patient is opting to receive Hospice in the home which is not an inpatient facility.**

A17.2. If you need to discharge a patient from Medicare home health when they move to the Medicare Home Hospice benefit, you are required to complete the RFA 9, Discharge comprehensive assessment. M2420, Discharge Disposition, will be Response "3-Patient transferred to a noninstitutional hospice."

[Q&A EDITED 08/07]

**Q18. I understand that the initial assessment visit (or Resumption of Care assessment) is to be done within 48 hours of the referral (or hospital discharge). What do we do if the patient puts us off longer than that? For example, the patient says, "I have an appointment today (Friday); please come Monday."**

A18. The initial assessment visit is to be done within 48 hours of the referral OR on the physician-ordered date. In the absence of a physician-ordered SOC date, if the patient refuses a visit within this 48-hour period, the agency should contact the physician to determine whether a delay in visiting would be detrimental to the plan of care. The call should be documented in the patient's chart for future reference. The ROC visit is to be done within 48 hours of the patient's hospital discharge. The agency should contact the physician to determine whether a delay in visiting will be detrimental. At the ROC, there is no regulatory language allowing the ROC to be delayed by physician order, greater than 48 hours from the inpatient facility discharge. The agency should make every effort to complete the ROC assessment within the 48 hours from the discharge home. If the patient refuses or isn't available, the ROC assessment should be completed as soon as possible, with any physician communication and circumstance details documented in the clinical record.

**Q19. An RN visited a patient for Resumption of Care following discharge from a hospital. The nurse found the patient in respiratory distress and called 911. There was no opportunity to complete the Resumption of Care assessment in the midst of this situation. What should be done in this situation?**

A19. Any partial assessment that was completed can be filed in the patient record, but HAVEN (or HAVEN-like software) will not allow a partial assessment to be exported for submission to the State agency. In situations like this, a note explaining the circumstances for not completing the assessment should be documented in the chart. If, after the 911 call, the patient is admitted to an inpatient facility and then later returns home again, a Resumption of Care assessment would be indicated at that point. When the 911 call results in the ER treating the patient and sending the patient back home, the Resumption of Care assessment would be completed at the next agency visit.

[Q&A EDITED 08/07]

**Q20. Can you clarify the difference between the 'initial assessment' and the 'comprehensive assessment?'**

A20. The initial assessment visit is conducted to determine the immediate care and support needs of the patient and, in the case of Medicare patients, to determine eligibility for the home health benefit including homebound status. If no reimbursable service is delivered, this visit is not considered the SOC and does not establish the SOC date. The SOC comprehensive assessment must be completed on or within 5 calendar days after the SOC date and in compliance with agency policies. In the interest of cost-effectiveness, many agencies have combined the initial assessment with the delivery of skilled service(s), assuming the patient is eligible for home care. This would make the initial assessment and the SOC the same date. Also in the interest of efficiency, many agencies also encourage the admitting clinician to complete the SOC comprehensive assessment on this initial visit as well. In this case the SOC date (M0030) is the same as the date the assessment is completed (M0090). These protocols and procedures are a matter of agency choice and agency policy, as long as the regulatory time requirements are met.

[Q&A ADDED 09/09; Previously CMS OCCB 01/09 Q&A #1]

**Q20.1. Can our agency send out a non-clinical person to be the initial contact with a patient, to explain forms, collect signed consent forms, HIPAA forms, patient rights forms, etc, and collect demographic information to pass on to the**



**assessing clinician who will visit the patient at some point after this "intake visit" to conduct the initial assessment visit, and the comprehensive assessment? Does this practice violate the need to have an RN, PT, OT or SLP conduct the initial assessment visit? Would the answer change if the person going to the home first to do the "intake visit" was an LPN?**

A20.1. The Comprehensive Assessment of Patients Condition of Participation (484.55) requires that the initial assessment visit must be completed by an RN, if nursing orders exist at the SOC and by an appropriate, qualified therapist if no nursing orders exist. It would not meet the requirements of the Condition for an individual who is not qualified to perform assessments to enter the home before the skilled clinician who will be performing the initial assessment. This requirement is designed to ensure that the patient's immediate needs can be assessed and met. If an agency allowed a non-clinical person to enter the home to collect demographic information and explain rights and responsibilities, etc, it is possible that a potentially life threatening condition may not be assessed and treated. LPNs are not qualified to complete assessments so therefore it would not be compliant with the Condition to allow an LPN to conduct the initial assessment.

The agency may have a non-clinical person (or LPN, etc.) contact the patient by phone prior to the initial assessment visit to gather or impart some of the information related to patient rights and services, but the actual first visit to the home constitutes the initial assessment visit and must follow conditions outlined in the CoPs.

**Q21. For a discharge assessment, does the clinical documentation need to include anything other than the OASIS discharge items?**

A21. The exact content of the discharge comprehensive assessment documentation (other than the required OASIS items) is left to each agency's discretion. To fulfill the comprehensive assessment requirement, agencies should remember that the OASIS data set does not, by itself, constitute a comprehensive assessment. HHAs should determine any other assessment items needed for a discharge assessment and include these in their comprehensive discharge assessment.

[Q&A EDITED 08/07]

**Q22. If a patient died before being formally admitted to an inpatient facility, do I collect OASIS for Death at Home?**

A22. The OASIS discharge due to death is used when the patient dies while still under the care of the agency (i.e., before being treated in an emergency department or admitted to an inpatient facility). A patient who dies en route to the hospital is still considered to be under the care of the agency and the death would be considered a death at home. A patient, who is admitted to an inpatient facility or the hospital's emergent care center, regardless of how long he/she has been in the facility, is considered to have died while under the care of the facility. In this situation, the agency would need to complete any agency-required discharge documents (e.g., a discharge summary) and a transfer assessment (RFA 7, Transfer to Inpatient Facility, Patient Discharged) to close out the OASIS episode.

[Q&A EDITED 09/09]

**Q23. A patient recently returned home from an inpatient facility stay. The Transfer comprehensive assessment (RFA 6) was completed. The RN visited the patient to perform the ROC comprehensive assessment but found the patient critically ill. She performed CPR and transferred the patient back to the ER where, he passed away. The ROC assessment, needless to say, was not completed. What OASIS assessment is required?**

A23. The Transfer assessment completed the requirements for the comprehensive assessment. No further OASIS data collection is required. The patient did not resume care with the HHA. The agency's discharge summary should be completed to close out the clinical record.

[Q&A ADDED 09/09; Previously CMS OCCB 10/07 Q&A #3]

**Q23.1. During a therapy-only episode, the patient had an accidental fall and was hospitalized. An OASIS Transfer without discharge (RFA 6) was completed. Upon return from the hospital, the patient refused to have therapy continued and requested to be discharged from home health. We did the Discharge OASIS instead of a Resumption of Care (ROC) on the 1st day upon return from the inpatient facility but when transmitted, we get a sequencing error message.**

A23.1. The reason you are getting the sequencing error is because you completed a Transfer OASIS and then submitted a Discharge OASIS. When a Transfer OASIS is submitted, the next expected submission would be a Resumption of Care (ROC) - RFA 3. If the patient did not resume services at your agency, then an internal agency discharge (with no OASIS collection) would be expected. .

It is not clear whether or not you made a visit when the patient returned home from the hospital. If the patient returned home from the hospital and refused further visits, the Transfer OASIS would be the last OASIS data collection required. You would not need to complete an OASIS Discharge, just your agency's internal agency discharge paperwork.

If the patient returned home from the hospital and you made one visit (the ROC visit) and then the patient refused further visits, you are not required to collect and submit the ROC OASIS data to the state system for one visit episodes (quality episodes). You are required by the Conditions of Participation (484.55) to perform a comprehensive assessment when resuming care of a patient following an inpatient stay of 24 hours or longer for reasons other than diagnostic tests, but OASIS is not required when only one visit is made at the ROC.

[Q&A EDITED 09/09]

**Q24. Is it ever acceptable for an LPN to complete the OASIS? For example, could an LPN complete the OASIS if she/he were the last to see a patient prior to an unexpected re-hospitalization?**

A24. The comprehensive assessment and OASIS data collection must be conducted by an RN, PT, OT or SLP as described in the regulations. This is no different from the previously existing Medicare Conditions of Participation (CoP) that set forth the qualification standards of those conducting patient assessments. Patient assessment is not included in the duties of an LPN. The CoP can be read or downloaded from

[http://www.access.gpo.gov/nara/cfr/waisidx\\_99/42cfr484\\_99.html](http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html) , click on "Conditions of Participation 484.55, Comprehensive Assessment of Patients"

[Q&A EDITED 09/09]

**Q25. Do you have any information on what agencies are to do if the beneficiary refuses to answer OASIS questions? Are agencies not to admit, based on the refusal?**

A25. The OASIS items should be answered as a result of the clinician's total assessment process, not administered as an interview. Conducting a patient assessment involves both interaction (interview) and observation. Many times the two processes complement each other. Interaction and interview (i.e., report) data can be verified through observation - observation data adds to the information requested through additional interview questions. Many clinicians begin the assessment process with an interview, sequencing the questions to build rapport and gain trust. Others choose to start the assessment process with a familiar procedure such as taking vital signs to demonstrate clinical competence to the patient before proceeding to the interview. We suggest that agencies that seem to report a high degree of difficulty with specific OASIS items might be well advised to review with their staff the processes of performing a comprehensive assessment, because all OASIS items are required to be completed. Sometimes such difficulties indicate that clinical staff might benefit from additional training or retraining in assessment skills. The OASIS Web-Based Training (WBT) includes considerable information to help clinicians with assessment processes and can be accessed online at <http://www.oasistraining.org/>. In addition, a list of supplemental references regarding patient assessment is included in Appendix A of the *OASIS-C Guidance Manual*, available at [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage)

The Privacy Act Notices are available at:

[http://www.cms.hhs.gov/OASIS/03\\_Regulations.asp#TopOfPage](http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage)

**Q26. What Privacy Act statements are required since MMA 2003 temporarily suspended OASIS data collection for non-Medicare/non-Medicaid patients?**

A26. For non-Medicare/non-Medicaid patients in agencies that temporarily suspended OASIS items in their comprehensive assessment, the Notice about Privacy for Patients Who Do Not Have Medicare or Medicaid Coverage (Attachment C) is not currently required.

For non-Medicare/non-Medicaid patients in agencies that continue to include OASIS items in their comprehensive assessment, the Notice about Privacy for Patients Who Do Not Have Medicare or Medicaid Coverage (Attachment C) is required.

For all Medicare and Medicaid patients receiving skilled services, the Statement of Patient Privacy Rights for Medicare and Medicaid patients (Attachment A) and the Privacy Act Statement (Attachment B) are required.

The Privacy Act Notices are available at

[http://www.cms.hhs.gov/OASIS/03\\_Regulations.asp#TopOfPage](http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage)

[Q&A EDITED 08/07]

**Q27. What should we do about OASIS when a patient refuses?**

A27. Remember that the regulations require that a comprehensive patient assessment be conducted at specified time points, which for some patients includes the use of standardized data items as part of the assessment. These items, of course, are the OASIS data set. To discuss patient refusal, we must first address the components of a patient consent process. Typically, patient consent forms (which must be signed by the patient or their designated representative) include 4 components: a consent to be treated by the HHA; a consent for the HHA to bill the pay source on behalf of the patient; a consent to release patient-specific information to the physician, the patient's insurance carrier or other payer, etc.; and acknowledgement that the patient has been informed of his or her rights and has received written information about these rights. Consenting to treatment (#1) would include the performance of a comprehensive assessment that is necessary to develop a plan of care/treatment; releasing information to the payer source (#3) would include transmitting data to the State agency as a representative of Medicare/Medicaid; and acknowledgement of patient rights (#4) would include the receipt of the Privacy Act statements regarding patient rights. What then is the patient 'refusing,' and what is the HHA's response? Does the patient refuse to be assessed (i.e., refuse to be treated)? Most agencies have written policies (based on input from legal counsel) about how to handle such situations, and whether or not to provide care to a patient who refuses to agree to be treated. Does the patient refuse to have his/her information released (to the physician, to the payer, etc.)? How does the HHA obtain physician orders if no patient-specific information can be released? What information can be provided to the fiscal intermediary (or other pay source) requesting patient records to verify the provision of services, patient eligibility for services, etc.? Again, most HHAs will have obtained a legal opinion and promulgated written policies about providing services to a patient who refuses to consent to release of information.

During the comprehensive assessment, does the patient refuse to answer a specific interview question -- for example, "What is your birth date?" In this case, please recall that the OASIS items are not an interview, but rather request standardized information on each HHA patient. Nearly all OASIS items can be obtained through observation of the patient in the normal assessment process, or through review of discharging facility paperwork or caregiver interview. Many items that can ONLY be obtained by interview have a response option of 'unknown' at SOC. Two exceptions to this include the patient's Medicare number (M0063), and the patient's birth date (M0066). These data typically are obtained for billing purposes, so we feel confident that HHAs can find other ways to obtain the information. If a patient refuses to answer an interview question, the clinician must assess the patient and record the appropriate response to the OASIS item. Note that all (appropriate) OASIS items must be answered for a specific assessment, or the assessment cannot be transmitted. In the experience of HHAs that used the OASIS data items as part of a comprehensive assessment for well over 3 years during the national demonstration, the items were already part of their clinical documentation -- which means that the clinicians were already assessing patients for these very factors.

Note that the Privacy Act statements (to be provided to the patient) are informational in nature. It is expected that they will be presented to (and discussed with) the patient in a way similar to the other patient rights information currently required by the Medicare Conditions of Participation.

[Q&A EDITED 09/09]

**Q28. How are we to handle physical, speech or occupational therapy-only patients when these disciplines do not assess for the same elements as skilled nursing? The data set seems skewed toward nursing issues.**

A28. OASIS data items are not meant to be the only items included in an agency's comprehensive assessment. They are standardized health assessment items that must be incorporated/integrated into an agency's own existing assessment processes. For a therapy-only case, the primary therapist may conduct the comprehensive assessment using the comprehensive assessment data items incorporated into their form that includes whatever other inquiries the agency currently makes for therapy-only cases. Refer to Appendix A in the *OASIS-C Guidance Manual* for additional discussion of this issue. The manual is available at [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage)

[Q&A EDITED 09/09]

**Q29. We have integrated OASIS data items into our current assessment questions. Staff feels strongly that they need the admission OASIS information as a reference point. My understanding was that staff was NOT to have the original set of OASIS items as a reference.**

A29. For assessment items that reflect a patient's current status, like M1830, Bathing or M2020, Management of Oral Medications, clinicians should not look back to previous assessments, but should select a response based on the patient's usual status on the day of assessment.

For items that are not limited to a patient's current status, the assessing clinician may be required to look back to the previous assessment, or other clinical documentation since the last OASIS assessment, e.g., M1910, Falls Risk Assessment, which reports if a patient received a fall risk assessment since the last OASIS assessment, or M2400, Intervention Synopsis, which reports whether the patient's plan of care since the previous OASIS assessment included physician-ordered interventions to prevent pressure ulcers. This "look back" may be required to determine if specific assessments were completed, what the results of such assessments were, and/or what actions (e.g., orders, interventions implemented) resulted.

[Q&A EDITED 08/07]

**Q30. For how long a period may agencies place a patient on 'hold' status when the patient has been hospitalized?**

A30. At this time, CMS is not defining policy relating to an agency's hospitalization of patients. The agency should carefully consider the requirements for collecting assessment information on patients who are transferred to an inpatient facility for 24 hours or longer (and occurs for reasons other than diagnostic testing). The agency should review their current transfer and discharge policies to determine how the data collection requirements can best be met for transfer to an inpatient facility, resumption of care, and discharge assessments. Bear in mind that certain considerations should be made for your Medicare PPS patients. Refer to the information on the OASIS Considerations for Medicare PPS Patients located at the QIES Technical Support website <https://www.qtso.com/download/OASISConsidForMedicarePPSPatRev.pdf> for suggestions in keeping your assessments in sync with Medicare billing.

[Q&A EDITED 08/07]

**Q31. Does OASIS data collection have to be initiated on the very first contact in the home (the initial assessment visit), or is it OK to begin OASIS data collection on the start of care visit, if these two visits are at different times?**

A31. The Start of Care OASIS items, which must be integrated into your agency's own comprehensive assessment, must be completed in a timely manner, but no later than five calendar days after the start of care date. The comprehensive assessment is not required to be completed on the initial visit; however, agencies may do so if they choose.

**Q32. Does the medication list need to be reviewed by an RN if the patient is only receiving therapy services?**

A32. The standard for the drug regimen review is not new; it was included in the previous Conditions of Participation (CoP) under the plan of care requirements. The comprehensive assessment must include a review of all medications the patient is using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects and drug interactions, duplicate drug therapy, and noncompliance with drug therapy. The scope of the drug regimen review has thus been narrowed from the previous CoP. Each agency must determine the capabilities of current staff members to perform comprehensive assessments, taking into account professional standards or practice acts specific to your State. No specific discipline is identified as exclusively able to perform this assessment.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/09 Q&A #6]

**Q32.1. For therapy only cases where the therapist is completing the comprehensive assessment, is it acceptable practice to have an office based RN complete the medication review by reviewing the med profile completed by the therapist during the home visit, and making telephone contact with the patient/caregiver for any necessary discussion of side effects, interactions, duplicate or compliance issues? My understanding is that one clinician must complete the comprehensive assessment. Is this practice out of compliance with that rule?**

A32.1. You are correct; only one clinician can complete a comprehensive assessment. CMS OASIS Category 2 Q&A 32 explains that your agency may develop policies regarding how to handle the drug regimen review in therapy only cases. In therapy only cases, it is acceptable for an RN in the office to perform additional portions of the medication regimen review after the therapist collects the information regarding the patient's medication regimen as part of the comprehensive assessment. This would not be viewed as a violation of the one clinician rule. If areas of concern are identified, the agency must notify the physician and obtain orders for any nursing intervention to further assess and resolve issues and educate the patient regarding medication changes and management. Note that the therapist's face-to-face assessment may need to include more than just creating a list of medications in order to allow the additional review to be completed by an in-office RN. For instance, in identifying potential ineffective drug therapy or non-compliance, the therapist may need to assess and report physical signs and symptoms (such as depressive symptoms, edematous feet, rash, pain), or may need to report observations (such as pills remaining in med planner from previous days), or subjective comments related to the patient's compliance with medications.

[Q&A EDITED 08/07]

**Q33. For patients who are discharged after a hospital stay or a visit to the doctor, is it necessary to complete the discharge assessment? We will not be able to make a home visit after the discharge order is obtained.**

A33. The patient who is discharged after a hospital stay will have had OASIS data reported at the point of transfer to the inpatient facility. No additional assessments or OASIS data collection are expected in this situation unless a resumption of care occurs. Therefore, the agency will complete any agency-required discharge documents (e.g., a discharge summary), but no further OASIS data are collected or reported. If the physician determines at an office visit that the patient does not need additional visits and requests discharge, the agency must report the patient status at the last qualifying visit prior to this date (e.g., the last visit performed by a clinician qualified to conduct a comprehensive assessment). When agency staff are aware that the patient's needs for home care are decreasing and that a physician visit is imminent, the possibility of such discharge must be considered. It would be appropriate to update the physician on the progress seen in the home and suggest that it may be time to discharge the patient. Close attention to the details of the comprehensive assessment thus can be incorporated into the home visit scheduled prior to the physician visit.

**Q34. Is it possible to have two home health agencies independently provide services to a patient, and if so, does each agency complete a comprehensive assessment, including the OASIS data items?**

A34. Two participating agencies providing home health services under a Medicare home health plan of care is not allowed under PPS. One agency is the primary provider, whereby the primary provider reimburses the secondary agency under mutually agreed-upon arrangements. In this case, the primary agency is responsible for making sure that comprehensive assessments (including OASIS items) are conducted when due and submitted under the primary agency's name.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 10/07 Q&A #7]

**Q34.1. We admit a patient for BID wound care and several days after our SOC, we are made aware by our own staff that it appears that the patient had been open to another home care agency 2 weeks prior to and at the time of our agency's SOC. What are the OASIS requirements for this Medicare patient assuming that our agency is closing?**

A34.1. You are asking which OASIS is required for a patient who is already open under an active plan of care at another home health agency when taken under care by your agency. When more than one agency provides care to a patient simultaneously, one agency is considered primary and is responsible for the billing and OASIS data collection requirements. In your situation, it appears that your agency was not aware that the patient was already open under a primary agency, and that no arrangement existed between your agency and the primary agency. There is no OASIS data collection that will resolve your problem. It is a billing issue and you should refer to the *Medicare Claims Processing Manual*, Chapter 10, Section 10.1.5.1 - More Than One Agency Furnished Home Health Services, located at <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf> and contact your Medicare Administrative Contractor (MAC) for guidance.



[Q&A EDITED 09/09]

**Q35. The patient's payer source changes from Medicare to Medicaid or private pay (or vice versa). The initial SOC/OASIS data collection was completed. Does a new SOC need to be completed at the time of the change in payer source?**

A35. Different States, different payers, and different agencies have had varying responses to payer change situations, so we usually find it most effective to ask, "Does the new payer require a new SOC?" HHAs usually are able to work their way through what they need to do if they answer this question. If the new payer source requires a new SOC (Medicare is one that DOES require a new SOC), then it is recommended that the patient be discharged from the previous pay source and re-assessed under the new pay source, i.e., a new SOC comprehensive assessment. The agency does not have to re-admit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails a new admission). If the payer source DOES NOT require a new SOC, then the schedule for updating the comprehensive assessment continues based on the original SOC date. The HHA simply indicates that the pay source has changed at M0150. OASIS data collection and submission would continue for a Medicare/Medicaid patient changed to another pay source until the patient was discharged. Because the episode began with Medicare or Medicaid as a payer, the episode continues to be for a Medicare/Medicaid patient. Transmittal 61, posted January 16, 2004, includes a section on special billing situations and can be found in the *Medicare Claims Processing Manual*. Go to <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf> ; scroll to "Section 80 - Special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your Medicare Administrative Contractor (MAC).

**Q36. Could you explain what the term 'start of care' actually means? Is it related to payment?**

A36. The start of care is established on the date the first billable service is provided.

[Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #1]

**Q36.1. I understand the comprehensive assessment cannot be completed before the SOC date. Does that mean it's OK to start it at the initial assessment as long as it is not completed until on or after the SOC date?**

A36. 1. The SOC is established on the day the first billable service is provided. The SOC comprehensive assessment must be completed on or within 5 days after the start of care date. An initial assessment may be performed prior to the SOC date, ( e.g. RN admitting for a therapy only case). If agency policy is for the RN to perform the initial assessment during a non-billable visit in order to meet the Condition of Participation (484.55) time requirement of 48 hours for the completion of the initial assessment, and the RN does not provide a billable service, the SOC is not yet established. If the PT does not visit that same day, the date of the RN's initial assessment visit is not the SOC date. If the PT visits the next day, the SOC date is the day the PT visits and provides a billable service. While the RN likely conducted at least part of a comprehensive assessment in order to meet the requirements of an initial assessment visit to determine immediate care and support needs of the patient, any information collected on that date may not contribute to the SOC comprehensive assessment, as it was collected prior to the SOC date. The SOC comprehensive assessment that will include the OASIS data that will be



transmitted to the state as the SOC assessment must be collected on or within 5 days after the SOC date, not before.

[Q&A EDITED 09/09]

**Q37. Please discuss dealing with 'unplanned or unexpected' discharges.**

A37. In providing patient care that focuses on achievement of outcomes, the HHA assumes responsibility for monitoring patient progress and for coordinating care among all participating providers. The agency thus is responsible for planning, coordinating, and communicating about improvement in patient status that can indicate the need for less frequent visits or even discharge. Agencies that do this well will have relatively few 'unexpected' discharges, though such events can occur (for example, when a patient unexpectedly moves out of the service area). To meet the various requirements for the comprehensive assessment, as well as collection and use of OASIS data, the following requirements must be met:

1. the discharge assessment must report patient status at an actual visit (i.e., the clinician must be able to assess the patient, not merely report on patient status from a telephone call);
2. the comprehensive assessment must be conducted by a qualified clinician (RN, PT, SLP, OT);
3. the encoded OASIS data must accurately reflect the patient's status at the time of the assessment; and
4. the HHA's clinical record must contain documentation matching the encoded data sent to the State.

**Situation:** The nurse conducts a routine visit (not SOC) for Mr. N on August 4. An aide visits August 5 and August 7. On August 8, the physician calls the agency and unexpectedly discontinues home care. What OASIS data are reported? What dates are used for M0090, M0903, and M0906? How does the agency note the patient's status at discharge?

The general principle to follow in these cases is to report the patient's status on the last visit by the clinician qualified to complete the comprehensive assessment with OASIS. We suggest the following approach:

1. All OASIS data required for discharge must be reported. Response 9 for M0100-Reason Assessment is Being Completed will indicate that the patient is being discharged from the agency, but NOT to an inpatient facility.
2. M0090 would be noted as August 8, the date the agency completes the assessment after learning of the need to discharge. (This is the date to be used for compliance with the completion of the discharge assessment and data transmission requirements. Note: Regulation allows up to two calendar days after identification of need to discharge for completion of the discharge assessment.)  
M0903 - Date of Last (Most Recent) Home Visit would be noted as August 7.  
M0906 - Discharge/Transfer/Death Date would be reported as August 8 (if your agency defines discharge date as the date the agency is notified of the need to discharge.)
3. To be compliant with the discharge comprehensive assessment requirement, the qualified clinician that last saw the patient should complete the agency's discharge documentation as completely as possible, based on the patient status

at that provider's last visit -- in this example, August 4. The clinician should note on this documentation that this is a situation of an unexpected discharge and the discharge assessment is 'based on the visit of mm/dd/yyyy.' The OASIS data from this assessment will be encoded and transmitted. The agency will thus have a discharge assessment recorded and a clinical record document that matches the OASIS data transmitted to the State. Note that the clinician cannot "create" information that s/he did not assess at the visit. See CMS Category 2 Q&A 37.1 & 37.2 for further guidance.

**Variation 1:** What if the same dates apply to the nurse's visit (August 4) and the date the physician calls the agency to discontinue services (August 8), but there have been no aide visits? What, if anything, is different from the situation described above?

Only one difference exists between this situation and the one described above. That is the date recorded in M0903 - Date of Last (Most Recent) Home Visit. In this variation, the date would be August 4, the date of the nurse's visit.

**Variation 2:** The situation is the same as Variation 1, but agency policy requires the discharge date to be the date of the last visit. What, if anything, is different from the situation in Variation 1?

The date recorded in M0090 - Date Assessment Completed would be August 8, the date that the agency completed the assessment after learning of the need to discharge. M0903 - Date of Last (Most Recent) Home Visit again would be August 4. Agency policy would dictate the date to be recorded in M0906 - Discharge/Transfer/Death Date, which would be recorded as August 4 (the last actual visit). This will produce a warning message in HAVEN or other data entry software, because the assessment was completed more than two days after the discharge. The warning will not hinder locking and transmission of data.

**Variation 3:** What if the visits on August 5 and August 7 were made by an LPN (or therapy assistant)? What, if anything, is different from the situation described above?

There is no difference from the initial situation described earlier. The LPN (or therapy assistant) is not qualified to perform the comprehensive assessment, therefore the recorded assessment must describe the patient's status at the nurse's (or qualified therapist's) visit. If the LPN/therapy assistant made the last visit before the MD discontinued services, the LPN/therapy assistant's last visit date would be recorded for M0903. In this case, that date would be August 7.

**Variation 4:** What if the nurse's August 4th visit was the SOC assessment, followed by the aide visits on August 5 and August 7? What, if anything, is different from the initial situation?

There is no difference from this situation and the initial one described. The HHA must report the patient's status from an actual visit -- in this case, the only possible visit would be the SOC assessment. The qualified clinician must complete the agency's discharge documentation as noted above, with the note that the assessment is 'based on the visit of mm/dd/yyyy.'

**Variation 5:** What if the nurse makes a visit on August 4, expecting this to be the discharge visit pending a final check with the patient a few days later? A telephone call to the patient on August 8 confirms that the patient is doing well, and the agency discharges the patient. What, if anything, is different from the situations described above?

There are some subtle differences from the situations described above. Because the nurse is expecting the discharge to occur, it is recommended that a complete assessment be recorded on August 4. However, the regulations will require an assessment congruent with the discharge date of August 8. The agency must assure the presence in the clinical record of a discharge assessment completed on (or within 48 hours of) the date recorded in M0090 (August 8 in this example). The HHA has two options for this precise situation: (1) To conduct a (most likely nonreimbursed) visit on or after August 8 to complete another discharge assessment, or (2) To follow the procedures for recording a discharge assessment dated August 8, based on the patient status of August 4 (and so noted in the clinical documentation). Possibly a better option would be to place the telephone call to the patient within 48 hours of the August 4 visit, thus placing the discharge assessment and the discharge date within 48 hours of each other.

**Variation 6:** The RN's last visit to the patient was July 3, the SOC date. Since then the LPN has been following the patient and her last visit was August 4, with aide visits on August 5 and 7, before the physician called to order the discharge on August 8 because the patient no longer wanted care. Would the RN be allowed to complete the discharge assessment based on the LPN's last visit?

The Conditions of Participation (CoP) require that a comprehensive assessment (including OASIS items) be conducted at the time of discharge. The CoP (and many state licensing laws) do not include "assessment" as a duty of the LPN. The CoP can be read or downloaded [http://www.access.gpo.gov/nara/cfr/waisidx\\_99/42cfr484\\_99.html](http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html), click on "Conditions of Participation 484.55, Comprehensive Assessment of Patients". The RN could not create an assessment as if it were fact without seeing a patient. In such a situation the RN did not inspect the patient's skin, observe the patient's performance of activities, or collect much of the non-OASIS data needed in a comprehensive assessment (e.g., vital signs, breath sounds, etc.). This makes evident some legal issues involved for the nurse and the agency. When a licensed clinician signs an assessment, he/she is attesting that the documentation contained therein is correct. It would be difficult to make such an assertion if the clinician signing the document had not assessed the patient. Lastly, there is the issue of the agency's responsibility for managing patient care. When an agency admits a patient, the agency has a responsibility to ensure that a LPN's care is supervised by a RN. CoP 484.30(a) states that the "registered nurse makes the initial evaluation visit, regularly reevaluates the patient's nursing needs, initiates the plan of care and necessary revisions..." This scenario is concerning because apparently the supervising RN did not know that the patient did not want further care or why. It would be important for the agency to evaluate the care and supervision provided. Were there truly no indications that the patient wanted or needed to be discharged? If such information had been reported to the RN, perhaps the RN could have completed a reassessment to determine if discharge or a change in care plan was appropriate. The agency would not know whether discharge was appropriate at this time or if there was another reason for the patient's request. In

this situation, a registered nurse from the agency should complete a discharge assessment by visiting the patient.

For a more in-depth explanation of the rationale behind this response go to page 3768 (middle column) of the *Federal Register* posted January 25, 1999, where this was specifically addressed in the preamble to the statement of the Condition of Participation (CoP), 484.55. CMS pointed out that in the CoP (prior to 1999), patient evaluation is listed in the duties of the registered nurse at 484.30(a) and therapy services at 484.32, but not in the duties of the LPN at 484.30(b). Many State regulations also stipulate that patient evaluation and comprehensive assessment are duties of the registered nurse, not a licensed practical nurse. You can read or download the above-mentioned regulation in the *Federal Register* at [http://www.cms.hhs.gov/OASIS/03\\_Regulations.asp#TopOfPage](http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage), scroll down to the heading, "Reporting Regulations," and click on the link to view the final "collection" regulation.

HHAs who discover a large number of unplanned or unexpected discharges must be aware that retrospective data reporting can negatively impact the agency's outcome report in two ways: (1) the clinician's recall of patient status information is likely to be less accurate than the information recorded immediately upon assessment, and (2) the patient's status at time of discharge may actually be better (i.e., improved) than it was at the time of the visit conducted by the RN, PT, SLP, or OT.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 10/08 Q&A #1]

**Q37.1. For unexpected discharges, I understand that it is necessary to complete the DC OASIS assessment (RFA 9) "based on the last visit made"...since it is not possible to do an actual assessment. Is the same true when the physician places the patient on hold mid-episode pending further orders, but at end of episode - gives no further orders?**

- a. Would the "patient status" items be completed at the end of the episode without an actual patient visit but based on the last patient visit?**
- b. Would items referring to the "last 14 days" (M1016, M1018 & M1600) be completed at the end of the episode based on actual DC end of episode date, or 14 days prior to the last actual visit?**
- c. Would M0090, Date Assessment Completed, be the end of episode discharge date?**
- d. Would M0903, Date of last (most recent) home visit, be different than M0906, DC Date?**

**Completion of the Discharge OASIS in this case might take a "collaborative" effort between supervisors and field personnel, but as long as one person signs the OASIS and is responsible for accuracy, would we be compliant?**

A37.1. Only one person can complete an assessment, it is not a collaborative effort between field staff and supervisors. When a clinician signs the assessment, it is an attestation that the data contained in the assessment is accurate and based on the clinician's assessment. If more than one clinician contributed to the assessment, it would not be likely that the signing clinician actually personally assessed and knows the accuracy of every data element.

If a physician places the patient on hold mid-episode and then there is an unexpected discharge, (without opportunity to conduct a final in-home discharge assessment visit), then the last qualified clinician (RN, PT, OT, or ST) that visited the patient should complete the RFA 9, Discharge comprehensive assessment. When the clinician completes the patient status items, it will be based on the patient's condition as it existed on the day the qualified clinician made that last visit. The items referring to the last 14 days should be answered based on changes that occurred during the two week period immediately preceding the last qualified clinician's visit date (See CMS OASIS Q&As Category 4b, Q43.1). The M0090 date is the date the assessment was actually completed, but to be compliant should be within 2 calendar days of the discharge date. M0903 would be the date of the last home visit made by anyone from the agency that was included on the plan of care, which in the case of an unplanned discharge means it will likely be different than the M0906 discharge date.

Information in the medical record cannot be "made up" or "created" in an effort to be compliant with the Comprehensive Assessment of Patient Condition of Participation (484.55). There may be situations when a Discharge Assessment cannot be completed if no one clinician has all the information needed to complete it. If it is not possible to complete the Discharge Assessment, careful documentation should be included in the medical record to explain the circumstances that led to the non-compliance.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/09 Q&A #3]

**Q37.2. In reviewing CMS OASIS Category 2 Question 37.1, the response states that “there may be situations when a Discharge Assessment cannot be completed if no one clinician has all the information needed to complete it”, in which cases the circumstances related to the non-compliance should be documented.**

**Our documentation software program does not allow us to begin a new SOC for a patient, unless they have had a discharge assessment from a previous episode. Therefore, our internal documentation of the discharge and explanation of circumstances is not sufficient to allow us to readmit the patient at a later date. Please advise.**

A37.2. In situations where it is discovered that no one completed a Discharge assessment and there is no one person at the agency who has all the information needed to complete the assessment, it may not be possible to produce a Discharge assessment. This, of course means you are non-compliant with the Condition of Participation 484.55, Comprehensive Assessment of Patients.

Some computer software systems may require an agency to enter OASIS data at discharge in order for the system to function as designed. If the agency chooses, they may go back to the SOC assessment and utilize that data to complete the assessment as a clinician qualified to perform a comprehensive assessment must have completed it. Carefully document in the clinical record why this is being done. (See CMS OASIS Q&As Category 2, Question 37 for more detail). Again, this will represent non-compliance with the CoP 484.55 because an assessment was not performed at discharge, but will allow you to submit a Discharge Assessment. Note this will have a negative impact on your outcomes, as there would not be any improvement in any of the outcome measures.

If this option is not selected, the agency should document in the chart why a Discharge assessment was not completed and perform an internal agency discharge to remove the

patient from the billing system. The patient will remain on the OASIS Patient Management Roster for 6 months and then be removed by the state.

[Q&A ADDED 09/09; Previously CMS OCCB 01/09 Q&A #2]

**Q37.3. We are seeking guidance related to the following scenarios:**

**A) A qualified clinician completes the visit for the initial visit and comprehensive assessment, however before finishing the documentation of the corresponding OASIS, the clinician quits. The other pieces of the comprehensive assessment documentation are complete. What are the appropriate steps to complete the OASIS?**

**B) The qualified clinician completes an OASIS and then quits. During review of the documentation, a clinical supervisor notes a discrepancy between an OASIS response and other clinical documentation. What are the appropriate steps to correct the OASIS assessment?**

**C) Are there any other circumstances when it is appropriate for the director or supervisor to make a correction to an OASIS answer in lieu of the assessing clinician?**

A37.3.

A) In your scenario you state that a qualified clinician completed the initial visit and comprehensive assessment but did not complete the OASIS data items. For patients that require OASIS data collection (skilled Medicare, skilled Medicaid and others as directed by agency policy) the OASIS data items are considered part of the comprehensive assessment. They are not to be separated, but are integrated into the comprehensive assessment in a clinically meaningful manner. If following this requirement, as detailed in the Introduction to the *OASIS-C Guidance Manual* and CMS OASIS Q&As, Category 4a, Question 22, it is not understood how a clinician could have compliantly completed the comprehensive assessment without completing the OASIS data items.

If the comprehensive assessment for a patient requiring OASIS data collection was completed in a non-compliant manner and the OASIS data items were not completed, the agency should send another qualified clinician out during the allowed timeframe for completing the assessment, within 5 days after the Start of Care (SOC) date, to start and complete an entire comprehensive assessment, not just the OASIS items. It would be required that another qualified clinician complete the entire assessment because only one person can complete an assessment, it is not a collaborative effort between field staff or field staff and supervisors. When a clinician signs the assessment, it is an attestation that everything contained in the assessment is truthful and accurate, based on that clinician's assessment. Information in the medical record cannot be "made up" or "created" in an effort to be compliant with the Comprehensive Assessment of Patient Condition of Participation's (484.55) required timeframes. Careful documentation should be included in the medical record to explain the circumstances that led to the non-compliance.

**B & C)** The comprehensive assessment, including the OASIS, can only be completed by one person. It is a legal document and when signed by a clinician, the signature is an attestation that all contained in the document is truthful and accurate. If an error is discovered upon review by a supervisor or other auditing staff and it can be validated that it is a true error and not just a discrepancy (a difference between two data items without knowledge of which data item is correct), that error should be corrected following

the agency's correction policy and established professional medical record documentation standards.

The following references from the Archived OASIS-B1 Implementation Manual (Located at [http://www.cms.hhs.gov/HomeHealthQualityInits/20\\_HHQIArchives.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage)) may be useful in developing or refining your agency's correction policy. Additionally, guidance found in the State Operations Manual Appendix B: Guidance to Surveyors: Home Health Agencies CoP 484.48 Clinical Record Interpretive Guidelines offers additional guidance.

### **Correction Policy References:**

#### **Chapter 2 OASIS Implementation Manual**

*The agency must correct any information that does not pass the CMS-specified edits (i.e., is missing, incorrect, or inconsistent). Staff entering data may need to contact the qualified clinician who assessed the patient for assistance in making those corrections. The clinician's recall of the patient assessment and clinical notes which document the assessment are better at a point in time closer to the assessment activity than if the edits and corrections are delayed.*

#### **Chapter 9 of the OASIS Implementation Manual, page 9.7, states:**

*Correction of clinical documentation errors is more time consuming because the documentation must be returned to the clinician with an explanation of the error. The clinician must correct the error promptly and return the record to the data entry staff person. The correction is then entered and the record checked again for errors. In some instances, the correction of one error can cause another error to surface, and the process must be repeated. The agency will benefit from designing a systematic process for correcting clinical documentation errors which functions efficiently despite clinicians' absences or their inability to return to the office. Revising such processes may indicate the need to review and revise the agency policy for correcting clinical records. This process should clearly define each step, identify responsible persons at each step, and estimate the time allowed for each step. If copies of documentation are submitted for data entry, the procedure will need to include steps to ensure the correction is made in the official agency clinical record as well as in the data submitted to the State agency. As with other process changes, once the process is finalized, it must be rigorously enforced. The agency can monitor its own compliance with the 30-day submission requirement by including this component in the tracking system. The correction policy has not changed and corrections can be made following guidance found on the CMS website. Go to the Survey and Certification page at: <http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp>. In the left column click on Policies and Memos to State and Regions, scroll to: New Correction Policy for HHAs, Memo # 01-12, posted 04/20/01.*

#### **Chapter 9 OASIS Implementation Manual**

**4. Why is it more time consuming to correct clinical documentation errors than data entry errors?**

*Most agencies require clinical documentation errors to be corrected by the clinician because the patient's record is a legal document that the clinician has signed. Therefore, the clinician must be made aware of the error (either by a person doing the upfront review or by the one running the edit check process) and must make arrangements to correct the error in the clinical record, which*



*then must be corrected in the data entered for reporting to the State. Because it is possible for the correction of one error to generate other errors, the edit check procedure must be run again after data are corrected. If additional errors are discovered, the process must be repeated.*

Chapter 10 OASIS Implementation Manual

*10. Where can I find information on correcting errors in my agency's production data submissions?*

*Information on correcting, inactivating, or deleting assessments from the state database (once the data have been transmitted) is found in CMS' Survey and Certification Memorandum 01-12, published on April 20, 2001, found at <http://www.cms.hhs.gov/SurveyCertificationGenInfo>; click on "Policy & Memos to States and Regions." This same memo is located on the QTSO web site at <http://www.qtso.com/hhdownload>; scroll down to the HHA Correction Policy.*

Chapter 12 OASIS Implementation Manual

*If differences are found that cannot be explained by other documentation in the clinical record, the care provider who completed the OASIS should be contacted to determine if the discrepancies were real (e.g., the patient did change significantly between the SOC visit and a visit the next day) or if an error was made when recording OASIS data. If data quality problems exist, the problems can be corrected. If clinical documentation must be amended, this should be done according to agency policy. Any corrections to OASIS data in the clinical record must also be reflected in the OASIS database maintained by the agency, and if data submission has already occurred, a correction must be submitted to the State.*

[Q&A EDITED 09/09]

**Q38. I assume that a patient who is no longer receiving skilled care but continuing to receive personal care only will cease OASIS data collection at the end of skilled care. Is this correct? If it is, how should OASIS items M0100 and M2420 and be answered in the discharge assessment?**

A38. We encourage HHAs to complete a discharge assessment at a visit when a patient receiving skilled care no longer requires skilled care, but continues to receive unskilled care. While this is not a requirement, conducting a discharge assessment at the point where the patient's skilled need has ended provides a clear endpoint to the patient's episode of care for purposes of the agency's outcome-based quality monitoring (OBQM), improvement (OBQI) and process measure reports. Otherwise, that patient will not be included in the HHA's OBQM, OBQI, and process measure statistics. It will also keep that patient from appearing on the HHA's roster report (a report you can access from your State's OASIS system that is helpful for tracking OASIS start of care and follow-up transmissions) when the patient is no longer subject to OASIS data collection. In this case, OASIS item M0100 (Reason for Assessment) should be marked with Response 9 (Discharge from agency). OASIS item M2420 (Discharge Disposition) should be marked with Response 1 - Patient remained in the community (without formal assistive services).

**Q39. [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat. 4b Q #21]**



**Q40.** [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat. 4b Q #16]

**Q41. When a patient is transferred to a hospital, but does not return to the agency, what kind of OASIS assessment is required?**

A41. No assessment is required at that point. The agency's last contact with the patient was at the point of transfer to the inpatient facility, so the transfer data conclude the episode from the point of OASIS data collection. If the agency had not already discharged the patient, there presumably would need to be some documentation placed in the clinical record to close the case for administrative purposes.

[Q&A EDITED 08/07]

**Q42. What should agencies do if the patient leaves the agency after the SOC assessment (RFA 1) has been completed and further visits were expected?**

A42. Completion of a SOC Comprehensive Assessment is required, even when the patient only receives a single visit in an episode. Effective December 2002, there is no requirement to collect OASIS data as part of the comprehensive assessment for a single-visit episode. Some payers (including Medicare PPS and some private insurers) require SOC OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required by regulation (but collected for payment) in this case, the agency may choose whether or not the data is transmitted to the State system.

If OASIS data is required for payment by a non-Medicare/non-Medicaid payer (M0150 response does not include Response(s) 1,2,3, or 4), the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State system. Regardless of pay source, no discharge assessment is required, as the patient receives only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however.

[Q&A ADDED 09/09; Previously CMS OCCB 04/09 Q&A #5]

**Q42.1. What do we do when the patient refuses more visits after just one nursing or therapy visit at the SOC/ROC and one MSW visit? Would a Discharge OASIS need to be completed? The information would match what was in the original SOC or ROC visit since MSWs cannot complete OASIS Assessments. What if the RN visits once and the HHA visits once.**

A42.1. You have described a situation where more than one visit was made - RN or therapist performs SOC comprehensive visit and then a MSW (or HHA) visits. Two visits were made. In this situation a Discharge comprehensive assessment is required.

[Q&A EDITED 08/07]

**Q43. Since RFAs 2 and 10 were eliminated in December 2002, what should we do if only one visit is made at Resumption of Care? All the references I've seen address only the issue of one visit at SOC.**

A43. Because the RFA 10 response originally stated, "after start/resumption of care," we advise you to follow the same instructions you would after only one visit at SOC (i.e., the ROC comprehensive assessment is required, but OASIS data collection is not required). No discharge comprehensive assessment or OASIS is required when no additional visits are made after the ROC visit. Agency clinical documentation should indicate that no additional visits occurred after the ROC assessment, and internal agency documentation of the discharge would be expected. You should be aware that the patient will continue to appear on the agency's roster report as an incomplete episode. The patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would get a warning that the new assessment was out of sequence. This will not prevent the agency from transmitting that assessment, however.

[Q&A EDITED 06/05]

**Q44. What type of comprehensive assessment is required for pediatric, maternity, and patients requiring only personal care, housekeeping or chore services?**

A44. All pediatric, maternity, and patients requiring only personal care, housekeeping or chore services are exempt from the OASIS data collection requirements. For pediatric, maternity, or personal care patients, the HHA will need to complete an agency-developed comprehensive assessment at the required time points. The agency may develop its own comprehensive assessment and tailor it to the needs of the patients of their case-mix. An HHA is not required to conduct a comprehensive assessment for individuals where HHA services are entirely limited to housekeeping or chore services.

**Q45. [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat 2 Q #39]**

[Q&A ADDED 06/05; Q&A EDITED 08/07]

**Q46. Home health patients may return to the hospital after a single visit. Some HHAs treat these as one-visit only episodes, do not collect OASIS data, and do not bill the Medicare program. Is this acceptable? In many instances, it appears that the patients were prematurely discharged from the hospital.**

A46. Yes, this is acceptable. This scenario appears to fit the criteria for one-visit only episodes for Start of Care or Resumption of Care that became effective December 16, 2002. Each patient must receive a comprehensive assessment. The agency is not required to collect the OASIS items, nor encode and submit the assessment. This assessment can be placed in the clinical record for documentation and planning purposes.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 10/07 Q&A #6]

**Q46.1. If we admit a Medicare patient to our home health agency and complete a SOC comprehensive assessment, do we have to submit the OASIS data to the state system if the patient is admitted to the hospital before the second visit? Our understanding of the OASIS regulations is that OASIS data collection and submission is not required when only one visit is made. We will be submitting the**

**data to our Medicare Administrative Contractor (MAC) for payment, but do not think we should have to submit it to the state for quality purposes as only one visit was made.**

A46.1. 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.

[Q&A ADDED 09/09; Previously CMS OCCB 07/09 Q&A #3]

**Q46.2. 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?**

A46.2. 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.

[Q&A ADDED 06/05]

**Q47. For discharge assessments done on therapy-only cases (or when therapy is the last skilled service in the home), could a nurse visit the patient within 2 days of the therapy discharge and perform the comprehensive assessment? The date of discharge would be the date the therapist actually discharged the patient, while the date the assessment was completed (M0090) would be the date the nurse actually completes the comprehensive assessment.**

A47. CMS regulations at 42 CFR 484.55(b) allow the therapist to conduct the discharge assessment at the discharge visit in either a therapy-only case or when the therapist is the last skilled care provider. If the agency policy is to have the RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge assessment after the last visit by the therapist. This planned visit should be documented on the Plan of Care. The RN visit to conduct the discharge assessment is a non-billable visit. The date of the actual discharge is determined by agency policy. When the agency establishes its policy regarding the date of discharge, it should be noted that a date for M0906 (Discharge/Transfer/Death Date) that precedes the date in M0903 (Date of Last/Most Recent Home Visit) would result in a fatal error, preventing the assessment from being transmitted.

[Q&A ADDED 08/07; Previously CMS OCCB 03/05 Q&A #1]

**Q48. 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?**

A48. 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

[Q&A ADDED 08/07; Previously CMS OCCB 03/05 Q&A #2]

**Q49. 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?**

A49. 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

[Q&A ADDED 09/09; Previously CMS OCCB 04/09 Q&A #3]

**Q49.1. When a PT only patient comes home from the hospital, can the PT go out within 24 hours of the patient's return from the hospital and then the RN complete the OASIS ROC the next day. This would keep the RN within the 2 day window. Our administrative policy requires that an RN make a non-bill visit to perform the comprehensive assessment and OASIS. The ROC date and the date on the OASIS would differ as the ROC would reflect the date of PT visit and the OASIS M0090, Date Assessment Completed, would reflect the following day when the RN completed the visit.**

A49.1. The ROC comprehensive assessment must be completed within 2 calendar days after the facility discharge date or knowledge of the patient's return home. Any clinician qualified to perform comprehensive assessments (RN, PT, OT, SLP) may complete the comprehensive assessment, following the agency's policy.

In a PT only ROC, there is no requirement that the PT complete the comprehensive assessment on the first visit. It would be compliant with the Condition of Participation, 484.55, Comprehensive Assessment of Patients, for the PT to perform a discipline-specific re-evaluation and then an RN complete the comprehensive assessment on a non-billable visit as long as the comprehensive assessment is completed within 2 calendar days of the facility discharge (or knowledge of the patient's return home). In this case, the ROC date, M0032, will be the date of the PT's visit (the first visit after the patient's return home) and the ROC comprehensive assessment's M0090, Date Assessment Completed, will be the date the RN completed the comprehensive assessment. The dates would not be the same if the RN visited and completed the comprehensive assessment the day after the PT visited and performed the evaluation. This still represents compliance with the regulations.

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #1]

**Q50. 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?**

A50. "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.

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #2]

**Q51. Start of Care visit - If both nursing and therapy are ordered at SOC, does the RN have to visit the patient before the therapist? If this is required and the PT visits before the RN, what is the impact on the agency?**

A51. The Condition of Participation, 484.55, Comprehensive Assessment of Patients, found at [http://www.access.gpo.gov/nara/cfr/waisidx\\_99/42cfr484\\_99.html](http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html), (click on "Conditions of Participation 484.55, Comprehensive Assessment of Patients") stipulates that a registered nurse must conduct the initial assessment unless it is a therapy only case. Since "initial" means first, when nursing orders exist at Start of Care, the RN must be the first person to see the patient and complete the initial assessment requirements.

The Conditions also require that if nursing orders exist at SOC, the RN must complete the SOC comprehensive assessment including the OASIS. This does not necessarily mean that the SOC comprehensive assessment must be completed by the RN on the SOC date or that the initiation of therapy must be delayed until the RN completes the comprehensive assessment. Federal guidelines state the SOC comprehensive assessment including the OASIS must be completed within 5 days after the SOC date. (See the OASIS Assessment Reference Sheet, <http://www.cms.hhs.gov/OASIS/Downloads/OASISRefSheet.pdf>). Of course, if your agency policies are more restrictive (e.g., require earlier completion), you must follow your policy.

You also asked what is the impact to the agency if the PT visits the patient before the RN when both nursing and PT are ordered at SOC. Your agency will be out of compliance with the Medicare Conditions of Participation when you allow the therapist to make the initial assessment visit when there are also nursing orders.

[Q&A ADDED 09/09; Previously CMS OCCB 04/09 Q&A #2]

**Q51.1. We know that for a PT only case where the RN is doing the SOC Comprehensive Assessment that it has to be done on or within 5 days after SOC date. If it is done prior to the SOC date, we understand that it is not valid and the RN will have to go back out and redo the assessment. This recently happened but it was not discovered until way after the fact (the 5 days had lapsed). Is there anything we can do? Can the PT derive the OASIS item answers from the PT evaluation? This would be out of compliance with our policies and procedures.**

A51.1. There would be no way of resolving this situation compliantly as the SOC comprehensive assessment was not done on or within 5 days after the SOC date. The situation was discovered too late to send an RN out to the home to perform a SOC comprehensive during the allowed timeframe and since the agency policy does not allow PTs to perform the comprehensive assessment at the SOC; their assessment findings cannot be utilized by the therapist to "create" a SOC comprehensive assessment. The agency could send out an RN to perform a SOC comprehensive assessment as soon as the situation is discovered. The M0090 date, Date Assessment Completed, will be the actual date the clinician visited the home and then completed the assessment. A warning message will result from the non-compliant assessment date, but this will not prevent assessment transmission.

Alternatively, the agency could maintain the non-compliant SOC comprehensive assessment that was completed before the SOC date. Either alternative demonstrates non-compliance, as the time period to achieve compliance has passed.

[Q&A ADDED 09/09; Previously CMS OCCB 07/08 Q&A #1]

**Q51.2. When a nurse completes a Resumption of Care (ROC) assessment for a PT only case, can the nurse do the ROC on one day and the therapist re-eval the following day? I know this can't be done at SOC, but not sure for ROC since episode has already been established.**

A51.2. The Comprehensive Assessment of Patients Condition of Participation (484.55) (d) states the comprehensive assessment must be completed within 48 hours of the patient's return home from the inpatient facility stay of 24 hours or longer for reasons other than diagnostic testing. It is acceptable for the RN to make a non-billable visit in a PT only case and complete the ROC assessment within 48 hours of discharge and the PT to visit to evaluate either before or after the RN's assessment visit, as long as the PT visit timing meets federal and state requirements, physician's orders, and is deemed reasonable by professional practice standards. The resumption of care date (reported in M0032) is the first visit following an inpatient stay, regardless of who provides it, whether or not the visit is billable, and whether or not the ROC assessment is completed on that first visit.

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #3]

**Q52. First scenario: A home care agency receives an order for RN and PT for a patient. The SN does the SOC OASIS assessment on the first billable visit of 1/1/07. The Physical therapist does his initial eval on 1/3/07 and upon review of the RN's SOC OASIS documentation, it is discovered that the patient's functional status documented on the OASIS differs from the PT evaluation.**

**Should the PT discuss his findings with the RN and, if agreed upon, make changes to the SOC OASIS completed on 01/01/07? Does another visit have to occur jointly? Is there a certain time frame this can happen?**

A52. While the comprehensive assessment must be completed by only one clinician, it is an excellent idea for all the disciplines caring for a patient to discuss assessment findings and their plans of care. The RN who performs the SOC comprehensive assessment on the SOC date, 1/1/07, has up to 5 days after the SOC (the date of the first billable visit) to complete the SOC OASIS assessment. When conferring with the PT

regarding his 1/3/07 visit assessment findings, the RN may discover the SOC OASIS responses chosen do not reflect the assessment findings of the therapist. The RN and PT should further discuss the patient's status to determine if:

- 1) The differences noted in the patient's status or ability would be considered **normal progression of disease or recovery based on the time that lapsed** between the two assessments, (e.g. the RN noted the patient required assistance of another at all times to ambulate on 1/1/07 due to weakness after hospital discharge. The PT conducted his evaluation on 1/3/07 and the patient's weakness had greatly improved and only needed supervision of another to ambulate at night when she was tired.) In this case, the differences noted can be attributed to normal progression of recovery and do not indicate that the 1/1/07 findings were necessarily inaccurate.
- 2) The differences noted in the patient's status were due to a **misunderstanding of the OASIS scoring guidance**, (e.g. the RN believed that M1840 Toileting Transferring only included the patient's ability to transfer on and off the toilet, not the ability to get to and from the toilet) After discussion, if the RN believes her original score was inaccurate because she inappropriately applied her assessment findings when selecting an OASIS response, changing her response to M1840 within the 5 day time period allowed for completing the assessment is acceptable. The M0090 date will be changed to reflect the date the assessment was completed.
- 3) The differences noted were due to a **difference in the interpretation of assessment findings**, (e.g. The RN observed the patient ambulating while holding onto furniture and walls and believed the patient was independent and needed no assistance. The PT made the same observation but understood the walls and furniture represented the patient's need for assistance for safe ambulation.) If after discussion, the RN believes her original score was inaccurate because she inappropriately interpreted her assessment findings, changing her response to M1860 within the 5 day time period allowed for completing the assessment is acceptable. The M0090 date will be changed to reflect the date the assessment was completed.
- 4) The differences noted were due to a **difference (or adequacy) in the assessment approach**, (e.g. The RN asked the patient if he could dress himself. The PT asked the patient to demonstrate gathering his clothes and putting on and removing select clothing items.) The RN should not base or change her assessment scores based solely on the assessment of the PT, if such assessment findings were not observed by the RN. If after discussion the RN questions the accuracy of her score because she believes she may not have gathered sufficient information necessary to determine the patient's ability to dress, the RN may choose to make another visit during the 5 day assessment time frame and further observe and assess the patient. The RN may determine that her original OASIS response is accurate and leave the assessment as originally completed. Or, the RN may select a different score based on the subsequent visit findings and report the new score as part of the SOC assessment. If the subsequent visit provides any information that is used to complete the comprehensive assessment, then the M0090 date should be changed to reflect the date the assessment was completed.
- 5) The differences, after discussion, **cannot be reconciled**. The RN's observations are not consistent with the PT's evaluation. The RN may choose to make another visit during the 5 day assessment time frame and further observe and assess the patient. The RN may determine that her original OASIS response is accurate and leave the assessment as originally completed. Or, the RN may select a different score based on the



subsequent visit findings and report the new score as part of the SOC assessment. If the subsequent visit provides any information that is used to complete the comprehensive assessment, then the M0090 date should be changed to reflect the date the assessment was completed.

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #4]

**Q53. A patient is recertified on 2/21/07 for a new cert period starting 2/26/07. The patient goes into the hospital on 2/23/07 and is discharged from the hospital on 2/26/07. We go back out to see her on 1st day of new episode 2/26/07. Would she require a ROC or a SOC OASIS?**

A53. Special guidance applies when the patient returns home from the inpatient facility on day 60 or 61. You will need to complete the ROC assessment and then make a decision based on the HIPPS code. If it did not change from the recert assessment, then you submit the ROC, as it is considered a continuous episode. If the HIPPS code did change from the recert assessment, home care would not be considered continuous and you would perform a “paper billing” discharge and then submit the assessment as a SOC. More details related to this guidance can be found in the Medicare Claims Processing Manual, Section 80-Special Billing Situations Involving OASIS Assessments located at <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf> (see excerpt below)

**“2. Beneficiary is Discharged From the Hospital on Day 60 or Day 61**

A hospital discharge may occur on day 60 or day 61 and the HHA performs a Resumption of Care assessment which DOES NOT change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this case, home care would be considered continuous if the HHA did not discharge the patient during the previous episode. (Medicare claims processing systems permit “same-day transfers” among providers.) The RAP for the episode beginning after the hospital discharge would be submitted with claim “from” and “through” dates in FL 6 reflected day 61. The RAP would not report a new admission date in FL 17. The HIPPS code submitted on the RAP would reflect the recertification OASIS assessment performed before the beneficiary’s admission to the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key in FL 63. This OASIS assessment would be submitted to the State Agency, as would the Resumption of Care assessment.

A hospital discharge may occur on day 60 or day 61 and the HHA performs a Resumption of Care assessment which DOES change the HIPPS code from a recertification assessment performed in the last 5 days (days 56-60) of the previous episode. In this case, home care would not be considered continuous and HHAs must discharge the beneficiary from home care for Medicare billing purposes. The RAP for the episode beginning after the hospital discharge would be submitted with claim “from” and “through” dates in FL 6 that reflected the first date of service provided after the hospital discharge. The RAP would also report a new admission date in FL 17. The HIPPS code submitted on the RAP would reflect the OASIS assessment performed after the patient returned from the hospital. This OASIS assessment would also be reflected in the claims-OASIS matching key in FL 63. This OASIS assessment would be changed to indicate a Start of Care assessment prior to submission to the State Agency.”

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #5]

**Q54. For a Medicare patient, a recert visit is done April 16th, which was the last day of the first cert period. The patient is hospitalized on April 18th, the second day of the new cert. No home care visits were provided in the new cert period before the hospitalization. Which assessments should be completed and is discharge required?"**

A54. If the Medicare PPS patient had a recertification assessment visit during the last five days of the episode, and then experiences a qualifying hospitalization in the new episode, the agency should complete a transfer assessment. This is true whether or not any home care visits have been made in the new episode. The agency may select RFA 6 or 7, depending on agency policy and practice.

If the agency selects RFA 7, then when the patient returns to home care services, a new SOC should be completed.

If the agency selects RFA 6, then when the patient returns to home care services within the episode, a SOC/ROC comprehensive assessment should be completed. In order to determine if this assessment should be reported as a SOC or a ROC, the HHRG/HIPPS code resulting from the assessment responses should be determined. If the resulting HHRG/HIPPS code is the same as from the recertification assessment performed in the last 5 days of the previous episode, then the two episodes are considered continuous. In this case the assessment should be reported as a ROC, no discharge is required, and the care continues on under the original certification periods. This is an example of a situation in which the first visit in a new certification period could be the Resumption of Care visit.

If the resulting HHRG/HIPPS code is not the same as from the recertification assessment performed in the last 5 days of the previous episode, then the two episodes would not be considered continuous. In this case the patient should be discharged through completion of agency discharge paperwork or process, and the new assessment should be reported as a SOC, establishing a new episode with a new certification period. All assessments completed (the SOC and recertification assessments completed in the previous episode, the transfer, and the SOC or ROC assessment in the next episode) should be transmitted to the State Agency. A discharge OASIS assessment under the previous episode is not required, and if the home health agency completed an RFA 6 upon transfer and the episodes were eventually determined to not be continuous (under the conditions explained above), the agency does not need to "correct" the RFA 6, (by changing to an RFA 7, indicating discharge). The submission of the assessment sequence (SOC RFA 1, Recert RFA 4, Transfer RFA 6, SOC RFA 1...) will be accepted by the State Agency, and the documentation contained within the clinical record(s) should clarify the events.

More details related to this guidance can be found in the Medicare Claims Processing Manual, Section 80-Special Billing Situations Involving OASIS Assessments located at <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf>, (see excerpt below)

### **3. Beneficiary is Admitted to Hospital on Day 61 Prior to Delivery of Services in the Episode**

A beneficiary may be hospitalized in the first days of an episode, prior to receiving home health services in the new episode. These cases are handled for billing and OASIS identically to cases in which the beneficiary was discharged on days 60 or 61. If the

HIPPS code resulting from the Resumption of Care OASIS assessment is the same as the HIPPS code resulting from the recertification assessment, the episode may be billed as continuous care. If the HIPPS code changes, the episode may not be billed as continuous care. The basic principle underlying these examples is that the key to determining if episodes of care are considered continuous is whether or not services are provided in the later episode under the recertification assessment performed at the close of the earlier episode.

[Q&A ADDED 09/09; Previously CMS OCCB 10/07 Q&A #5]

**Q54.1 Our patient's recertification was due August 12<sup>th</sup>. The nurse completed the recertification assessment on August 8<sup>th</sup>. Later that night, August 8<sup>th</sup>, the patient fell, broke her leg and is now in the hospital on her recertification date. Do we submit the recertification assessment and continue on with paperwork including the Transfer OASIS and new Plan of Care or do we keep the Recertification paperwork and complete a Transfer OASIS, and pick back up after the discharge from the inpatient facility as a new referral?**

A54.1 The Conditions of Participation require that a follow-up comprehensive assessment be conducted during last 5 days of every 60 day episode. In your scenario, the follow-up assessment was performed during the required timeframe, but then the patient's condition changed and required what we will assume is a qualifying transfer to an inpatient facility during the recertification assessment timeframe. If your agency completed an RFA 7 - Transfer with Discharge, then regardless of when/if the patient returned to your agency, submission of the Recertification assessment would not be necessary. Therefore, it is acceptable to not submit the Recert assessment to the State system, but rather to maintain the completed Recert assessment in the patient's clinical record, with documentation explaining the situation. It would also be acceptable to submit the Recert assessment to the State system.

If your agency completed an RFA 6 - Transfer without Discharge, then if the patient were to return to your agency on Day 60 or 61, special instructions would apply to determine if the episode is to be considered continuous or not. In order for the episodes to be considered continuous, the HIPPS codes resulting from both the Recertification assessment and the Resumption of Care assessments would need to match, and both assessments would need to be submitted to the State system.

If the conditions required for continuous episodes are not met, it is acceptable to not submit the Recertification assessment to the State system, but rather to maintain the completed Recert assessment in the patient's clinical record, with documentation explaining the situation. In either case, collection and submission of the Transfer assessment would be required.

(More complete details related to this guidance, reference the prior CMS OASIS Q&As Category 2, Questions 53 – 55 and the Medicare Claims Processing Manual, Section 80-Special Billing Situations Involving OASIS Assessments located at <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf>).

[Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #3]

**Q55. In the new Q&As that were posted in May 2007 it states that if an agency has done a recert and then the patient goes to the hospital and the agency does a transfer without dc, then when the patient comes back the clinician does the**

**comprehensive assessment. Depending on the HIPPS code would depend on if they did a ROC or a SOC. But what if the agency had not done the recert and the patient went to the hospital on day 58. When the patient comes out would they do a new SOC? (Since there is no HIPPS code to match up with).**

A55. If a patient is transferred to the hospital on day 58, before the recertification assessment was completed, and the stay in the inpatient facility met the criteria for a Transfer, the agency would complete a Transfer OASIS. When the patient returns home, if it is on 59 or 60 and they have not been discharged from the home care agency, a Resumption of Care (RFA 3) assessment would be completed, and would satisfy both the ROC and the recertification requirements. If the patient's stay extends beyond the end of the current certification period, a SOC would be completed. The agency would also need to perform a "paper" discharge from the previous episode, (no OASIS DC required).

[Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #1]

**Q56. If a patient converts to a payer requiring a new SOC, is it OK to do the SOC OASIS on next visit (under the new pay source) even if that visit isn't scheduled for up to a week after the last visit under the old payer?**

A56. When a patient is changing pay sources to a payer which requires a new SOC, then the agency must provide an initial assessment visit within 48 hours of the time of referral or on the physician's ordered Start of Care date. If the orders for the new episode are for SN to begin on a date a week away, then the initial assessment visit and SOC Comprehensive Assessment may be completed one week after the discharge visit under the old pay source, if that meets the physician's ordered start of care date. Alternatively, the agency may have completed the initial assessment requirements (determined immediate care and support needs, and eligibility for the home health benefit if appropriate) at the last visit under the old pay source, in which case the SOC comprehensive assessment may still be conducted at the next visit (in a week), noting that if the patient were to develop problems and require services in between the visits, the SOC may need to be completed sooner.

[Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #2]

**Q57. Has there been any regulatory changes that prohibit a nurse from doing the initial SOC OASIS if only therapy is ordered?**

A57. There have not been any regulatory changes to the Condition of Participation (CoPs), 484.55, Comprehensive Assessment of Patient Standard (a) Initial assessment of patients. But the Standard does not prohibit a nurse from performing the initial assessment visit when there are therapy only orders. It states that the RN must complete the initial assessment visit when nursing orders exist at SOC. If there are therapy only orders, no nursing at all, the appropriate therapist may complete the initial assessment visit. Agencies are at liberty to develop policies that are more restrictive than the CoPs (e.g., policies that allow or require the RN to perform the initial assessment visit during a non-billable visit when there are no nursing orders at SOC).

[Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #4]

**Q58. Medicare patient goes to hospital, agency completes RFA 6, Transfer, patient not discharged. Patient returns home with orders for one PT visit to evaluate new equipment. PT does eval and determines no further visits are**

**necessary. Should HHA complete ROC, even though no further visits are going to be provided? And if the HHA completes the ROC, would they complete a DC on the same day?**

A58. In responding to the question, it will be assumed that the single PT visit conducted at the resumption of care was a skilled and covered visit, that the resumption of care visit occurred within the existing 60-day episode, and that we are discussing a Medicare PPS patient.

A comprehensive assessment must be completed when the patient returns home from an inpatient stay of 24 hours or greater for any reason other than diagnostic tests, even though there will only be the one PT visit. The Conditions of Participation 484.55

Comprehensive Assessment of Patients, Standard (d) states:

The comprehensive assessment must be updated and revised within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests.

However, since 2002, OASIS is not a required part of the comprehensive assessment for known one-visit patient episodes. CMS Q&A Cat 2 Q43 clarifies that a ROC comprehensive assessment is required, even if it is the only visit conducted after the inpatient discharge, but that the assessment should be treated like a one-visit only episode at the start of care (i.e., comprehensive assessment is required, but OASIS data collection is not required). While there is not a regulatory requirement to collect OASIS as part of these assessments, there may be a reimbursement requirement by the payer to do so.

No discharge comprehensive assessment or OASIS is required when only one visit is made. The agency would complete their own internal discharge paperwork.

[Q&A ADDED 09/09; Previously CMS OCCB 10/07 Q&A #4]

**Q58.1. A patient is ordered and needs only a single Physical Therapy visit (no other disciplines ordered/needed). Is a SOC OASIS required? If the SOC OASIS is required, is a D/C OASIS also required?**

A58.1. Completion of a SOC comprehensive assessment is required, even when the patient is known to only need a single visit in the episode. While there is no requirement to collect OASIS data as part of the comprehensive assessment for a known one-visit episode, some payers (including Medicare PPS and some private insurers) require OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required by regulation (but collected for payment) for such one-visit episodes, the agency may choose whether or not the data for skilled Medicare/Medicaid patients is transmitted to the State system in these cases. If OASIS data is required for payment by a non-Medicare/non-Medicaid payer [M0150 response does not include Response(s) 1,2,3, or 4], the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State system. Regardless of pay source, no discharge assessment is required, as the patient received only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent OASIS discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the

agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however.

[Q&A ADDED 09/09; Previously CMS OCCB 07/09 Q&A #1]

**Q59. 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?**

A59. 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.

[Q&A ADDED 09/09; Previously CMS OCCB 07/09 Q&A #2]

**Q60. 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?**

A60. 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.

### CATEGORY 3 - FOLLOW-UP ASSESSMENTS

[Q&A EDITED 08/07]

**Q1. When is a recertification (follow-up) assessment due for a Medicare/Medicaid skilled care patient?**

A1. A Medicare/Medicaid skilled-care adult patient who remains on service into a subsequent episode requires a follow-up comprehensive assessment (including OASIS items) during the last 5 days of each 60-day period (days 56-60, counting from the start of care date) until discharged.

[Q&A EDITED 08/07]

**Q2. What are the requirements for follow-up comprehensive assessment for pediatric and maternity patients where the payer is Medicaid?**

A2. Pediatric and maternity patients have been exempt from the OASIS data collection requirements; however, the agency must still perform a follow-up comprehensive assessment at any time up to and including day 60. The timetable for the subsequent 60-day period would then be measured from the completion date of the most recently completed assessment. The agency may develop its own comprehensive assessment form for these clients. Clinicians may perform the follow-up comprehensive assessment more frequently than the last 5 days of the 60-day episode without conducting another comprehensive assessment on day 56-60, and remain in compliance with § 484.55(d).

[Q&A EDITED 09/09]

**Q3. A patient is hospitalized and comes back to the agency on day 56. Which assessment do we complete? A resumption of care (ROC) or follow-up (FU) or do we need to do both?**

A3. When the patient returns to the agency during the last 5 days of an episode, the ROC assessment should be completed, fulfilling both the ROC and recertification requirements. M2200, Therapy Need, should forecast therapy use for the upcoming episode. You can find the instructions (mentioned above) for handling this type of situation in the OASIS Considerations for Medicare PPS Patients document found at the QIES Technical Support website

<https://www.qtso.com/download/OASISConsidForMedicarePPSPatRev.pdf>

Transmittal 61, posted January 16, 2004, includes a section on special billing situations and can be found in the *Medicare Claims Processing Manual*. Go to <http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf> ; to "Section 80 - special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your Medicare Administrative Contractor (MAC).

**Q4.** [Q&A RETIRED 08/07; Outdated]

**Q5. Must both a recertification and a Resumption of Care (ROC) assessment be completed when a patient returns to the agency from an inpatient stay a day or two before the last 5 days of a payment episode?**

A5. In your example, if the patient were discharged from the inpatient facility on day 53, the agency would be required to complete a ROC assessment no later than day 55 and

a recertification assessment within days 56-60, because the regulations require that the ROC assessment be done within 2 days of the discharge from the inpatient facility.

If the patient were discharged from the inpatient facility on day 54 or 55, the ROC assessment could be done on day 56 or 57, respectively (providing the physician was in agreement). In that case, refer to the answer to Q3 in this category.

**Q6. Please clarify the 60-day certification period referred to in the regulations. Hasn't CMS been flexible in allowing a shorter certification period if the patient's condition changed?**

A6. Collecting uniform data on patients at uniformly defined time points means that certification periods will need to be less flexibly defined. Therefore, HHAs must adhere to a 60-day certification period, based on the SOC date. The HAVEN data specifications have been developed according to this schedule, and agencies will be in compliance with the regulations if they adhere to this schedule.

[Q&A EDITED 09/09]

**Q7. Should my agency be concerned about 'counting out' 60-day intervals in order to schedule the follow-up assessment?**

A7. To assist agencies determine the correct 60-day time frame for scheduling OASIS follow-up assessments, go to the QIES Technical Support Office website <https://www.qtso.com>, click on OASIS and download 'Scheduling OASIS Follow-up Assessment'. There you will find the current year calendar in pdf file, which will help you determine a patient's first, second and third certification periods based on the start of care date.

[Q&A EDITED 08/07]

**Q8. Is it necessary to make a visit in order to complete the follow-up reassessment?**

A8. Yes, the follow-up comprehensive assessment must be performed in the physical presence of the patient. A telehealth interaction does not constitute an in-person visit for the purposes of completing the required comprehensive assessment.

[Q&A EDITED 09/09]

**Q9. If a clinician's visit schedule is 'off track' for a visit in the last 5 days of the 60-day certification period, can a visit be made strictly for the purposes of doing an assessment? Will this visit be reimbursed by Medicare?**

A9. Under PPS, a visit can be made for only the purpose of performing an assessment, but it will not be considered a billable visit unless appropriate skilled services are performed. A recertification assessment not completed during the appropriate time frame raises a number of issues, including non-compliance with home health conditions of participation (CoP), a potential likelihood of a visit made without physician's orders, and payment related issues for Medicare PPS patients. Although it is not explicitly spelled out in the CoP, the expectation that accompanies the requirement to update the comprehensive assessment between days 56 & 60 is that the orders for the ensuing 60 days will be based on the results of that assessment. The patient's care orders essentially expire at the end of day 60, so day 61 begins a new payment episode. If the



patient is a Medicare patient, you should discuss any payment-related issues with your Medicare Administrative Coordinator (MAC).

[Q&A EDITED 09/09]

**Q10. What if the patient refuses a visit during the 5-day recert window?**

A10. Most patients are willing to receive a visit if the visit schedule and required time points have been explained to them during the episode. In addition, PPS requires a visit during the same 'window' for the agency to receive continued reimbursement for a specific Medicare patient. If the HHA is completely unable to schedule a visit during this period, the follow-up assessment should be completed as soon after this period as possible.

Although it is not explicitly spelled out in the CoP, the expectation that accompanies the requirement to update the comprehensive assessment between days 56 & 60 is that the orders for the ensuing 60 days will be based on the results of that assessment. The patient's care orders essentially expire at the end of day 60, so day 61 begins a new payment episode. The agency should be aware of potential legal issues associated with completing the assessment late, considering that the agency may not have orders for visits after the end of the 60-day period. If the patient is a Medicare patient, you should discuss any payment-related issues with Medicare Administrative Coordinator (MAC).

[Q&A ADDED 06/05; EDITED 9/09; Previously CMS OCCB 10/04 Q&A #1]

**Q11. If an agency misses the recertification assessment 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? Will any data transmission problems be encountered?**

A11. 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 the assessment is completed, 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 this 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, as it does demonstrate non-compliance with the comprehensive assessment update standard (of the Conditions of Participation). For the Medicare PPS patient, payment implications may arise from this missed assessment. Any payment implications must be discussed with the agency's Medicare Administrative Coordinator (MAC).

[Q&A EDITED 08/07]

**Q12. What are the indications for an 'other follow-up' (RFA 5) assessment?**

A12. In the preamble to the comprehensive assessment regulation, it is noted that a comprehensive assessment with OASIS data collection is required when there is a major decline or improvement in health status. Each agency must determine its own policies regarding examples of major decline or improvement in health status and ensure that the

clinical staff is adhering to these policies. In the event the agency determines that an assessment at a point in time not already required is necessary (based on its own policies), reason for assessment (RFA) #5 under M0100 would be selected.

**Q13. If a resumption of care assessment is performed, does the clock 'reset' with respect to follow-up assessment, i.e., is the follow-up due 60 days after resumption of care or does it remain 60 days from the original start of care date?**

A13. Unless the patient has been discharged, the due dates for follow-up assessments are calculated from the original start of care date rather than from the resumption of care date. For additional guidance on transferring patients with or without discharge and resuming care, see the OASIS Considerations for Medicare PPS Patients document found at the QIES Technical Support website  
<https://www.qtso.com/download/OASISConsidForMedicarePPSPatRev.pdf>

**Q14. Our agency has a custodial service program that provides personal care and patients remain on service for several years. How do we determine the reassessment date?**

A14. Note that the certification periods and the recertification follow-up assessment window are ALWAYS calculated relative to the start of care date.

**Q15.** [Q&A DELETED 08/07; Question focus was Physician's Orders. Refer to State Survey Agency for guidance.]

**Q16. Since OASIS is temporarily suspended for non-Medicare/non-Medicaid patients, must I complete the Follow-up assessment at day 56-60?**

A16. For the non-Medicare/non-Medicaid patient, the assessment may be performed any time up to and including the 60<sup>th</sup> day. The timetable for the subsequent 60-day period would be measured from the completion date of the most recently completed assessment. Another way of stating this clarification is that clinicians may perform the comprehensive assessment more frequently than the last 5 days of the 60-day period without conducting another assessment on day 56-60, and remain in compliance with 484.55(d).

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #6]

**Q17: I am trying to find clarification on how to use RFA 5 for decline or improvement. When I review the OASIS time points, it lists RFA 5 as a SCIC with or without hospitalization. Does the RFA 5 only have to be done when payment is affected? If the patient improved, I would think we would be discharging, thus RFA 9. I don't understand what RFA 5 is used for.**

A17: When the patient experiences an event that meets your agency's definition of a major decline or improvement in the patient's health status, you are required to complete the RFA 5, the Other Follow-up assessment, in order to be compliant with the Medicare Conditions of Participation – Section 484.55(d). In the preamble to the comprehensive assessment regulation, 484.55, it is noted that a comprehensive assessment (with OASIS data collection, if applicable) is required when there is a major decline or improvement in health status. CMS encouraged each agency to develop its own

guidelines and policies for this type of assessment and did not provide written requirements about what constitutes a significant decline or improvement.

This requirement to complete an RFA 5 for a patient experiencing a major decline or improvement in health status should not be confused with the Significant Change in Condition (SCIC) payment adjustment which was introduced in the initial Home Health Prospective Pay System (PPS) model. Regardless of the pay source or impact, current regulations require that any patient experiencing a major decline or improvement (as defined by your agency) is expected to receive a follow-up comprehensive assessment. Following agency policy, if the clinician identifies that there has been a major decline or improvement, the clinician will complete the assessment and evaluate the plan of care and modify as needed.

You stated that if a patient had a major improvement, you would discharge, but that may not be true if the patient had continuing home care needs. For example, if your patient had a CVA and at SOC and subsequently experienced a significant resolution of neurological symptoms, this patient may meet the criteria for your agency's definition of a major improvement. If the patient continued to have nursing needs related to medication management, you may not discharge until those goals were met. The RFA 5 would serve as the vehicle to reassess the patient's status after the major change in status.

[Q&A ADDED 09/09; Previously CMS OCCB 04/08 Q&A #2]

**Q18. Since the SCIC assessment is no longer available, what should we do when additional services must be added after the SOC has been submitted and the HHRG established? If a nursing-only patient experiences a fall several weeks into the episode resulting in the initiation of PT, what OASIS assessment should we complete to get additional payment?**

A18. The Other Follow-up (RFA 5) is still expected to be completed when the patient experiences a major decline or improvement in health status, as defined by your agency policy. Information collected as part of this Follow-up assessment will be helpful in ensuring appropriate re-evaluation and revision of the patient's plan of care in the presence of major changes in patient condition. This assessment continues to be a requirement of the Conditions of Participation (CoPs), even though under PPS 2008, data from the RFA 5 assessment will in no way impact the episode payment as it may have under the previous PPS model.

Under PPS 2008, if the patient experiences a major improvement or decline in status after the SOC assessment time frame, assessments should continue to be completed per the CoPs and agency policy, and appropriate care plan changes made per physician orders. In some cases, (e.g., a status decline resulting in an increase in nursing visits for treatment of a new wound) no additional payment would be received, as the Significant Change in Condition (SCIC) payment adjustment has been eliminated with PPS 2008. In cases where the major decline or improvement in the patient's status results in more therapy visits being provided (compared with the number initially reported in M2200, Therapy Need, at the SOC), upon submission of the final claim (which will indicate the number of therapy visits provided) the claims processing system will autocorrect the payment to reflect the number of therapy visits provided and reimburse the agency accordingly, even if more therapy visits were provided during the episode than were projected at any of the OASIS data collection time points that capture M2200.

No specific action related to OASIS data collection or correction is necessary or expected in order for the agency to receive payment for the actual number of qualified therapy visits provided.

[Q&A ADDED 09/09; Previously CMS OCCB 10/08 Q&A #2]

**Q19. Now that the Significant Change in Condition (SCIC) payment adjustment is no longer part of home health Prospective Payment System (PPS), please clarify for us the correct documentation for SCIC's now. First, are SCIC's still required, and if so, do we use the Other Follow-Up Assessment (RFA 5) form? And since this won't affect payment, do we still need to transmit this assessment, or keep on file only?**

A19. The Other Follow-up (RFA 5) is still expected to be completed when the patient experiences a major decline or improvement in health status, as defined by your agency policy. Information collected as part of this Follow-up assessment will be helpful in ensuring appropriate re-evaluation and revision of the patient's plan of care in the presence of major changes in patient condition. This assessment continues to be a requirement of the Conditions of Participation (CoPs), even though under PPS 2008, data from the RFA 5 assessment will in no way impact the episode payment as it may have under the previous PPS model.

There has been no change in the OASIS reporting regulation. You are required to submit the OASIS data, including the RFA 5 - Other Follow-up, within 30 days from M0090, Date Assessment completed.

## CATEGORY 4 - OASIS DATA SET: FORMS and ITEMS

### Category 4A - General OASIS forms questions.

**Q1.** [Q&A RETIRED 09/09; Outdated]

**Q2. When integrating the OASIS data items into an HHA's assessment system, can the OASIS data items be inserted in an order that best suits the agency's needs, i.e., can they be added in any order, or must they remain in the order presented on the OASIS form?**

A2. Integrating the OASIS items into the HHA's own assessment system in the order presented on the OASIS data set would facilitate data entry of the items into the data collection and reporting software. However, it is not mandatory that agencies do this. Agencies may integrate the items in such a way that best suits their assessment system. Some agencies may wish to electronically collect their OASIS data and upload it for transmission to the State. As long as the agency can format the required CMS data submission file for transmission to the State agency, it doesn't matter in what order the data are collected.

[Q&A EDITED 08/07]

**Q3. Are agencies allowed to modify skip patterns through alternative sequencing of OASIS data items?**

A3. While we encourage HHAs to integrate the OASIS data items into their own assessment instrument in the sequence presented on the OASIS data set for efficiency in data entry, we are not precluding them from doing so in a sequence other than that presented on the OASIS data set. Agencies collecting data in hard copy or electronic form must incorporate the OASIS data items EXACTLY as they are written into their own assessment instrument. Agencies must carefully consider any skip instructions contained within the questions in the assessment categories and may modify the skip language of the skip pattern as long as the resulting data collection complies with the original and intended skip logic. When agencies encode the OASIS data they have collected, data MUST be transmitted in the sequence presented on the OASIS data set. The software that CMS has developed for this function (HAVEN) prompts the user to enter data in a format that will correctly sequence the item responses and ultimately be acceptable for transmission. HAVEN includes certain editing functions that flag the user when there is missing information or a question as to the accuracy or validity of the response. Agencies may choose to use software other than HAVEN to report their data so as long as the data are ultimately presented to the State agency in the required CMS data submission format found on the CMS Website at [http://www.cms.hhs.gov/oasis/04\\_dataspecifications.asp](http://www.cms.hhs.gov/oasis/04_dataspecifications.asp). This file that contains the OASIS data items in the same order as contained on the OASIS data set.

[Q&A EDITED 09/09]

**Q4. Are any quality assurance tools available to help us verify that our staff is using the OASIS correctly?**

A4. We are not aware of any standardized quality assurance tool that exists to verify that clinical staff members are using OASIS correctly. A variety of audit approaches might be used by an agency to validate the appropriate responses to OASIS items. For

example, case conferences can routinely incorporate OASIS items as part of the discussion. Multi-discipline cases with visits by two disciplines on adjacent days can contribute to discussion of specific items. (Note that only one assessment is reported as the 'OASIS assessment.') Supervisory (or peer) evaluation visits can include OASIS data collection by two clinicians, followed by comparison of responses and discussion of any differences. Other approaches to data quality monitoring are included in the *OASIS-C Guidance Manual*, Appendix B available at [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage)

[Q&A EDITED 09/09]

**Q5. How do I cut and paste the OASIS questions on the website into our HHA's own assessment?**

A5. CMS will post the OASIS data set in both .PDF format, i.e., read only format, and Word format on the OASIS Data Sets page at [http://www.cms.hhs.gov/HomeHealthQualityInits/12\\_HHQIOASISDataSet.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage)

[Q&A EDITED 09/09]

**Q6. Do you have anything available that would help us integrate the OASIS items into our own assessment?**

A6. The most current version of OASIS will be found on the CMS OASIS website. HHAs are required to incorporate the OASIS data items exactly as written into the agency's comprehensive assessment. For agencies using software that does not accommodate bolding or underlining for emphasis of words in the same manner as the current OASIS data set, capitalizing those words is acceptable. We also recommend including the M item numbers when integrating to alert clinicians that the M items MUST be assessed and completed. Ultimately this will minimize delays in encoding due to uncompleted OASIS data items. Please refer to Chapter 4 of the OASIS-C Guidance Manual (available at [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage)) for illustrative examples of pages from a comprehensive assessment showing an integration of the OASIS data items with other agency assessment items for several time points. The OASIS data sets are available at [http://www.cms.hhs.gov/HomeHealthQualityInits/12\\_HHQIOASISDataSet.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage)

[Q&A EDITED 09/09]

**Q7. Is there a separate OASIS admission form that can be used for rehab-only cases where skilled nursing is not involved?**

A7. CMS does not have sample rehab assessment examples, though such assessments have been developed by commercial vendors. If an agency chooses to develop its own rehab-specific assessment forms, the principles for documenting OASIS items into an agency's clinical documentation are outlined in Appendix A of the *OASIS-C Guidance Manual* available at [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage)

**Q8.** [Q&A RETIRED 09/09; Outdated]

[Q&A EDITED 08/07]

**Q9. Are the OASIS data sets (all time points) to become part of the patient's record? Do we keep them in the charts? Of course, our admission OASIS data set will be part of the chart because we have our admission assessment included in the OASIS questions. But with the ROC, Transfer, DC, do we make this part of the record?**

A9. The Comprehensive Assessment Final Rules, published January 25, 1999, state that the OASIS data items are to be incorporated into the HHA's own assessments, not only for the start of care, but for all the time points at which an update of the comprehensive assessment is required. Because all such documentation is part of the patient's clinical record, it follows that the OASIS items are also part of the clinical record. Verifying the accuracy of the transmitted OASIS data (part of the Condition of Participation [CoP] on Reporting OASIS information) requires that the OASIS data be retained as part of the clinical documentation. To access the CoP, go to <http://www.cms.hhs.gov/center/hha.asp>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

[Q&A EDITED 08/07]

**Q10. If the OASIS data elements are being filled out for the Start of Care, Follow-up and Discharge, is there an additional nursing note required as a Federal regulation? Or is an additional nursing note (as a summary of data gathered) not required, assuming the OASIS elements include all necessary patient information?**

A10. As noted in CFR §484.55 (the Condition of Participation [CoP] regarding comprehensive assessment), "each patient must receive a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes." The preamble to this rule also notes that the OASIS data set is not intended to constitute a complete comprehensive assessment. Each agency must determine, according to their policies and patient population needs, the additional assessment items to be included in its comprehensive assessment forms. Clinical notes are to be completed as required by 42 CFR 484.48 and the home care agency's clinical policies and procedures. To access the CoP, go to <http://www.cms.hhs.gov/center/hha.asp>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

**Q11.** [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat. 2 Q #7]

**Q12.** [Q&A RETIRED 09/09; Outdated]

**Q13.** [Q&A RETIRED 09/09; Outdated]

**Q14.** [Q&A RETIRED 09/09; Outdated]

**Q15.** [Q&A RETIRED 08/07; Outdated]

**Q16.** [Q&A RETIRED 01/08 due to changes in OASIS data set and skip patterns at follow-up (RFA 4, 5)]

[Q&A EDITED 08/07; ADDED 06/05; Previously CMS OCCB 08/04 Q&A #1]

**Q17. Unless otherwise indicated, scoring of OASIS items is based on the patient's status on the “day of the assessment.” Does the “day of the assessment” refer to the calendar day or the most recent 24- hour period?**

A17. Since home care visits can occur at any time of the day, and to standardize the time frame for assessment data, the “day of the assessment” refers to the 24-hour period directly preceding the assessment visit, plus the time the clinician is in the home conducting the assessment. This standard definition ensures that fluctuations in patient status that may occur at particular times during the day can be considered in determining the patient’s ability and status, regardless of the time of day of the visit.

**Q18.** [Q&A RETIRED 09/09; Outdated]

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/08 Q&A #4]

**Q19. Must the OASIS-C items (on the screen and when printed) match the data set language and format exactly?**

A19. The OASIS hard copy information for the chart printed out by a point of care system must match the OASIS-C data set exactly, including formatting and wording for the items. If the printout of the assessment (i.e., the "hard copy" to be retained in the patient's clinical record) does not match the assessment data entered and submitted to the state, that may be problematic for the following reasons: 1) State surveyors will likely review records and compare the record on site in the agency with the data submitted to the state; 2) If a patient record was requested by the Fiscal Intermediary for medical review, it would be imperative that the printed record match the data collected and submitted to the state (since the same data were used to document the plan of care and calculate the billing codes); and 3) One way for an agency to monitor quality is to review responses to OASIS items in clinical records and compare those responses with data collected at prior and subsequent visits to the same patient. If any of these processes would be complicated by the printouts received from your system, it could create problems for the agency.

Due to the size and complexity of some of the items (e.g. M1020/1022/1024/1308/2100/22502400) the formatting may be modified to fit the computer screen as long as the hard copy print out matches the data set and the modification in no way impacts the accuracy of the item scoring.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/08 Q&A #2]

**Q20. Our agency has been using a typical OASIS form that integrated the comprehensive assessment information with OASIS (as required by the Conditions of Participation) within one single form. We recently decided to use two separate forms. One form is the Comprehensive Assessment as stated above and the second is CMS OASIS-C. Someone told us that this was unacceptable and a single, physically integrated form is required. Is this true?**

A20. In order to be compliant with the Medicare Condition of Participation, 484.55, Comprehensive Assessment of Patients, the OASIS Assessment Items must be



integrated into the agency's comprehensive assessment forms and arranged in a clinically meaningful manner. The data items may not be kept on a separate form and attached as a separate document to the comprehensive assessment.

#### **Category 4B - OASIS Data Items**

##### **Q1. PTS. Can the Patient Tracking Sheet be combined with another form such as the agency's referral form?**

A1. The agency may choose to use the Patient Tracking Sheet as any other clinical documentation, integrating additional items as desired. If the agency typically collects other items at SOC and updates them only as necessary during the episode of care, these items might be good choices to integrate with the other Tracking Sheet items. The patient's telephone number might be an example of such an item.

##### **Q2. PTS. Can other (agency-specific) items be added to the Patient Tracking Sheet?**

A2. The agency can incorporate other items into the Patient Tracking Sheet (PTS) as needed for efficient care provision. Examples of such items that would "fit" nicely with the OASIS PTS items would be the patient's street address, telephone number, or directions to the patient's residence.

##### **Q3. PTS. Must the clinician write down/mark every single piece of information recorded on the Patient Tracking Sheet (e.g., could clerical staff enter the address, ZIP code, etc.)?**

A3. Consistent with professional and legal documentation principles, the clinician who signs the assessment documentation is verifying the accuracy of the information recorded. At the time of referral, it is possible for clerical staff to record preliminary responses to several OASIS items such as the address or ZIP code. The assessing clinician then is responsible to verify the accuracy of these data.

##### **Q4. What do the "M0000" numbers stand for?**

A4. The "M" signifies a Medicare assessment item. The following four characters are numbers that identify the specific OASIS item.

**Q4.1.** [Q&A RETIRED 09/09; Outdated]

**Q5.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A EDITED 08/07]

##### **Q6. M0030. Is the start of care date (M0030) the same as the original start of care when the patient was first admitted to the agency, or is it the start of care for the current certification period?**

A6. The start of care date (M0030) is the date of the first reimbursable service and is maintained as the start of care date until the patient is discharged. It should correspond to the start of care date used for other documentation, including billing or physician orders.

**Q7. M0030. What if a new service enters the case during the episode? Does it have a different SOC date?**

A7. There is only one Start of Care date for the episode, which is the date of the first billable visit.

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #7]

**Q7.1. M0030. If PT and HHA are ordered, and a registered nurse does a non-billable initial assessment visit to establish needs and eligibility for a therapy only patient, can the home health aide make a “reimbursable” visit prior to the day the therapist makes the first “skilled” visit for a Medicare patient? And wouldn’t the aide’s visit establish the SOC?**

A7.1. The "start of care" is defined as the first billable visit. It is possible that the visit that establishes the SOC is not skilled, as in the scenario presented in the question above where the aide’s visit is both reimbursable and establishes the start of care for the episode. The Conditions of Participation 484.55, Comprehensive Assessment of Patients Interpretive Guidelines states "For all practical purposes, the start of care date is the first billable home visit. For payers other than Medicare, the first billable visit might be a visit made by a home health aide." More recent instruction in the Medicare Benefits Manual (Chapter 7, Sequence of Qualifying Services) does state that now, even for Medicare, the first billable visit might be a visit made by a home health aide, once the need and eligibility has been established.

**Q8.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q9.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A EDITED 08/07]

**Q10. M0063. If the patient has Medicare, but Medicare is not the primary pay source for a given episode, should the patient’s Medicare number be entered?**

Q10. The patient’s Medicare number should be entered, whether or not Medicare is the pay source for the episode. Keep in mind that Medicare is often a secondary payer, even when another payer will be billed first. In order to bill Medicare as a Secondary Payer, the patient must be identified as a Medicare patient from the start of care. If the agency does not expect to bill Medicare for services provided by the agency during the episode, then Medicare would not be included as a pay source on M0150, even though the patient’s Medicare number is reported in M0063.

**Q11.** [Q&A RETIRED 08/07; Replaced by updated Q&A.]

**Q12.** [Q&A RETIRED 08/07; Outdated]

**Q12.1.** [Q&A RETIRED 08/07; Outdated]

[Q&A EDITED 08/07]

**Q13. M0080. Why are Social Workers not included on OASIS item M0080?**

A13. In item M0080 - Discipline of Person Completing Assessment, you will find the initials of clinicians (RN, PT, SLP/ST, OT) who can initiate a qualifying Medicare home

health service and/or are able to complete the assessment. Social workers are not able to initiate a qualifying Medicare home health benefit or complete the comprehensive assessment, but may support other qualifying services. In the Medicare Conditions of Participation (CoP), CFR 484.34, conducting a comprehensive assessment of the patient is not considered a service that a social worker could provide. To access the CoP, go to <http://www.cms.hhs.gov/center/hha.asp>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 04/08 Q&A #3]

**Q13.1. M0080. Can a speech therapist do a non-bill admission for a physical therapy only patient?**

A13.1. The Comprehensive Assessment of Patients Condition of Participation (484.55) states in Standard (a) (2) "When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional." Some agencies' policies make this practice more restrictive by limiting some of the allowed disciplines (i.e., PT, OT, and/or SLP) from completing the initial assessment visit and/or comprehensive assessment, and require an RN to complete these tasks, even in therapy only cases where the therapy discipline establishes program eligibility for the payer. While not necessary, it is acceptable for agencies to implement this type of more stringent/restrictive practice. Even though there are no orders for nursing in a therapy only case, the RN may complete the initial assessment visit and the comprehensive assessment, as nursing, as a discipline, establishes program eligibility for most, if not all payers.

In a case where PT is the only ordered service, and assuming physical therapy services establish program eligibility for the payer, the PT could conduct the initial assessment visit and the SOC comprehensive assessment. Likewise, assuming skilled nursing services establish program eligibility for the payer, the RN could complete these tasks as well, even in the absence of a skilled nursing need and related orders. If speech pathology services were also a qualifying service for the payer, it would be acceptable, although not required, for the SLP to conduct the initial assessment visit and/or complete the comprehensive assessment for the PT only case, even in the absence of a skilled SLP need and related orders. Likewise, a PT could admit, and complete the initial assessment visit and comprehensive assessment for an SLP-only patient, where both PT and SLP were primary qualifying services (like the Medicare home health benefit).

It should be noted that under the Medicare home health benefit (and likely under other payers as well), the visit(s) made by the RN, (or SLP, or PT, etc.) to complete the initial assessment and comprehensive assessment tasks would not be reimbursable visits, therefore would not establish the start of care date for the home care episode.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/09 Q&A #4]

**Q13.2. M0080. Who can complete the OASIS data collection that occurs at the Transfer and Death at Home time points? Can someone in the office who has never seen the patient complete them? Does it have to be an RN, PT, OT or SLP?**

A13.2. Since the Transfer and Death at Home OASIS time points require data collection and not actual patient assessment findings, any RN, PT, OT or SLP may collect the

data, as directed by agency policy. The OASIS-C Guidance Manual, under M0100, explains that a home visit is not required at these time points. As these time points are not assessments and do not require the clinician to be in the physical presence of the patient, it is not required that the clinician completing the data collection must have previously visited the patient. The information can be obtained over the telephone by any RN, PT, OT or SLP familiar with OASIS data collection practices. This guidance applies only to the Transfer and Death time points, as a visit is required to complete the comprehensive assessments and OASIS data collection at the Start of Care, Resumption of Care, Recertification, Other Follow-up and Discharge.

[Q&A EDITED 08/07]

**Q14. M0090. We have 5 calendar days to complete the admission/start of care assessment. What date do we list on OASIS for M0090 - Date Assessment Completed when information is gathered on day 1, 3 and 5?**

A14. Generally, you would enter the last day that assessment information was obtained on the patient in his/her home, if all clinical data items were completed. However, if the clinician needs to follow-up, off site, with the patient's family or physician in order to complete an OASIS or non-OASIS portion of the comprehensive assessment, M0090 should reflect the date that last bit of information is collected.

[Q&A EDITED 08/07]

**Q15. M0090. We had a patient admitted to the hospital on April 15 and found out about it on April 19. When we enter the transfer (patient discharged) assessment (M0100 reason for assessment 7) into HAVEN, we get a warning message that the record was not completed within correct timing guidelines. (M0090) date should be no earlier than (M0906) date AND no more than 2 days after M0906 date.**

A15. That message is intended to be a reminder that you should complete a transfer assessment within 48 hours of learning of it. The regulation states that the assessment must be completed within 48 hours of learning of a transfer to an inpatient facility, so in this case, the assessment has been completed in compliance. The warning does not prevent the assessment from being transmitted. If you find that this warning occurs consistently, you may want to examine whether your staff are appropriately tracking the status of patients under their care.

[Q&A EDITED 08/07]

**Q16. M0090. Is the date that an assessment is completed, in M0090, required to coincide with the date of a home visit? When must the date in M0090 coincide with the date of a home visit?**

A16. M0090, date assessment completed, records the date the assessment is completed. The start of care (SOC), resumption of care (ROC), follow-up, and discharge assessments (reason for assessments [RFA] 1, 3, 4, 5, and 9 for M0100) must be completed through an in-person contact with the patient; therefore these assessments will most often coincide with a home visit. The transfer or death at home assessments (RFAs 6, 7, or 8 for M0100) will report in M0090 the date the agency completes the assessment after learning of the event.

In the situation where the clinician needs to follow up, off site, with the patient's family or physician in order to complete a specific clinical data item that the patient is unable to answer, M0090 should reflect that date.

[Q&A ADDED 06/05; EDITED 08/07]

**Q17. M0090. If an HHA's policy requires personnel knowledgeable of ICD-9-CM coding to complete the diagnosis after the clinician has submitted the assessment, should M0090 be the date that the clinician completed gathering the assessment information or the date the ICD-9-CM code is assigned?**

A17. The HHA has the overall responsibility for providing services, assigning ICD-9-CM codes, and billing. CMS expects that each agency will develop their own policies and procedures and implement them throughout the agency in a manner that allows for correction or clarification of records to meet professional standards. It is appropriate for the clinician to enter the medical diagnosis on the comprehensive assessment. The HHA can assign a qualified coder to determine the correct numeric code based upon the written diagnosis provided by the assessing clinician. The date at M0090 (Date Assessment Completed) should reflect the actual date the assessment is completed by the qualified clinician. If agency policy allows the assessment to be performed over more than one visit, the date of the last visit (when the assessment is finished is the appropriate date to record. The M0090 date should not necessarily be delayed until coding staff verify the numeric codes.

[Q&A EDITED 08/07]

**Q18. M0090. Should the date in M0090, reflect the date that a supervisor completed a review of the assessment?**

A18. While a thorough review by a clinical supervisor may improve assessment completeness and data accuracy, the process for such review is an internal agency decision and is not required. The assessment completion date (to be recorded in M0090) should be the last date that data necessary to complete the assessment is collected.

[Q&A ADDED 06/05]

**Q19. M0090. A provider has decided to complete discharge assessments for all patients when payers change because they believe that, by doing so, their reports will better indicate their patients' outcomes. Before making this policy shift they need answers to the following questions:**

- a. Can the agency perform the RFA 09 and RFA 01 on the same visit?
- b. If so, what is the discharge date for the RFA 09 at M0090?
- c. If so, what is the admission date for RFA 01 at M0090?
- d. Will recording of the same date for both of these assessment result in errors when transmitted to the state agency?

A19. Under normal business practices, one home health visit should not include two types of assessments and be billed to two payer sources. The discharge date for the (RFA 09) Discharge from Agency should be the last date of service for the payer being terminated. The admission date for the new Start of Care (RFA 01) assessment should be the next scheduled visit, according to the plan of care. The agency may send a batch including both assessments to the state system. An edit is in place at the state system to sort for an assessment to close an open patient episode prior to opening a new episode.

[Q&A ADDED 08/07; M item numbers updated 09/09; Previously CMS OCCB 07/06 Q&A #2]

**Q19.1. M0090. 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 M2200. If the RN selects a response for M2200 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?**

A19.1. 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 M2200. 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. M2200 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 M2200 response and this would not violate the requirement that the assessment be completed by one clinician.

[Q&A ADDED 09/09; Previously CMS OCCB 10/07 Q&A #9]

**Q19.2. M0090. I understand that M0090, Date Assessment Completed, is the day the last information needed to complete the assessment is collected, and at discharge, it is generally the last visit. Due to the Notice of Provider Non-Coverage which must be given to Medicare recipients two days before discharge, there have been occasions when the notice was not signed at the discharge visit. In order to give the patient the 2 day notice, we hold discharging until after they have had the patient sign the notice, and call them back in two days to confirm the discharge plan, however, the OASIS is completed based on the last visit. When this happens, the system gives us an error when we put in the last visit date versus that last discharge date, even though the assessment is based on the last visit.**

A19.2. M0090, Date Assessment Completed, is the date the clinician gathered the last piece of information necessary to complete the assessment. In most cases, but not all, M0090 is the day of a visit. Sometimes the clinician may gather information off site, such as Therapy Need, or other items that are dependent on a call back from a caregiver or physician or other non-patient assessment data, like dates. M0906, Discharge Date, is defined by agency policy. For some agency's it is the date of the last visit, but other agencies may define it to be one or two days or more after the last visit. It is not prescribed by regulation, except that the discharge date cannot occur before the date of the last visit. Regulation requires that the discharge assessment must be completed within two calendar days of the actual discharge date or within two calendar days of learning of the need to discharge in the case of an unplanned or unexpected discharge.

In the case you described, the discharge date (M0906) could be defined by the agency's policy as two days after the last visit to allow for the 2-day notice. The clinician would then have up to two calendar days to complete the assessment (M0090). The bulk of the assessment items could be completed on the visit and then M0906 discharge date and M0090 date assessment completed (the last items you needed to complete the assessment) could be determined 2 days after the date of the last visit, once the

discharge was a certainty. Establishing a policy that defines the discharge date in this way prevents the problem with the timing of the data submission and is compliant with the regulation. The problem occurs when you complete the assessment (M0090) before the actual discharge date (M0906).

[Q&A ADDED & M item number updated 09/09; Previously CMS OCCB 04/08 Q&A #4]  
**Q19.3. M0090. Should the M0090 date be changed when a correction is made after a clinician has completed the assessment but before the assessment is locked? For example, the nurse completes the assessment with a M2200 response of 3 visits on February 1<sup>st</sup> and records that date at M0090. On Feb 2<sup>nd</sup> the nurse learns that the therapist assessed the patient and received physician orders for 10 therapy visits. Should the M0090 date be changed to February 2<sup>nd</sup> to reflect the date that M2200 is corrected?**

A19.3. If the original assessing clinician gathers additional information during the SOC 5 day assessment time frame that would change a data item response, the M0090 date would be changed to reflect the date the information was gathered and the change was made. If an error is identified at any time, it should be corrected following the agency's correction policy and M0090 would not necessarily be changed.

[Q&A ADDED & M item number updated 09/09; Previously CMS OCCB 01/09 Q&A #4 & 7]

**Q19.4. M0090. I was reviewing CMS OASIS Q&A 4, above, and noted that the response states: "if the original assessing clinician gathers additional information during the SOC 5 day assessment time frame", M0090 would need to reflect that more recent date. Our practice is to hold the OASIS SOC until all the therapy disciplines have submitted the add-on orders, complete with their frequencies. Then the OASIS document is submitted with the totaled number. This should be our best estimate of the actual number of visits planned for the patient by therapy. My question is: In our situation, would "original assessing clinician" extend to the record review department? Would they need to change the M0090 answer once the totaled number of visits is added and put in M2200?**

A19.4. Only one clinician can complete the comprehensive assessment including the OASIS. If the clinician responsible for completing the OASIS assessment gathers new information during the 5-day assessment time period, s/he may change the response to that item and change the M0090 date to reflect the date the latest new information was gathered. This would apply to M2200.

If the OASIS is completed by the assessing clinician and then, through an internal review process in the office, it is discovered that the OASIS data contains one or more errors, the identified data item(s) could be corrected by the qualified clinician responsible for performing the review following your agency's correction policy and in such cases of error correction, M0090 would not be changed

[Q&A ADDED 09/09; Previously CMS OCCB 07/09 Q&A #4]

**Q19.5. M0090. 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?**

A19.5. 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.

[Q&A EDITED 08/07]

**Q20. M0100. Does 'transfer' mean 'transfer to another non-acute setting' or 'transfer to an inpatient facility?'**

A20. Transfer means transfer to an inpatient facility, i.e., the patient is leaving the home care setting and being transferred to a hospital, rehabilitation facility, nursing home or inpatient hospice for 24 hours or more for reasons other than diagnostic testing. Note that the text of the item indicates that it means transfer to an inpatient facility.

[Q&A EDITED 08/07]

**Q21. M0100. For a one-visit Medicare PPS patient, is Reason for Assessment (RFA) 1 the appropriate response for M0100? Is it data entered? Is it transmitted? Is a discharge OASIS completed?**

A21. Completion of a SOC Comprehensive Assessment is required, even when the patient is known to only need a single visit in the episode. While there is no requirement to collect OASIS data as part of the comprehensive assessment for a known one-visit episode, some payers (including Medicare PPS and some private insurers) require SOC OASIS data to process payment. If collected, RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. Since OASIS data collection is not required by regulation (but collected for payment) in this case, the agency may choose whether or not the data is transmitted to the State system.

If OASIS data is required for payment by a non-Medicare/non-Medicaid payer (M0150 response does not include Response(s) 1,2,3, or 4), the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State system. Regardless of pay source, no discharge assessment is required, as the patient receives only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however.

**Q22. [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]**



[Q&A ADDED 06/05; M number updated 09/09]

**Q23. M0100. A patient receiving skilled nursing care from an HHA under Medicare is periodically placed in a local hospital under a private pay arrangement for family respite. The hospital describes this bed as a purely private arrangement to house a person with no skilled services. This hospital has acute care, swing bed, and nursing care unit. The unit where the patient stays is not Medicare certified. Should the agency do a transfer and resumption of care OASIS? How should the agency respond to M0100 and M2410?**

A23. Yes, if the patient was admitted to an inpatient facility, the best response to M0100-Reason for Assessment (RFA) is Transfer to an Inpatient Facility. Depending on the agency policy, the choice may be RFA 6 transfer to an inpatient facility – patient not discharged or RFA 7 transfer to an inpatient facility – patient discharged. The agency will need to contact the inpatient facility to verify the type of care that the patient is receiving at the inpatient facility and determine the appropriate response to M2410. If the patient is using a hospital bed, response 1 applies; if the patient is using a nursing home bed, response 3 applies. If the patient is using a swing-bed it is necessary to determine whether the patient was occupying a designated hospital bed, response 1 applies; or a nursing home bed, response 3 applies. The hospital utilization department should be able to advise the agency of the type of bed and services the patient utilized.

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #3]

**Q23.1. M0100. 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”?**

A23.1. 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”.

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #4]

**Q23.2. M0100. 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?**

A 23.2. 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.

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #5]

**Q23.3. M0100. 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?**

A23.3. 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.

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #6]

**Q23.4. M0100. 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?**

A23.4. 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.

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #7]

**Q23.5. M0100. 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?**

A23.5. 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.

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #9]

**Q23.6. M0100. For the purposes of determining if a hospital admission was for reasons "other than diagnostic tests" how is "diagnostic testing" defined? I understand plain x-rays, UGI, CT scans, etc. would be diagnostic tests. What**

**about cardiac catheterization, an EGD, or colonoscopy? (A patient does receive some type of anesthesia for these). Does the fact that the patient gets any anesthesia make it surgical verses diagnostic?**

A23.6. Diagnostic testing refers to tests, scans and procedures utilized to yield a diagnosis. Cardiac catheterization is often used as a diagnostic test to determine the presence or status of coronary artery disease (CAD). However, a cardiac catheterization may also be used for treatment, once other testing has established a definitive CAD diagnosis. Each case must be considered individually by the clinician without making assumptions. The fact that the procedure requires anesthesia does not determine whether or not the procedure is purely diagnostic or not. Utilizing the definition of diagnostic testing, a clinician will be able to determine whether or not a certain procedure or test is a diagnostic test.

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #10]

**Q23.7. M0100 & M2410. HHAs are providing services for psychiatric/mental health patients. The physician admits the patient to the hospital for "observation & medication review" to determine the need to adjust medications. These admissions can occur as often as every 2-4 weeks. The patient(s) are admitted to the hospital floor under inpatient services (not in ER or under "observation status"). The patient(s) are observed and may receive some lab work. They are typically discharged back to home care services within 3-7 days. Most patients DO NOT receive any treatment protocol (i.e. no medications were added/stopped or adjusted, no counseling services provided) while they were in the hospital. Is this considered a hospitalization? How do you answer M0100 & M2410?**

A23.7. In order to qualify for the Transfer to Inpatient Facility OASIS assessment time point, the patient must meet 3 criteria:

- 1) Be admitted to the inpatient facility (not the ER, not an observation bed in the ER)
- 2) Reside as an inpatient for 24 hours or longer (does not include time spent in the ER)
- 3) Be admitted for reasons other than diagnostic testing only

In your scenario, you are describing a patient that is admitted to the inpatient facility, and stays for 24 hours or longer for reasons other than diagnostic testing. An admission to an inpatient facility for observation is not an admission for diagnostic testing only. This is considered a hospitalization. The correct M0100 response would be either 6-Transfer to an Inpatient Facility, patient not discharged or 7-Transfer to an Inpatient Facility, patient discharged, depending on agency policy. M2410 would be answered with Response 1-Hospital as you state the patient was admitted to a hospital.

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #11]

**Q23.8. M0100 & M2300. Observation Status/Beds - A patient is held for several days in an observation bed (referred to as a "Patient Observation" or "PO" bed) in the emergency or other outpatient department of a hospital to determine if the patient will be admitted to the hospital or sent back home. While under observation, the hospital did not admit the patient as an inpatient, but billed as an outpatient under Medicare Part B. Is this Emergent Care? Should we complete a transfer, discharge the patient, or keep seeing the patient. Can we bill if we continue to provide services?**

A23.8. For purposes of OASIS M2300 Emergent Care - the status of a patient who is a being held in an emergency department for outpatient observation services is response 1 - hospital emergency department (whether or not they are ever admitted to the inpatient facility). If they are held for observation in a hospital outpatient department, response 3 should be reported for M2300.

If from observation status the patient is eventually admitted to the hospital as an inpatient (assuming the transfer criteria are met), then this would trigger the Transfer OASIS assessment, and the agency would complete RFA 6 or RFA 7 data collection, depending on whether the agency chose to place the patient on hold or discharge from home care.

During the period the patient is receiving outpatient observation care, the patient is not admitted to a hospital. Regardless of how long the patient is cared for in outpatient observation, the home care provider may not provide Medicare billable visits to the patient at the ER/outpatient department site, as the home health benefit requires covered services be provided in the patient's place of residence. Outpatient therapy services provided during the period of observation would be included under consolidated billing and should be managed as such. The HHA should always inform the patient of consolidated billing at the time of admission to avoid non-payment of services to the outpatient facility.

If the patient is not admitted to the hospital, but returns home from the emergency department, based on physician orders and patient need, the home health agency may continue with the previous or a modified plan of care. An Other Follow-up OASIS assessment (RFA 5) may be required based on the agency's Other Follow-up policy criteria. The home health agency would bill for this patient as they would for any patient who was seen in an emergency room and returned home without admission to the inpatient facility following guidance in the Medicare Claims Processing manual.

The CMS Manual System Publication, 100-04 Medicare Claims Processing: Transmittal 787 - the *January 2006 Update of the Hospital Outpatient Prospective Payment System Manual Instruction for Changes to Coding and Payment for Observation* provides guidance for the use of two new G-codes to be used for hospital outpatient departments to use to report observation services and direct admission for observation care. Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #12]

**Q23.9. M0100. An HHA has a patient who has returned home from a hospital stay and they have scheduled the nurse to go in to do the Resumption of Care visit within 48 hours. However, this patient receives both nursing and physical therapy and the PT cannot go in on the 2nd day (tomorrow) and would like to go in**

**today. I have found the standard for an initial assessment visit must be done by a registered nurse unless they receive therapy only. Is this the same case for resumption? Is it inappropriate for the PT to go in the day before and resume PT services and the nurse then to go in the next day and do the ROC assessment update?**

A23.9. The requirement for the RN to complete an initial assessment visit prior to therapy visits in multidisciplinary cases is limited to the SOC time point. At subsequent time points, including the ROC, either discipline (the RN or PT in the given scenario) could complete the ROC assessment. While the assessment must be completed within 48 hours of the patient's return home from the inpatient facility, there is no requirement that other services be delayed until the assessment is completed. Therefore, assuming compliance with your agency-specific policies and other regulatory requirements, there is no specific restriction preventing the PT from resuming services prior to the RN's completion of the ROC assessment.

[Q&A ADDED 09/09; Previously CMS OCCB 04/09 Q&A #6]

**Q23.10. M0100. If a patient goes into a hospital as a "planned admission", do we have to do a Transfer? We have a patient who is admitted routinely for chemotherapy treatments as planned admissions. Is this different than an admission for "planned" diagnostic testing? If it is a planned admission for testing and "something goes wrong", does it become a Transfer?**

A23.10. An RFA 6 or 7, Transfer to the Inpatient Facility, is required any time the patient is admitted to an inpatient facility for 24 hours or longer for reasons other than diagnostic testing. The fact that it was a planned admission is not a factor in determining if the Transfer OASIS data collection and submission are required. The patient who goes routinely into an inpatient facility for chemotherapy would require an RFA 6 or 7, Transfer, if they are admitted to an inpatient for 24 hours or longer since they are receiving treatment and not just diagnostic testing.

If a patient is admitted for diagnostic testing only and does not receive treatment, they do not require an RFA 6 or 7, Transfer, no matter how long they stay in the inpatient facility. If it was a planned admission for diagnostic testing and the patient ends up receiving treatment, a Transfer would be required if they stay in the inpatient bed is for 24 hours or longer.

**Q23.11. [Q&A RETIRED 09/09]**

[Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #6]

**Q23.12. M0110. When we collect OASIS for a private insurance or Medicare HMO patient because the payer source pays using a "Medicare PPS-like" model, how do we answer M0110, Episode Timing? To select a response, do we define an episode as just Medicare PPS paid episodes? Or for these non-Medicare PPS patients, should we define an episode as any paid by a payer using the PPS model?**

A23.12. M0110 was developed for use in refining the PPS model and payment for the Medicare home health benefit. In that analysis, the definition of episode is specific to those episodes where Medicare fee-for-service (PPS) is the payer. When M0110 is collected on an OASIS-required patient and/or to facilitate Medicare PPS payment, this

definition must be applied. If a non-Medicare PPS payer requests/requires information on episode timing to be collected using different definitions or parameters, the “payer-specific” information should be collected separately from the established OASIS items (i.e., the M0110 item should not be used, with parameters different than those required by CMS, to gather other payer-specific data).

[Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #9]

**Q23.13. M0110. A patient is admitted to Agency A on July 5<sup>th</sup>, 2007 (with an end of payment episode date of Sept 2<sup>nd</sup>), then recertified on Sept 3<sup>rd</sup> (with an end of episode date November 1<sup>st</sup>, 2007). Agency B admits on Jan 1, 2008. Is agency B’s episode Early or Later?**

A23.13. When determining if 2 eligible episodes are adjacent, the HHA should count the number of days from the last day of one episode until the first day of the next episode.

Adjacent episodes are defined as those where the number of days from the last day of one episode until the first day of the next episode is not greater than 60. The first day after the last day of an episode is counted as day 1, and continues counting to, and including, the first day of the next episode. In the scenario presented, In this example, November 1<sup>st</sup> was the last day of the episode (day 120) and January 1 is the first day of the next episode. When counting the number of days from the last day of one episode (Nov 1<sup>st</sup>), November 2<sup>nd</sup> would be day 1, and Jan 1 would be day 61. Since the number of days from the end of one episode to the start of the next is more than 60 days, these two episodes are not adjacent. The episode starting January 1<sup>st</sup> would be reported by Agency B as “early”.

December 31 represents day 60 in this example. If the next episode started December 31 instead of January 1, that episode would be considered adjacent since the number of days counted is not greater than 60. The episode starting December 31 would be reported by Agency B as “later.” All other episodes beginning between November 2 and December 31 in this example would also be reported as “later”.

[Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #10]

**Q23.14. M0110. Agency 1 provides 90 days of care (1 and 1/2 episodes) under Medicare PPS and the patient is discharged. Agency 2 admits under Medicare PPS and begins care at what would have been a day in the 2<sup>nd</sup> episode (lets say day 45 in the second episode) had agency 1 still been caring for the patient. Is agency 2 still in an early episode? Or is this now a later episode for M0110?**

A23.14. It would be reported as a later episode. Agency 1 provided care for one full payment episode, then recerted to establish a second payment episode, though the patient was discharged before the end of this 2<sup>nd</sup> episode. A partial episode payment will apply to the 2<sup>nd</sup> episode when Agency 2 admits the patient to their service under Medicare PPS, and the episode started by Agency 2 will be the third adjacent episode because there was not more than 60 days between the last billable visit provided by Agency 1 and the first billable visit provided by Agency 2. Since it was the third in a series of adjacent episodes, it should be reported as “Later” for M0110.

[Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #11]

**Q23.15. M0110. If a Medicare PPS patient is admitted and discharged with goals met several times within one 60-day period, is each admission counted when**

**determining early vs. later episodes? For example, a patient is admitted 10/1 and discharged 10/15 (episode #1- early?), then readmitted 10/30 and discharged 11/15 (episode #2-early?), then readmitted 11/20 (episode #3- later?). Would this represent 3 distinct episodes, for the purpose of determining M0110 Episode Timing?**

A23.15. For M0110, episodes are considered adjacent if there was no greater than 60 days between the last day of one Medicare Fee-for-Service (MC FFS) or PPS payment episode and the first day of the subsequent PPS payment episode. If a home care agency admits a Medicare patient and they had not been in a Medicare FFS Payment episode in the 60 days prior to the admission, the correct M0110 response would be "Early". If this patient was under the Medicare FFS benefit on 10/1 and was then discharged 10/15 and readmitted 10/30, a new payment episode would begin. The agency would receive a partial episode payment for the 10/1 - 10/15 episode. When an episode is ended by an intervening event that causes it to be paid as a partial episode payment [PEP] adjustment, then the last billable visit date is the end of the episode. When completing M0110 at the 10/30 episode, the patient would still be in an "Early" episode, as it would be the second in a series of adjacent episodes (assuming there was not an additional adjacent episode previous to the 10/1 episode). If that patient was then discharged on 11/15 (receiving a PEP payment) and readmitted on 11/20, the correct response to M0110 would now be "Later" as the patient would be in the third adjacent episode in the series.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/08 Q&A #3]

**Q23.16. M0110. We had a Medicare patient who received 2 contiguous episodes of service which did not meet the home health benefit. In order to receive payment from a secondary insurer, we submitted demand bills to our intermediary, fully expecting, and receiving denials. One month after being discharged from care, the patient now needs services which do meet Medicare eligibility and we are completing a new SOC to initiate a new episode under Medicare PPS. When answering M0110, should the previous 2 episodes, which were billed to, but denied by the intermediary, be considered when counting adjacent episodes or should they be ignored, since payment under Medicare PPS was denied? For the purposes of defining Medicare PPS episodes for M0110, does it mean the episode was **BILLED AND PAID** by Medicare PPS, or just that it was **BILLED** to the Medicare via the Medicare Administrative Contractor (MAC)?**

A23.16. Denied episodes should not be counted when determining the correct response to M0110 Episode Timing.

[Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #7]

**Q23.17. M0110. When the clinician is unsure if there have been any adjacent episodes, is it better to report M0110 Episode Timing as "early" or "unknown" (which defaults to "early")? If Medicare makes the adjustment automatically to correct this if it was wrong, will it make a difference if we marked "early" vs. "unknown" initially?**

A23.17. The use of the unknown response for M0110 may be impacted by agency preference/practice. Some agencies may choose not to invest the resources necessary to determine whether episodes are early or later episodes and it is perfectly acceptable for an agency to select "UK" consistently for M0110. Other providers who want to ensure

an accurate RAP payment in the case of later episodes may choose to invest the resources to determine which episode the patient is in, and this is also compliant practice. Marking “early” and “unknown” have the same effect on payment calculations. If a M0110 response is determined to be inaccurate at the time of the final claim, payment will be auto-adjusted to the correct episode amount.

[Q&A ADDED & M item number updated 09/09; Previously CMS OCCB 10/07 Q&A #10]  
**Q23.18. M0110 and M2200. If we determine that we answered M2200, Therapy Need or M0110, Episode Timing, incorrectly at SOC, ROC or Recert, what actions do we have to take?**

A23.18. In the Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Final Rule available at:  
<http://www.cms.hhs.gov/homehealthpps/hhppsrrn/ItemDetail.asp?ItemID=CMS1202451> it states:

“The CWF will automatically adjust claims up or down to correct for episode timing (early or later, from M0110) and for therapy need (M2200) when submitted information is found to be incorrect. No canceling and resubmission on the part of HHAs will be required in these instances. Additionally, as the proposed rule noted, providers have the option of using a default answer reflecting an early episode in M0110 in cases where information about episode sequence is not readily available.”

Since medical record documentation standards require a clinician to correct inaccurate information contained in the patient’s medical record, if it comes to the clinician’s attention that the OASIS response for M0110 - Episode Timing is incorrect, the original assessment may be corrected following the agency’s correction policy. Agencies can make this non-key field change to their records and retransmit the corrected assessment to the State system. For example, if the clinician chose “Early” and during the episode, s/he learned that the patient was in a “Later” episode, M0110 may be corrected. Alternatively, in order to maintain compliance with standard medical record accuracy expectations, the clinician or agency could otherwise document the correction in a narrative correction note, or other format, since CMS is not specifically requiring the correction to be made to the OASIS assessment.

It is quite possible that providers may underestimate or overestimate the number of therapy visits M2200 that will be required in the upcoming episode. Because M2200 is an estimation of an exact number of therapy visits the agency expects to provide and the CWF will automatically adjust claims if the estimation is found to be incorrect, there will be no need to go back to the original OASIS assessment and change the M2200 response and resubmit the data.

The clinician cannot be expected to correct what is unknown to them and since in these specific cases the Common Working File (CWF) will automatically adjust claims found to be incorrect, no extraordinary efforts need to be taken after the original data collection to determine the accuracy of the data specific to M0110 and M2200.

Q&A ADDED 09/09; M item number updated 09/09; Previously CMS OCCB 01/08 Q&A #12]



**Q23.19. M0110 & M2200. I have entered an assessment into HAVEN, it is ready to be locked and exported, but when I try to calculate the HIPPS Code I receive a message that grouper returned blank values. Why is this?**

A23.19. If M0110 or M2200 are marked as 'Not Applicable' then the Grouper will not return a value for the HIPPS Score. To determine how these fields should be completed please contact your state's OASIS Education Coordinator. [

[Q&A EDITED 08/07]

**Q24. M0150. For M0150, Current Payment Sources for Home Care, what should be the response if the clinician knows that a patient has health insurance but that the insurance typically won't pay until attempts have been made to collect from the liability insurance (e.g., for injuries due to an auto accident or a fall in a public place)?**

A24. The purpose of this data item is to identify the current payer(s) that your agency will bill for services provided by your agency during this home care episode. Note that the text of M0150 asks for the "current payment sources" (emphasis added) and contains the instruction, "Mark all that Apply." For Medicare patients, the clinician should indicate at admission that the patient has Medicare coverage and any other coverage available that the agency will bill for services and mark all of the appropriate responses. The item is NOT restricted to the primary payer source. When a Medicare patient has a private insurance pay source as the primary payer, Medicare should always be treated as a likely/possible secondary payer. For example, when a Medicare patient is involved in a car accident and someone's car insurance is paying for his/her home care, Medicare is the secondary payer and the response to M0150 should include either response 1 or 2 as appropriate for that patient. The only way an agency can bill Medicare as a secondary payer is to consider that patient a Medicare patient from day 1, so that all Medicare-required documentation, data entry and data submission exist. Although the agency may "intend" that the private pay source will pay the entire cost of the patient's home care that usually cannot be verified at start of care and may not be determined until the care is completed.

**Q25. M0150. Please clarify what Title V and Title XX programs are?**

A25. Title V is a State-determined program that provides maternal, child health, and crippled children's services, which can include home health care. Title XX of the Social Security Act is a social service block grant available to States that provide homemaking, chore services, home management, or home health aide services. (Title III, also mentioned in Response 6 to M0150 is part of the Older Americans Act of 1965 that gives grants to State Agencies on Aging to provide certain services including homemaker, home-delivered meals, congregate nutrition, and personal care aide services at the State's discretion.)

**Q26.** [Q&A RECALLED 08/07]

[Q&A ADDED 06/05; Previously CMS OCCB 10/04 Q&A #2]

**Q27. M0150. 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)?**

A27. 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.

[Q&A EDITED 09/09]

**Q28. M0150. The patient's payer source changes from Medicare to Medicaid or private pay. The initial SOC/OASIS data collection was completed. Does a new SOC need to be completed at the time of the change in payer source?**

A28. Different States, different payers, and different agencies have varying responses to these payer change situations, so we usually find it most effective to ask, "Does the new payer require a new SOC?" HHAs usually are able to work their way through what they need to do if they answer that question. If the new payer source requires a new SOC (Medicare is one that DOES require a new SOC), then it is recommended that the patient be discharged from the previous pay source and re-assessed under the new pay source, i.e., a new SOC comprehensive assessment. The agency does not have to re-admit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails a new admission). If the payer source DOES NOT require a new SOC, then the schedule for updating the comprehensive assessment continues based on the original SOC date. The HHA simply indicates that the pay source has changed at M0150. OASIS data collection and submission would continue for a Medicare/Medicaid patient changed to another pay source without a discharge. Because the episode began with Medicare or Medicaid as a payer, the episode continues to be for a Medicare/Medicaid patient. Transmittal 61, posted January 16, 2004, includes a section on special billing situations and can be found in the *Medicare Claims Processing Manual*. Go to [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c10.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c10.pdf); scroll to "Section 80 - special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your Medicare Administrative Contractor (MAC).

**Q29.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #8]

**Q29.1. M0150. Do I mark response 1, Medicare (traditional fee-for-service) if the patient's payer is VA?**

A29.1. 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.

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #9]

**Q29.2. M0150. 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?**

A29.2. 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.

**Q29.3.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A ADDED 09/09; Previously CMS OCCB 10/07 Q&A #11]

**Q29.4. M0150. It has come to our attention that we have been answering M0150 incorrectly. How far do we need to go back when correcting our errors?**

A29.4. CMS regulations in the Conditions of Participation 484.20 state the encoded OASIS must be accurate. When errors are identified, follow guidance in the Medicare Conditions of Participation (CoP). The CoPs require your agency to have a policy defining how corrections are made to patient clinical records. The policy must be in compliance with any state and federal laws, and the agency must follow the policy. It should specify who is allowed to make corrections, how the corrections are to be made, and the circumstances under which such corrections can be made. The policy should clarify any differences in procedures to be followed when correcting demographic information versus correcting patient information that the clinician assessed as part of the examination of the patient. The clinical record is a legal document; consequently changes must be made only with very careful consideration. If the correction is to an OASIS item, the correction should be submitted to the state as well as corrected in the clinical record. Data entry/transmission staff should be aware that corrections involving clinical records must be made in accord with these established policies and procedures.

Regarding corrections to OASIS data already submitted to the State, information about correcting the OASIS can be found at <https://www.gtso.com/hhdownload.html>; scroll down the list of available resources and click on the link for HHAcCorrectionPolicy.pdf. Additionally, the State Operations Manual (SOM) and the Conditions of Participation, 484.48, Clinical Record, address the issue of corrections. You can download the SOM at [http://cms.hhs.gov/manuals/Downloads/som107ap\\_b\\_hha.pdf](http://cms.hhs.gov/manuals/Downloads/som107ap_b_hha.pdf)

If the correction has an impact on billing, you need to correct to submit an accurate claim. There are no time limits on submitting correct claims beyond those contained in the Medicare Claims Processing Manual. If the correction has no billing impact, corrections should be made for at least the last 12 months of data to ensure accurate quality reporting.

[Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #14]

**Q29.5. M0150. CMS Q&A Cat 4b Q24 says that "when a Medicare patient has a private insurance pay source, Medicare is always a likely secondary payer", therefore whenever we have a private insurance patient who also has Medicare, for M0150 we routinely mark both "1 - Medicare" and "8 - Private Insurance" (for health) and/or "11 - Other" (for auto, etc.), just in case Medicare ends up getting billed for a portion of the home care services. Are we interpreting this guidance accurately? And, for those cases where Medicare never ends up getting billed for services, can we retroactively correct M0150, eliminating response "1" or inactive the assessments altogether, since OASIS data collection/submission is not required for Private Pay patients only?**

A29.5. M0150, Current Payer Sources, is asking for identification and reporting of any payers the agency plans to bill for services during this episode of care. When a Medicare patient is admitted for home care services under a private insurer and the Medicare eligibility criteria are met, Medicare is always a likely payer and may be included in M0150. This action will ensure that OASIS data is collected in the event, Medicare is a payer. If at the end of the episode, the agency did not bill Medicare for services, (and assuming there were no other Medicare or Medicaid payers for home health services), then the agency should take action to delete any and all assessments (e.g., SOC, transfer, ROC, discharge), clarifying in the clinical chart why the assessment is being deleted. Simply correcting M0150 and resubmitting to the state, or inactivating affected assessments will not adequately remove the patient from the database. If the assessment is not deleted, the patient identifiable data will remain in the database, and may inappropriately impact the agency's OBQI and OBQM reports.

[Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #15]

**Q29.6. M0150. CMS Q&A Category 4b Q24 states that if a patient is involved in an auto accident the M0150 response should be 1 or 2 as appropriate for that patient. Would we also pick response 11 - Other and enter auto insurance or UK - Unknown?**

A29.6. Response 8 - refers to private health insurance. Response 11 – Other (specify) would be selected for home care services expected to be covered by auto insurance.

[M number updated 09/09]

**Q30. M1000. If the patient has outpatient surgery within the 14-day time frame described in M1000, should 1 or NA be marked?**

A30. The correct response would be 'NA' for M1000 because the patient's status would have been an outpatient for this situation.

[Q&A EDITED 09/09]

**Q31. M1000. For M1000, what is the difference between response 1 (long-term nursing facility) and 2 (skilled nursing facility)?**

A31. Response 1, Long-term nursing facility, would be appropriate if the patient was discharged from a Medicare-certified skilled nursing facility, but did not receive care under the Medicare Part A benefit in the 14 days prior to home health care. Response 2, Skilled nursing facility, would be appropriate if the patient was discharged from a Medicare certified nursing facility where they received a skilled level of care under the

Medicare Part A benefit or a transitional care unit within a Medicare-certified nursing facility during the last 14 days.

**Q32.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #11]

**Q32.1. M1000. When a patient is discharged from an inpatient facility in the last 5 days of the certification period, should M1000 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?**

A32.1. When completing a Resumption of Care assessment which will also serve as a Recertification assessment, M1000 should reflect inpatient facility discharges that have occurred during the two-week period immediately preceding the first day of the new certification period.

[Q&A ADDED & M item number updated 09/09; Previously CMS OCCB 10/07 Q&A #12]

**Q32.2. M1000. We had a client who was admitted to an inpatient facility for less than 24 hours. We did not do a Transfer OASIS because the criteria for it were not met. Two days later the patient was discharged from our agency and we completed a discharge comprehensive assessment. Approximately 1 week later, the client developed a wound and was readmitted to our agency. When completing the new SOC comprehensive assessment, how do we mark M1000 regarding Inpatient Facility Discharge in the Past 14 Days?**

A32.2. M1000 asks if the patient was discharged from an inpatient facility during the past 14 days. In your scenario, you describe a patient who was admitted and discharged from an inpatient facility during the 14 days prior to the completion of the new RFA 1 SOC comprehensive assessment. The inpatient stay would be reported in M1000.

M1000 does not ask you to only report inpatient facility stays that meet the criteria for the OASIS Transfer, i.e. it does not require that the stay in the inpatient facility is for 24 hours or greater for reasons other than diagnostic test. It simply asks whether the patient was discharged from an inpatient facility during the past 14 days

[Q&A ADDED & M item number updated 09/09; Previously CMS OCCB 04/09 Q&A #7]

**Q32.3. M1000. We are seeing more patients referred to our agency that have been in observation bed status while in the hospital (not admitted). What would be the correct response to M1000 in this case?**

A32.3. M1000, Inpatient Facility Discharge, is asking from which of the following inpatient facilities was the patient discharged during the past 14 days. If the patient had been admitted to the hospital as an inpatient and was placed under observation, it is considered a hospital discharge. If the patient was placed under observation utilizing one of the two G-codes for hospital outpatient department observation services, then it would not be an inpatient facility discharge and therefore not reportable in M1000.

[M number updated 09/09]

**Q33. M1005. In OASIS field M1005, if there is no date, do you just fill in zeros?**

A33. As noted in the skip instructions for item M1000, if the patient was not discharged from an inpatient facility within the past 14 days, (i.e., M1000 has a response of NA), M1005, M1010 and M1012 should be skipped. If the patient was discharged from an inpatient facility during the past 14 days, but the date is unknown, you should mark UK at M1005 and leave the date blank.

[Q&A EDITED 09/09]

**Q34. M1010. How would additional inpatient facility diagnoses and ICD-9-CM codes be entered into M1010 since the field only allows for six sets of codes? When we include this item in our clinical forms, can we add more lines?**

A34. M1010 requests only those diagnoses that required treatment during the inpatient stay, not all diagnoses that the patient may have. Agencies should carefully consider whether additional information is needed and, if so, include only the most relevant diagnoses in M1010. OASIS items must be reproduced in the agency clinical forms exactly as they are written. If the agency desires additional information, the most appropriate course of action may be to insert an additional clinical record item immediately following M1010.

**Q35. M1010. It takes days (sometimes even a week) to get the discharge form from the hospital. How can we complete this item in a timely manner?**

A35. Information regarding the condition(s) treated during the inpatient facility stay has great relevance for the SOC/ROC assessment and for the plan of care. The agency may instruct intake personnel to gather the information at the time of referral. Alternatively, the assessing clinician may contact the hospital discharge planner or the referring physician to obtain the information.

[Q&A EDITED 09/09]

**Q36. M1010. Can anyone other than the assessing clinician enter the ICD codes?**

A36. Coding may be done in accordance with agency policies and procedures, as long as the assessing clinician determines the primary and secondary diagnoses and records the symptom control ratings. The clinician should write-in the medical diagnoses requested in M1010, M1016, and M1020/1022/1024, if applicable. A coding specialist in the agency may enter the actual numeric ICD-9 codes once the assessment is completed. The HHA has the overall responsibility for providing services, assigning ICD-9-CM codes, and billing. It is expected that each agency will develop their own policies and procedures and implement them throughout the agency that allows for correction or clarification of records to meet professional standards. It is prudent to allow for a policy and procedure that would include completion or correction of a clinical record in the absence of the original clinician due to vacation, sick time, or termination from the agency.

**Q37.** [ Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q38.** [Q&A RETIRED 09/09; Outdated]

**Q39.** [Q&A RETIRED 09/09; Outdated]

[M number updated 09/09]

**Q40. M1016. If the patient had a physician appointment in the past 14 days, or has a referral for home care services, does that qualify as a medical/treatment regimen change?**

A40. A physician appointment by itself or a referral for home health services does not qualify as a medical or treatment regimen change.

[M number updated 09/09]

**Q41. M1016. If the treatment regimen change occurred on the same day as the visit, does this qualify as within the past 14 days?**

A41. A treatment regimen change occurring on the same day as the assessment visit does qualify as occurring within the past 14 days.

**Q42.** [Q&A RETIRED 08/07; Duplicate of CMS Q&A Cat4b, Q #40.]

**Q42.1.** [Q&A RETIRED 09/09; Outdated]

[Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #13]

**Q42.2. M1016. 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 M1016 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 M1016.**

A42.2. Physical therapy (or any other discipline) ordered at SOC and then discontinued during the episode, qualifies as a service change for M1016 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 M1016, 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 when determining diagnoses for M1016.

[M number updated 09/09]

**Q43. M1016. For the medical diagnosis in the changed medication section at OASIS item M1016, does this need to be the current diagnosis we are seeing the patient for, or a diagnosis that is specific for the medication?**

A43. Item M1016 identifies the diagnosis(es) causing a change to the patient's treatment regimen, health care services, or medication within the past 14 days. The ICD-9 code can be a new diagnosis or an exacerbation of an existing condition that is specific to the changed medical or treatment regimen. Also note that this item is not restricted to medications, but refers to any change in medical or treatment regimen.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 10/07 Q&A #13]

**Q43.1. M1016. In the case of an unplanned discharge, how do we calculate the 14-day look back period when responding to M1016?**

A43.1. M1016 is asking if there was a medical or treatment regimen change within the past 14 days. M1016 information in Chapter 3 of the OASIS-C Guidance Manual states "The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period the date of admission is day 0 and the day immediately prior to the date of admission is day 1." However, in the case of an unplanned discharge, often the discharge assessment visit date is several days prior to the actual discharge date. In the case of an unplanned or unexpected discharge, the assessment data is based on the last visit made by a qualified clinician. In the case of an unplanned discharge, M1016 should be answered based on medical or treatment changes that occurred during the two-week period immediately preceding the "last qualified clinician" visit date on which the discharge assessment is based.

[Q&A EDITED 09/09]

**Q44. M1020/M1022/M1024. It is difficult to understand when an ICD-9-CM code must be entered at M1024. Where can we find help?**

A44. For clarification of OASIS items M1020/M1022/M1024 please refer to the OASIS-C Guidance Manual Appendix D (formerly Attachment D to Chapter 8), at [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage)

[Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #14]

**Q44.1. M1020/M1022/M1024. 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?**

A44.1. 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 M1020, 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.

[Q&A EDITED 09/09]



**Q44.1.5 M1020/M1022/M1024/M1010. Can anyone other than the assessing clinician enter the ICD codes?**

A44.1.5. Coding may be done in accordance with agency policies and procedures, as long as the assessing clinician determines the primary and secondary diagnoses and records the symptom control ratings. The clinician should write-in the medical diagnoses requested in M1010, M1016, and M1020/1022/1024, if applicable. A coding specialist in the agency may enter the actual numeric ICD-9 codes once the assessment is completed. The HHA has the overall responsibility for providing services, assigning ICD-9-CM codes, and billing. It is expected that each agency will develop their own policies and procedures and implement them throughout the agency that allows for correction or clarification of records to meet professional standards. It is prudent to allow for a policy and procedure that would include completion or correction of a clinical record in the absence of the original clinician due to vacation, sick time, or termination from the agency.

[Q&A EDITED 09/09; Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #13]

**Q44.2. M1020/M1022. Is it true that you can never change M1020 or M1022 from the original POC (cert) until the next certification?**

A44.2. Guidance in Chapter 3 of the OASIS-C Guidance Manual, M1020/1022/1024, states the primary diagnosis is the chief reason the agency is providing home care, the condition most related to the plan of care. Secondary diagnoses are defined as “all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care.” “In general, M1022 should include not only conditions actively addressed in the patient’s plan of care but also any comorbidity affecting the patient’s responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.” M1020, Primary Diagnosis and M1022, Other Diagnoses are reported at Start of Care, Resumption of Care and Follow-up/Recertification. At each time point, after completing a comprehensive assessment of the patient and receiving input from the physician, the clinician will report the patient’s current primary and secondary diagnoses. Diagnoses may change following an inpatient facility stay - the Resumption of Care and following a major change in the patient’s health status - the Other Follow up. The chief reason an agency is caring for a patient may change. The focus of the care may change. At each required time point the clinician will assess and report what is true at the time of the assessment.

**Q. 44.3.** [Q&A RECALLED 09/09]

[Q&A ADDED & M item numbers updated 09/09; Previously CMS OCCB 04/08 Q&A #6]

**Q.44.4. M1024. Can ICD-9 codes that are case mix codes be placed in M1024 on any OASIS which is a Non-PPS Payer? (Example: Medicaid HMO)**

A44.4. M1024 is an optional item and an agency is not required to complete it. When an agency chooses to complete M1024 in order to facilitate accurate payment, the general OASIS data collection instruction states “If a provider reports a V code in M1020/240 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M1024.” The intention is that the case mix diagnoses that were replaced by V-Codes in M1020 and/or M1022 should be reported in M1024 to facilitate payment for any patient for whom the OASIS 1.6 data set is being used to determine an

HHRG/HIPPS. M1024 is optional, and may be completed for any assessment which will be used to generate an HHRG/HIPPS code for payment, including payers other than Medicare PPS.

[Q&A ADDED & M item numbers updated 09/09; Previously CMS OCCB 07/09 Q&A #5]

**Q44.5. M1024. Is there any regulation that would prohibit the use of applying diagnostic codes to M1024 on our Non-MC or non-PPS OASIS patients when any V-code replaces a diagnostic code?**

A44.5. M1024, 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 M1024 apply to patients that fall under the Medicare prospective payment system. M1024, 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.

**Q44.6.** [Q&A RECALLED 09/09]

**Q44.7.** [Q&A RECALLED 09/09]

**Q45** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q46.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q47. M1030. Does an IM or SQ injection given over a 10-minute period “count” as an infusion?**

A47. No, this injection does not “count” as infusion therapy.

[Q&A EDITED 08/07]

**Q48. M1030. If the patient refuses tube feedings, does this “count” as enteral nutrition?**

A48. If the patient’s refusal has resulted in the patient not receiving enteral nutrition on the day of the assessment, response 3 would not be appropriate at the time of the assessment. The refusal of the tube feedings would be noted in the clinical record. Flushing the feeding tube does not provide nutrition.

**Q49.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q50. M1030. Do therapies provided in the home have to be documented in the clinical record?**

A50. It seems clear that any of the therapies identified in M1030 (IV/infusion therapy, parenteral nutrition, enteral nutrition) would be acknowledged in the comprehensive assessment and be noted in the plan of care. Even if the family or caregiver manages the therapies completely independently, the clinician is likely to evaluate the patient’s nutritional or hydration status, signs of infection, etc. It is difficult to conceive of a situation where the answer to this question would be “no.”

[Q&A EDITED 09/09]

**Q51. M1030. Does M1030 relate to other OASIS items?**

A51. Note the subsequent item of M2100e. (Types and Sources of Assistance), which addresses IV/infusion therapy and enteral/parenteral equipment or supplies.

[Q&A EDITED 09/09; ADDED 06/05; Previously CMS OCCB 08/04 Q&A #3]

**Q52. M1030. If the discharge visit includes discontinuing IV or infusion therapy, should the OASIS item (M1030 Therapies at Home) reflect the presence of these services on the discharge assessment?**

A52. If the patient was receiving IV or infusion therapy on the day the discharge assessment was completed, those respective services can be marked as “present” at the assessment.

**Q53. [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]**

[Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #15]

**Q53.1. M1030. 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 M1030, Therapies?**

A53.1. No, M1030 Response 3 captures the administration of enteral nutrition. Medication administration alone is not considered nutrition.

[Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #16]

**Q53.2. M1030. 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 M1030, Therapies?**

A53.2. No, M1030 Response 3 captures the administration of enteral nutrition. Hydration alone is not considered nutrition.

**Q53.3. [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]**

[Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #18]

**Q53.4. M1030. 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 M1030, do you mark both 1 and 2?**

A53.4. 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.

[Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 05/07 Q&A #14]

**Q53.5. M1030. If a patient's appetite is poor and he/she has a g-tube and the physician orders Ensure prn through the g-tube? Does this count as enteral nutrition for this item?"**

A53.5. If a PRN order exists and the patient meets the parameters for administration of the feeding based on the findings from the comprehensive assessment, or has met such parameters and/or received enteral nutrition at home in the past 24 hours, the assessing clinician would mark Response 3. The clinician could not mark response 3 automatically when a PRN order exists at SOC because it is unknown if the patient will ever receive the enteral nutrition.

[Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/07 Q&A #5]

**Q53.6. M1030. We have been admitting patients, status post lumpectomy, for breast cancer. After the surgery, they are discharged with an eclipse (bulb) that has Marcaine or Lidocaine that infuses pain medication into the wound bed. After 48 hours the bulb can be removed. If the patient still has this bulb on at start of care, should Response 1 be marked for M1030?**

A53.6. When a patient is receiving an infusion at home, M1030 should be marked with Response 1-Intravenous or infusion therapy. If the patient you describe is receiving a local anesthetic via an infusion device while in the home, M1030 would be marked "1" at SOC.

[Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 10/07 Q&A #14]

**Q53.7. M1030. For M1030, is Pedialyte, an electrolyte based drink, considered enteral nutrition?**

A53.7. M1030, Response 3 is selected when the patient receives enteral nutrition while in the home. Oral electrolyte maintenance solutions, such as Pedialyte, are administered to prevent dehydration and are not designed to act as nutrition. Response 3 would not be selected unless other forms of enteral nutrition are being administered in the home.

[Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 01/08 Q&A #18]

**Q53.8. M1030. Is medication administered via the transdermal route considered an infusion (Response 1) for M1030, Therapies at Home?**

A53.8. A transdermal medication is absorbed through the skin and should not be considered an infusion for M1030, Therapies the patient receives at home. M1030 Response 1 IV or infusions involve a therapeutic drug or solution that is administered via an infusion device, including a needle flush, implanted or external pump, or other infusion device, such as an eclipse bulb.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/09 Q&A #6]

**Q53.9. M1030, M2020, M2100 e. 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 M1030, M2020, M2100 at SOC?**

A.53.9. M1030, 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.

M2020, Management of Oral Medications, would be NA-no oral medications prescribed.

M2100, Types and Sources of Assistance, e. 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 the level of caregiver ability and willingness to provide assistance with managing the equipment.

**Q54.** [Q&A RETIRED 09/09; Outdated]

**Q55.** [Q&A RETIRED 09/09; Outdated]

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/09 Q&A #8]

**Q55.1. M1036.** In answering M1036 Risk Factors, what does CMS consider "drug dependency" (response 4)? A consultant instructed our agency to interpret it to mean any drugs that the patient is dependent on. The consultant then commented that response 4 should be marked for most patients. The specific example in the reviewed chart was a patient who was very dependent on all of their respiratory drugs. We previously interpreted this to mean dependency on illegal drugs. Please clarify.

A55.1. Chapter 3 of the OASIS-C Guidance Manual defines the intent of M1036, "Identifies specific factors that may exert a substantial impact on the patient's health status response to medical treatment, and ability to recover from current illnesses, in the care provider's professional judgment." The intent of the item is not to address those medications/drugs that the individual takes/consumes/administers to achieve a therapeutic effect, such as insulin, blood pressure medication, cardiac arrhythmia medication, respiratory medication, etc. It is also necessary to acknowledge that situations can occur where the once-therapeutic use of medication becomes a true dependency situation, e.g. pain medications.

**Q56.** [Q&A RETIRED 09/09; Outdated]

**Q57.** [Q&A RETIRED 09/09; Outdated]

**Q57.1.** [Q&A RETIRED 09/09; Outdated]

**Q57.2** [Q&A RETIRED 09/09; Outdated]

**Q58.** [Q&A RETIRED 09/09; Outdated]

**Q59.** [Q&A RETIRED 09/09; Outdated]

**Q60.** [Q&A RETIRED 09/09; Outdated]

**Q61.** [Q&A RETIRED 09/09; Outdated]

**Q62.** [Q&A RETIRED 08/07]

**Q63.** [Q&A RETIRED 09/09; Duplicative of Q#64.2]

**Q64. M1200. Does information on vision documented in OASIS have to be backed up with documentation elsewhere in the patient's record?**

A64. A patient who has partially or severely impaired vision (responses 1 or 2) is likely to require adaptations to the care plan as a result of these limitations. Therefore, it is likely that the vision impairments would be included in additional assessment data or as rationale for care plan interventions.

[Q&A ADDED 08/07; M item number updated 09/09; Previously CMS OCCB 07/07 Q&A #6]

**Q64.1. M1200. If a patient has a physical deficit, such as a neck injury, limiting his range of motion, which affects his field of vision and ability to see obstacles in his path, how is M1200, Vision to be answered? Is the physical impairment to be considered? Visual acuity has not been affected.**

A64.1. When selecting the correct response for M1200, Vision, the clinician is assessing the patient's functional vision, not conducting a formal vision screen or distance vision exam to determine if the patient has 20/20 vision. Therefore physical deficits or impairments that limit the patient's ability to use their existing vision in a functional way would be considered. If a patient sustained an injury that limits neck movement, the patient may not be able to see obstacles in their path. A patient who has sustained a facial injury may have orbital swelling that makes it impossible for them to see and they must locate objects by hearing or touching them. Conversely, it is possible for a patient to be blind in one eye (technically not "normal vision"), but still be appropriately scored a "0" on M1200 if with the patient's existing vision, they are able to see adequately in most situations and can see medication labels or newsprint

[Q&A ADDED 09/09; M number updated 09/09; Previously CMS OCCB 07/08 Q&A #5]

**Q64.2. M1200. Our patient has dementia and is unable to answer questions related to his vision appropriately or read a medication bottle out loud. He has no obvious visual problems as outlined in M1200 response 1 or 2. How does a clinician correctly answer this question given this level of verbal impairment?**

A64.2. When a patient is cognitively impaired, the clinician will need to observe the patient functioning within their environment and assess their ability to see functionally. Does it appear the patient can see adequately in most situations? Can they see eating and grooming utensils? Do they appear to see the buttons on their shirt/blouse? If so, the patient would be reported as a "0-Normal vision" even though the constraints of the dementia may not allow the patient to communicate whether they can see newsprint or medication labels.

[Q&A EDITED 09/09]

**Q65. M1220. Our agency would like clarification concerning M1220 - Understanding of Verbal Content in patient's own language. If a patient speaks Spanish and there is an interpreter, it is difficult to ascertain the level of complexity of interpreted instructions. How are we to answer this?**

A65. You will need to ask the interpreter to help you determine at what level the patient is responding. Responses to 0, Understands: clear comprehension without cues or repetitions and UK, Unable to assess understanding should be relatively simple to determine. To determine the difference between levels 1, 2 or 3, you can interact with

the interpreter to determine with what difficulty the patient is responding. Inasmuch as the assessment includes assistance from an interpreter, your clinical documentation of the visit should indicate the presence of an interpreter who assists with communication between clinician and patient.

**Q66.** [Q&A RETIRED 09/09; Outdated]

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #19]

**Q66.1. M1220. 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 concerning M1220 - Understanding of Verbal Content, 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 M1220 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?**

A66.1. M1220 is an evaluation of the patient's ability to comprehend spoken words and instructions 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.

**Q67.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q68.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q69.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q70.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A ADDED 06/05; M item number updated 09/09; Previously CMS OCCB 08/04 Q&A #6]

**Q71. M1242. If a patient uses a cane for ambulation in order to relieve low back pain, does the use of the cane equate to the presence of pain interfering with activity?**

A71. If use of the cane provides adequate pain relief that the patient can ambulate in a manner that does not significantly affect distance or performance of other tasks, then the cane should be considered a "non-pharmacological" approach to pain management and should not, in and of itself, be considered as an "interference" to the patient's activity. However, if the use of the cane does not fully alleviate the pain (or pain effects), and even with the use of the cane, the patient limits ambulation or requires additional assistance with gait activities, then activity would be considered as "affected" or "interfered with" by pain, and the frequency of such interference should be assessed when responding to M1242.

[Q&A ADDED 06/05; M item number updated 09/09; Previously CMS OCCB 08/04 Q&A #7]

**Q72. M1242. Would a patient who restricts his/her activity (i.e., doesn't climb stairs, limits walking distances) in order to be pain-free thus be considered to have pain interfering with activity? And if so, would the clinician respond to M1242 based on the frequency that the patient limits or restricts their activity in order to remain pain-free?**

A72. Yes, a patient who restricts his/her activity to be pain-free does indeed have pain interfering with activity. Since M1242 reports the frequency that pain interferes with activity (not the presence of pain itself), then M1242 should be scored to reflect the frequency that the patient's activities are affected or limited by pain, even if the patient is pain free at present due to the activity restriction.

[Q&A ADDED 06/05; Previously CMS OCCB 10/04 Q&A #3]

**Q73. M1242. A patient takes 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. Is pain interfering with the patient's activity?**

A73. M1242 identifies the frequency with which pain interferes with a patient's activities, taking into account any treatment prescribed. If a patient is pain-free as a result of the treatment, M1242 should be answered 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, but also is described as having medication side effects that interfere with activity. Medication side effects are not addressed in responding to M1242 and, given the information in the scenario; pain apparently is not interfering with the patient's activity.

**Q74.** [Q&A RETIRED 09/09; Outdated]

**Q75.** [Q&A RETIRED 09/09; Outdated]

**Q76.** [Q&A RETIRED 08/07]

**Q77.** [Q&A RETIRED 08/07; Outdated]

**Q77.1.** [Q&A RETIRED 08/07; Outdated]

**Q77.2.** [Q&A RETIRED 08/07; Outdated]

**Q78.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q79, 80, 81, 82, 86** have been renumbered and moved to **Q112.6-112.10**

**Q83.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q84.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q85.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]



**Q87.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #22]

**Q87.1. M1300's. Do CMS OASIS instructions supersede a clinical wound nurse training program?**

A87.1. CMS references, not clinical training programs should be used to guide OASIS scoring decisions. While CMS utilizes the expert resources of organizations like the Wound Ostomy Continence Nurses Society and the National Pressure Ulcer Advisory Panel to help suggest assessment strategies to support scoring of the integumentary items, in some cases, the OASIS scoring instructions are unique to OASIS and may not always coincide or be supported by general clinical references or standards. While CMS provides specific instructions on how OASIS data should be classified and reported, OASIS scoring guidelines are not intended to direct or limit appropriate clinical care planning by the nurse or therapist. For instance, even though for OASIS data collection purposes a bowel ostomy is excluded as a skin lesion or open wound, such data collection exclusion does not suggest that the clinician should not assess, document and include in the care plan findings and interventions related to the ostomy.

**Q88. M1340/M1350.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #22]

**Q88.1. M1340/M1350. Is a peritoneal dialysis catheter considered a surgical wound? Isn't the opening in the abdominal wall a type of ostomy?**

A88.1. 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.

[Q&A EDITED 09/09]

**Q89. M1306-M1350. Are diabetic foot ulcers classified as pressure ulcers, stasis ulcers, or simply as wound/lesions at M1350?**

A89. The clinician will have to speak with the physician who must make the determination as to whether a specific lesion is a diabetic ulcer, a pressure ulcer, stasis ulcer, or other lesion. There are some very unique coding issues to consider for ulcers in diabetic patients (vs. ulcers in non-diabetic patients), and the physician should be aware of these in his/her contact with the patient. In responding to the OASIS items, an ulcer diagnosed by the physician as a diabetic ulcer would be considered a lesion (respond "yes" to M01350, if it will receive clinical intervention and was not reported in one of the prior OASIS wound items), but it would not be considered a pressure ulcer or a stasis ulcer.

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #23]

**Q89.1. M1306-M1340. If a pressure ulcer or a burn is covered with a skin graft, does it become a surgical wound?**

A89.1. 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.

[Q&A EDITED 09/09]

**Q89.2. M1306-M1324. When answering the pressure ulcer items, how is a pressure ulcer that has been sutured closed categorized?**

A.89.2. Since it is relatively uncommon to encounter direct suture closure of a pressure ulcer, it is important to make sure that the pressure ulcer was not closed by a surgical procedure (such as skin advancement flap, rotation flap, or muscle flap). A pressure ulcer that is sutured closed (without a flap procedure) would still be reported as a pressure ulcer.

[Q&A ADDED & M item number updated 09/09; Previously CMS OCCB 10/07 Q&A #16]

**Q89.3. M1306-M1324. In the NPUAP's 2/2007 Pressure Ulcer Stages document, for the description of a Stage IV pressure ulcer it states "Exposed bone/tendon is visible or directly palpable." What does "directly palpable" mean? I can palpate bone through healthy, intact tissue.**

A89.3. Within the context of answering OASIS Pressure Ulcer items, "directly palpable" means visible.

**Q90.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q90.1.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q91.** [Q&A RETIRED 09/09; Outdated]

**Q92.** [Q&A RETIRED 09/09; Outdated]

**Q93.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q94. M1306-M1324. If a Stage 3 pressure ulcer is closed with a muscle flap, what is recorded? What if the muscle flap begins to break down due to pressure?**

A94. If a pressure ulcer is closed with a muscle flap, the new tissue completely replaces the pressure ulcer. In this scenario, the pressure ulcer "goes away" and is replaced by a surgical wound. If the muscle flap healed completely, but then began to break down due to pressure, it would be considered a new pressure ulcer. If the flap had never healed completely, it would be considered a non-healing surgical wound.

**Q95. M1306-M1324. If a pressure ulcer is debrided, does it become a surgical wound as well as a pressure ulcer?**

A95. No, as debridement is a treatment procedure applied to the pressure ulcer. The ulcer remains a pressure ulcer, and its healing status is recorded appropriately based on assessment.

[Q&A EDITED 09/09]

**Q96. M1306-M1324. If a single pressure ulcer has partially granulated to the surface, leaving the ulcer open in more than one area, how many pressure ulcers are present?**

A96. Only one pressure ulcer is present.

**Q97.** [Q&A RETIRED 09/09; Outdated]

**Q98. M1306-M1324. Can a previously observable Stage 4 pressure ulcer that is now covered with slough or eschar be categorized as Stage 4?**

A98. No, a pressure ulcer that is covered with eschar cannot be staged until the wound bed is visible. The status of the pressure ulcer needs to correspond to the visual assessment by the skilled clinician on the date of the assessment. This is documented on the Wound, Ostomy, and Continence Nurses (WOCN) Association website at [www.wocn.org](http://www.wocn.org) in the WOCN Guidance Document and at the NPUAP site at [www.npuap.org](http://www.npuap.org).

[Q&A ADDED 09/09; Previously CMS OCCB 10/08 Q&A #3]

**Q98.1. M1306-M1324. If a patient has a Stage III pressure ulcer on the first episode, and in the second episode it is covered with slough, can it still be reported a Stage III?**

A98.1. A pressure ulcer covered with slough obscuring visibility of the wound bed is considered unstageable. If a pressure ulcer that was previously stageable develops eschar/slough that completely obscures the wound bed, it would no longer be considered stageable in the OASIS data set.

**Q99.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q99.1.** [Q&A RETIRED 09/09; Outdated]

**Q100.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q101.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A EDITED 09/09]

**Q102. M1340-M1342. Is a gastrostomy that is being allowed to close on its own considered a surgical wound?**

A102. A102. A gastrostomy that is being allowed to close would be excluded from consideration as a surgical wound, because it is an ostomy. It may be reported in M1350 if it was receiving intervention from the home health agency.

[Q&A EDITED 09/09]

**Q103. M1340. If the patient had a port-a-cath, but the agency was not providing any services related to the cath and not accessing it, would this be coded as a surgical wound?**

A103. Yes.

[Q&A EDITED 09/09]

**Q104. M1340. Are implanted infusion devices or venous access devices considered surgical wounds? Does it matter whether or not the device is accessed routinely?**

A104. Yes, the surgical sites where such devices were implanted would be considered surgical wounds. It does not matter whether the device is accessed at a particular frequency or not.

[Q&A ADDED 06/05; Previously CMS OCCB 08/04 Q&A #9]

**Q105. M1340. If debridement is required to remove debris or foreign matter from a traumatic wound, is the wound considered a surgical wound?**

**A105.** No. Debridement is a treatment to a wound, and the traumatic wound does not become a surgical wound.

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #26]

**Q105.1. M1340. 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 question?**

A105.1. 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.

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #27]

**Q105.2. M1340. 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 bowel ostomy.**

A105.2. No, the presence of sutures does not automatically equate to a surgical wound. In the examples given, a peripheral IV, even if sutured in place, is not a surgical wound. A pressure ulcer does not become a surgical wound by being sutured closed, and the bowel ostomy would be excluded from M01350 and M1340.

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #28]

**Q105.3. M1340. Since an implanted venous access device is considered a surgical wound for M1340, when it is initially implanted, is the surgical incision through which it was implanted a second surgical wound (separate from the venous access device?).**

A105.3. No. The surgical incision is considered a surgical wound until it has been epithelialized completely for 30 days, after which it is considered a scar. The site of the venous access device is initially considered a surgical wound, as long as it is in place.

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #29]

**Q105.4. M1340. If an abscess is incised and drained, does it become a surgical wound?**

A105.4. No, an abscess that has been incised and drained is an abscess, not a surgical wound.

[Q&A ADDED 09/09; M item number updated 09/09; Previously CMS OCCB 10/07 Q&A #18]

**Q105.4.1. M1340. If, when reading op reports I find that tissue and/or other structures (mesh, necrotic tissue etc.) were excised when the operation procedure**

**only states I&D, is the resulting wound a surgical wound even though the surgery is labeled I&D?**

A105.4.1. A simple I&D of an abscess is not a surgical wound for OASIS reporting. A surgical procedure that involves excision of necrotic tissue beyond general debridement (such as excision of a necrotic mass), excision of mesh or other appliances or structures goes beyond a simple I&D and the resulting lesion, until healed, would be reported as a surgical wound for M1340.

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #17]

**Q105.5. M1340. I understand that a simple I&D of an abscess is not a surgical wound. Does it make a difference if a drain is inserted after the I&D? Is it a surgical wound if the abscess is removed?**

A105.5. For purposes of scoring the OASIS integumentary items, a typical incision and drainage procedure does not result in a surgical wound. The procedure would be reported as a surgical wound if a drain was placed following the procedure. Also, if the abscess was surgically excised, the abscess **no** longer exists and the patient would have a surgical wound. It is considered a surgical wound until it has been epithelialized completely for 30 days, after which it is considered a scar.

[Q&A ADDED 09/09; M item numbers updated 09/09; Previously CMS OCCB 07/08 Q&A #8]

**Q105.5.1. M1340. An I&D is not considered a surgery - but a drain inserted during this procedure makes the wound a surgical wound. Dilemma: This makes the OASIS answer for surgical wound a yes but we cannot code aftercare because we don't code the I&D as a surgery - but we do have surgical wound care. This is quite confusing.**

A105.5.1. The OASIS M0 item response will not always mirror diagnoses and ICD-9 codes found in M1020 and M1022. Continue to score the OASIS following current CMS guidance, and follow ICD-9 CM coding guidance for code selection for M1020 and M1022.

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #18]

**Q105.6. M1340. A patient, who has a paracentesis, has a stab wound to access the abdominal fluid. Is this a surgical wound?**

A105.6. When a surgical procedure creates a wound in which a drain is placed (e.g., an incision or stab wound), the presence of the drain (or drain wound site until healed) should be reported as a surgical wound. If a needle was inserted to aspirate abdominal fluid and then removed (no drain left in place), it should not be reported as a surgical wound.

**Q105.7. [Q&A RETIRED; Duplicative of Q105.11]**

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #20]

**Q105.8. M1340. Does a patient have a surgical wound if they have a traumatic laceration and it requires plastic surgery to repair the laceration?**

A105.8. Simply suturing a traumatic laceration does not create a surgical wound. A traumatic wound that required surgery to repair the injury would be considered a surgical wound (e.g., repair of a torn tendon, repair of a ruptured abdominal organ, or repair of other internal damage), and the correct response to M1340 for this type of wound would be 1 or 2 depending on whether or not it was observable.

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #21]

**Q105.9. M1340. Is a PICC placed by a physician under fluoroscopy and sutured in place considered a surgical wound? It would seem that placement by this procedure is similar to other central lines and would be considered a surgical wound.**

A105.9. Even though the physician utilized fluoroscopy to insert the peripherally inserted central catheter (PICC) and sutured it in place, it is not a surgical wound, as PICC lines are excluded as surgical wounds for OASIS data collection purposes.

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 07/07 Q&A #8]

**Q105.10. M1340. If a surgical wound is completely covered with steri-strips is it considered non observable?**

A105.10. Chapter 3 of the OASIS-C Guidance Manual states, "A [surgical] wound is considered not observable if it is covered by a dressing (or cast) which is not to be removed, **per physician's order**." Although unusual, if the steri-strip placement did not allow sufficient visualization of the incision, and if the physician provided specific orders for the steri-strips to not be removed, then the wound would be considered not observable. However, a surgical wound with steri-strips should be considered observable in the absence of physician orders to not remove strips for assessment, or if usual placement allows sufficient visualization of the surgical incision to allow observation of clinical features necessary to determine the surgical wound's healing status (e.g., incisional approximation, degree of epithelialization, incisional necrosis (scab), and/or signs or symptoms of infection).

[Q&A ADDED 08/07; M item number updated 09/09; Previously CMS OCCB 07/07 Q&A #9]

**Q105.11. M1340. Is a heart cath site (femoral) considered a surgical wound? If not, what if a stent is placed?**

A105.11. If a cardiac catheterization was performed via a puncture with a needle into the femoral artery, the catheter insertion site is not reported as a surgical wound for M1340. The fact that a stent was placed does not have an impact.

[Q&A ADDED 09/09; Previously CMS OCCB 10/07 Q&A #17]

**Q105.12. M1340. If a drain was placed post-op and removed prior to admission to home health is the drain site considered a surgical wound upon admission to home care?**

A105.12. A wound with a drain is reported as a surgical wound at M0482. It remains a surgical wound after the drain is pulled until it heals and becomes a scar.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 10/07 Q&A #19]

**Q105.13. M1340. A patient had a skin cancer lesion removed in a doctor's office with a few sutures to close the wound. Is this considered a surgical wound?**

A105.13. A shave, punch or excisional biopsy, utilized to remove and/or diagnose skin lesions, does result in a surgical wound. It is considered a surgical wound until it has been epithelialized completely for 30 days, after which it is considered a scar.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 04/08 Q&A #10]

**Q105.14. M1340. Are arthrocentesis sites considered surgical wounds? Thorocentesis sites?**

A105.14. When a surgical procedure creates a wound in which a drain is placed (e.g., an incision or stab wound), the presence of the drain (or drain wound site until healed) should be reported as a surgical wound. If a needle was inserted to aspirate fluid and then removed, (no drain left in place), it should not be reported as a surgical wound.

If a physician performs a surgical procedure via arthroscopy, the arthrocentesis site would be considered a surgical wound. After it has been epithelialized completely for 30 days, it is considered a scar.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/08 Q&A #7]

**Q105.15. M1340. Is an implanted mechanical left ventricle device (LVAD) that has an air vent exiting through lower right abdomen a surgical wound?**

A105.15. The Left Ventricular Assist Device's (LVAD/HeartMate) cannula exit site would be considered a surgical wound until the LVAD is discontinued. After it has been epithelialized completely for 30 days, it is considered a scar.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/08 Q&A #10]

**Q105.16. M1340. Is a chest tube site a surgical wound?**

A105.16. A chest tube site is a thoracostomy. Ostomies are excluded as surgical wounds in the OASIS. A chest tube site is not a surgical wound even if a chest tube or drain is present. It may be reported in M1350 if they are receiving intervention from the home health agency.

[Q&A ADDED 09/09; M item number updated 09/09; Previously CMS OCCB 10/08 Q&A #5]

**Q105.17. M1340. Would an enterocutaneous fistula that developed as a result of a surgery be documented as a surgical wound?**

A105.17. A fistula is a complication of surgery but it is not a surgical wound. Though fistulas are sometimes located within surgical wounds, answering M1340 & M1342 would be based on the condition of the surgical wound, not the fistula, using the WOCN OASIS Guidance document. For example, if the only opening in a 3 month-old closed surgical wound healed by primary intention was an enterocutaneous fistula then the answer to M1340 (Does this patient have a surgical wound?) would be "0-No".

[Q&A ADDED 09/09; Previously CMS OCCB 07/09 Q&A #8]

**Q105.18. M1340. 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?**

A105.18. No, a retention suture that utilizes a button to prevent damage to the skin is not considered a surgical wound.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/09 Q&A #9]

**Q105.19. M1340. 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?**

A105.19. 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 they were completely epithelialized for 30 days, after which they would be considered a scar.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/09 Q&A #10]

**Q105.20. M1340. Is a VP shunt for hydrocephalus a current surgical wound, no matter how old it is?**

A105.20. The incision created to implant the VP shunt is a surgical wound until it heals. After the incision is completely epithelialized for 30 days, it is no longer considered a current surgical wound, as the VP shunt is neither venous access device nor an infusion device.

[Q&A EDITED 09/09]

**Q106. M1340. Is a peritoneal dialysis catheter considered a surgical wound?**

A106. Both M1340 and M01350 should be answered "Yes" for a patient with a catheter in place that is used for peritoneal dialysis. You should consider the catheter for peritoneal dialysis (or an AV shunt) a surgical wound (as are central lines and implanted vascular access devices).

**Q107.** [RETIRED 09/09; Outdated]

**Q108.** [RETIRED 09/09; Outdated]

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 10/08 Q&A #6]

**Q108.1. M1340 & M1342. Recently released guidance states that a surgical wound becomes "healed" or no longer reportable as a surgical wound on M1340 30 days after complete epithelialization. Determining a specific timeframe in regards to complete epithelialization presents some issues. For instance, if we get a post surgery patient who has been in the nursing home and then to home health, we**



**may not know when complete epithelialization occurs. Please provide further clarification.**

A108.1 If, at the SOC or other assessment time points, the clinician assesses the wound to be completely epithelialized (including no sign of infection or separation), and the date of complete epithelialization is unknown, the clinician will have to make a determination regarding the wound status based on the history of the date of surgery, any reported wound healing progress/complications and clinical assessment findings.

Since for the purposes of the OASIS, a surgical wound is considered healed and no longer counted as a current surgical wound 30 days after complete epithelialization, (assuming no sign of infection or separation), then if based on the surgery date, it is clear that the wound could not possibly have been fully epithelialized for at least 30 days, Response 0 – Newly epithelialized should be reported.

If the wound appears completely epithelialized (no sign of infection or separation) and the date of epithelialization is unknown, but based on the known wound history and date of surgery it is possible that the wound could have been fully epithelialized for at least 30 days, then the wound status is deemed “healed” and no longer reportable as a surgical wound. CMS will remind HHAs of their responsibility to comply with the HH Conditions of Participation, (see 42 CFR 484.18), when a surgery date is not provided on the referral. CMS expects the documentation within the patient’s medical record to reflect consultation with the patient’s physician therefore it is difficult to envision the HHA being unable to ascertain the patient’s date of surgery.

[Q&A EDITED 09/09]

**Q109. M1340 & M1342. Is a mediport "nonobservable" because it is under the skin?**

A109. Please refer to the definition of “not observable” used in the OASIS surgical wound items in the *OASIS-C Guidance Manual* – “not observable” is an appropriate response ONLY when a non-removable dressing is present. This is not the case with a mediport. As long as the mediport is present, whether it is being accessed or not, the patient is considered as having a current surgical wound.

**Q110.** [Q&A RETIRED 09/09; Outdated]

**Q111.** [Q&A RETIRED 08/07; Outdated due to revision of WOCN guidance]

[ADDED & EDITED 09/09; Previously CMS OCCB 10/08 Q#4]

**Q.111.1. M1342 & M1350. What standards are used to assess cemented surgical wounds when answering OASIS items M1342, Healing status and M1350, Skin lesion/Open wound?**

A111.1. M1342: When assessing a surgical incision that has been cemented rather than sutured, continue to follow the WOCN OASIS Wound Item Guidance applicable to the surgical incision, located at [www.wocn.org](http://www.wocn.org).

1. If the wound can be visualized, it is observable. Only surgical wounds that have a dressing that cannot be removed by physician order and obscures visualization of the incision are considered non-observable.

2. For the purposes of determining the healing status, a surgical wound is not reportable as a current surgical wound in the OASIS surgical wound items 30 days after complete

epithelialization. The incision must be clean, dry and completely closed with no signs or symptoms of infection. The resulting scar would only be reported as a wound/lesion (M1350) if it received clinical intervention by the home health agency and was not reported in one of the prior OASIS wound items.

3. The status of the most problematic (observable) surgical wound (M1342) is determined by assessment of the skilled clinician following the WOCN OASIS Wound Item Guidance.

M1350: If the wound that is cemented meets the OASIS criteria to be a skin lesion or open wound for M1350, (a lesion or open wound excluding bowel ostomies, other than those described in prior OASIS wound items, that is receiving clinical intervention by the home health agency), then it would be considered a skin lesion or open wound for M1350. If the OASIS criteria excluded the wound type from being reported in M1350 (i.e., bowel ostomy), then the wound would not be reported on M1350, regardless of the type of closure utilized.

**Q112.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q112.1.** [Q&A RETIRED 09/09; Outdated]

**Q112.2.** [Q&A RETIRED 09/09; Outdated]

**Q112.3.** [Q&A RETIRED 09/09; Outdated]

[Q&A ADDED 09/09; Previously CMS OCCB 07/08 Q&A #9]

**Q112.4. M1342. If staples remain in a surgical wound, would it be considered as not healing?**

A112.4. A surgical wound with staples in place would only be considered not healing if it meets the WOCN Guidance on OASIS Skin and Wound Status M0 Items' definition of not healing. The WOCN guidance can be found at [www.wocn.org](http://www.wocn.org). Presences of staples, in and of themselves, do not meet the WOCN criteria for non-healing.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/08 Q&A #12]

**Q112.5. M1342. Does the presence of a "scab" indicate a non-healing wound?**

A112.5. [Q&A ADDED 09/09; Previously CMS OCCB 07/08 Q&A #12]

A scab is a crust of dried blood and serum and should not be equated to either avascular or necrotic tissue when applying the WOCN guidelines. Therefore while the presence of a scab does indicate that full epithelialization has not occurred in the scabbed area, the presence of a scab does not meet the WOCN criteria for reporting the wound status as "not healing".

This represents a retraction of previous guidance that indicated a scab was considered avascular or necrotic tissue, and therefore an indicator of a non-healing surgical wound. *(Note: This new CMS guidance will supersede prior archived guidance found in CMS OASIS Q&As; Category 4, Questions 112.1, 112.2, and 112.3)*

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 10/08 Q&A #7]

**Q112.6. M1342. Once the needle is removed from an implanted venous access device, before a scab has formed, the wound bed may be clean but non-granulating. Is it true that based on the WOCN Guidance, the wound would be reported as Response 3 - Not healing for M1342?**

A112.6. When a needle is inserted and removed from an implanted venous access device, it is possible that the skin that was pierced by the needle could have a resulting wound that would heal by secondary intention. Usually, with good access technique and current needle technology there will be no perceptible wound. Occasionally, if there was an extremely large bore needle or traumatic entry or removal, there may be a resulting wound that heals by secondary intention. In this situation, the accessing clinician would rely on the WOCN's OASIS Wound Guidance document to determine the healing status. Note that a scab is a crust of dried blood and serum and should not be equated to either avascular or necrotic tissue when applying the WOCN guidelines. Therefore while the presence of a scab does indicate that full epithelialization has not occurred in the scabbed area, the presence of a scab does not meet the WOCN criteria for reporting the wound status as "not healing".

[Q&A EDITED 09/09; Formerly Q79]

**Q112.7. M1350. How many different types of skin lesions are there anyway?**

A112.7. Many different types of skin lesions exist. These may be classified as primary lesions (arising from previously normal skin), such as vesicles, pustules, wheals, or as secondary lesions (resulting from changes in primary lesions), such as crusts, ulcers, or scars. Other classifications describe lesions as changes in color or texture (e.g., maceration, scale, lichenification), changes in shape of the skin surface (e.g., cyst, nodule, edema), breaks in skin surfaces (e.g., abrasion, excoriation, fissure, incision), or vascular lesions (e.g., petechiae, ecchymosis).

Note that for the purposes of scoring M1350 you will only report if the patient has a skin lesion or open wound that is receiving intervention by your agency, other than those already described in the other OASIS wound items, excluding bowel ostomies.

[Q&A EDITED 09/09; Formerly Q 80]

**Q112.8. M1350. Is a pacemaker considered a skin lesion?**

A112.8. A pacemaker itself is an implanted device but is not an implanted infusion or venous access device. The (current) surgical wound or (healed) scar created when the pacemaker was implanted is reported in M1350 only if it is receiving clinical intervention and had not already been described in M1340, Does this patient have a Surgical Wound or M1342, Status of the Most Problematic (Observable) Surgical Wound.

[Q&A EDITED 09/09; Formerly Q81]

**Q112.9. M1350. How should M1350 be answered if the wound is not observable?**

A112.9. The definition of the term "nonobservable" varies depending on the specific OASIS item being assessed. If you know from referral information, communication with the physician, etc. that a wound exists under a nonremovable dressing and it is receiving clinical intervention by the home health agency and it had not already be reported in a prior OASIS wound item, then the wound is considered to be present for M1350, and the item would be answered "Yes."

[Q&A EDITED 09/09; Formerly Q82]

**Q112.10. M1350. Is a new suprapubic catheter, new PEG site, or a new colostomy considered a wound or lesion?**

A112.10. A new suprapubic catheter site (cystostomy), new PEG site (gastrostomy) would be considered a skin lesion or wound at M1350, if there were receiving clinical intervention. Bowel ostomies are excluded from consideration in responding to M1350. Ostomies are not reported as surgical wounds in M1340, Does this patient have a Surgical Wound or M1342, Status of the Most Problematic (Observable) Surgical Wound.

[Q&A EDITED 08/07; Formerly Q86]

**Q112.11. M1350. Are implanted infusion devices or venous access devices considered skin lesions at M1350?**

A112.11. If they are receiving clinical intervention by the home health agency and had not already be reported in a prior OASIS wound item.

[Q&A EDITED 09/09]

**Q113. M1400. How should I best evaluate dyspnea for a chairfast (wheelchair-bound) patient? For a bedbound patient?**

A113. M1400 asks when the patient is noticeably short of breath. In the response options, examples of shortness of breath with varying levels of exertion are presented. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest. If the patient does not have shortness of breath with moderate exertion, then either response 0 or response 1 is appropriate. If the patient is not short of breath on the day of assessment, then response 0 applies. If the patient only becomes short of breath when engaging in physically demanding transfer activities, then response 1 seems most appropriate.

In the case of the bedbound patient, the level of exertion that produces shortness of breath should also be assessed. The examples of exertion given for responses 2, 3, and 4 also provide assessment examples. Response 0 would apply if the patient were never short of breath on the day of assessment. Response 1 would be most appropriate if demanding bed-mobility activities produce dyspnea.

[Q&A ADDED 08/07; M item number updated 09/09 Previously CMS OCCB 07/06 Q&A #31]

**Q113.1. M1400. 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.**

A113.1. Since the patient's supplemental oxygen use is not continuous, M1400 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.

[Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #12]

**Q113.2. M1400. What is the correct response to M1400, Dyspnea, if a patient uses a CPAP or BiPAP machine during sleep as treatment for obstructive sleep apnea?**

A113.2. Sleep apnea being treated by CPAP is not the same as dyspnea at rest (response 4 for M1400). M1400 asks about dyspnea (shortness of breath), not sleep apnea (absence of breath during sleep).

The two problems are not the same. Dyspnea refers to shortness of breath, a subjective difficulty or distress in breathing, often associated with heart or lung disease. Dyspnea at rest would be known and described as experienced by the patient. Sleep apnea refers to the absence of breath. People with untreated sleep apnea stop breathing repeatedly during their sleep, though this may not always be known by the individual. If the apnea does not result in dyspnea (or noticeable shortness of breath), then it would not be reported on M1400. If, however, the sleep apnea awakens the patient and results in or is associated with an episode of dyspnea (or noticeable shortness of breath), then response 4 - At rest (during day or night) should be reported.

[Q&A UPDATED 09/09; ADDED 08/07; Previously CMS OCCB 07/07 Q&A #13]

**Q113.3. M1400. Patient currently sleeps in the recliner or currently sleeps with 2 pillows to keep from being SOB. They are currently not SOB because they have already taken measures to abate it. Would you mark M1400, #4 At Rest or 0, Not SOB?**

A113.3. M1400 reports what is true at the time of the assessment (the 24 hours immediately preceding the visit and what is observed during the assessment). If the patient has not demonstrated or reported shortness of breath during that timeframe, the correct response would be "0-Not short of breath" even though the environment or patient activities were modified in order to avoid shortness of breath.

**Q114.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A ADDED 08/07; M item number updated 09/09; Previously CMS OCCB 07/07 Q&A #14]

**Q114.1. M1410. If patient is on a ventilator, do you mark O2 & ventilator or is the O2 inclusive with the ventilator in this question?**

A114.1. M1410 instructs the assessor to mark all that apply. As it is possible for a patient to be ventilated with entrained room air and thus be on a ventilator without oxygen therapy, it would be accurate to mark both Responses 1-Oxygen and 2-Ventilator when the patient is receiving oxygen through the ventilator.

**Q115.** [Q&A RETIRED 08/07; Duplicative of Archived Chapter 8 guidance]

**Q116.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q117. M1610. Is the patient incontinent if she only has stress incontinence when coughing?**

A117. Yes, the patient is incontinent if incontinence occurs under any situation(s).

**Q118.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A ADDED 06/05; M number updated 09/09; Previously CMS OCCB 03/05 Q&A Q #5]

**Q119. M1610. 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 M1610, to reflect improvement in status?**

A119. 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 M1610.

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 M1610 would be 1 (patient is incontinent), followed by response 0 to M1615 (timed-voiding defers incontinence).

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #23]

**Q119.1. M1610. How long would a patient need to be continent of urine in order to qualify as being continent?**

A119.1. Utilize clinical judgment and current clinical guidelines and assessment findings to determine if the cause of the incontinence has been resolved, resulting in a patient no longer being incontinent of urine. There are no specific time frames that apply to all patients in all situations.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 04/08 Q&A #11]

**Q119.2. M1610. How should we answer M1610 for a patient with a nephrostomy tube? Can we interpret M1610 to mean if the urinary diversion is pouched with an ostomy appliance it is not a catheter but if it is accessed with a tube or catheter (external or otherwise) then the patient has a catheter? What about the patients with continent urinary diversions? They have a stoma but are accessing with intermittent catheterizations. Would they be reported as having a catheter on M1620?**

A119.2. When a patient has urinary diversion, with or without a stoma that is pouched for drainage the appropriate M1620 response would be "0-No incontinence or catheter". The appropriate response for a patient with urinary diversion, with or without a stoma, that has a catheter or "tube" for urinary drainage would be "2 -Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic)." A patient that requires intermittent catheterization would be represented by Response 2, even if they have continent urinary diversions.

[Q&A EDITED 09/09]

**Q120. M1615. How should I respond to M1615, When does Urinary Incontinence Occur, for the patient with an ureterostomy?**

A120. If the patient had an ureterostomy, M1615 should have been answered with response 0 (no incontinence or catheter) if it was pouched and response 2, (patient

requires a urinary catheter) if it had a catheter or tube inserted for urinary drainage. From both of these responses, you are directed to skip M1615, When does Urinary Incontinence Occur?

**Q121.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #32]

**Q121.1. M1615. If a patient is utilizing timed-voiding to defer incontinence and they have an “accident” once-in-a-while, can you still mark M1615 “0 – Timed-voiding defers incontinence”?**

A121.1. If the patient utilizes timed-voiding but still has an “occasional” accident, the appropriate response may be “1-Occasional stress incontinence”, which is defined in Chapter 3 of the OASIS-C Guidance Manual as a patient who is unable to prevent escape of relatively small amounts of urine when coughing, sneezing, laughing, lifting, moving from sitting to standing position, or during other activities (stress) which increase abdominal pressure.

If incontinence happens with regularity, then Response 2, 3, or 4 would be appropriate, based on when the incontinence occurs.

Once implementing timed-voiding as a compensatory mechanism to manage urinary incontinence, 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”.

**Q122. M1620. How should you respond to this item if the patient is on a bowel-training program? How would that be documented in the clinical record?**

A122. A patient on a regular bowel evacuation program most typically is on that program as an intervention for fecal impaction. Such a patient may additionally have occurrences of bowel incontinence, but there is no assumed presence of bowel incontinence simply because a patient is on a regular bowel program. The patient's elimination status must be completely evaluated as part of the comprehensive assessment, and the OASIS items answered with the specific findings for the patient. The bowel program, including the overall approach, specific procedures, time intervals, etc., should be documented in the patient's clinical record.

[M item number updated 09/09]

**Q123. M1630. If a patient with an ostomy was hospitalized with diarrhea in the past 14 days, does one mark Response 2 to M1630?**

A123. Response #2 is the appropriate response to mark for M1630 in this situation. By description of the purpose of the hospitalization, the ostomy was related to the inpatient stay.

**Q124.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #33]

**Q124.1. M1710 & M1720. What does unresponsive mean?**

A124.1. It means the patient is unable to respond or the patient responds in a way that you can't make a clinical judgment about the patient's level of orientation. 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.

[Q&A EDITED 08/07]

**Q125. M1745. Are the behaviors to be considered in responding to this item limited to only those listed in M1740?**

A125. No, there are behaviors other than those listed in M1740 that can be indications of alterations in a patient’s cognitive or neuro/emotional status resulting in behaviors of concern for the patient’s safety or social environment. Other behaviors such as wandering can interfere with the patient’s safety, and if so, the frequency of these should be considered in responding to the item.

[Q&A EDITED 09/09; Q&A ADDED 06/05; Previously CMS OCCB 08/04 Q&A #3]

**Q126. M1750. At discharge, does M1750 pertain to the services the patient has been receiving up to the point of discharge or services that will continue past discharge? The psych nurse is the only service being provided.**

A126. OASIS items refer to what is true at the time of the assessment (unless another timeframe is specified). Therefore, for the situation described, if the psych nurse is the only service provided at the time of the discharge assessment, the correct response is “yes.” Note that if the psychiatric nurse discharges on Tuesday, but the Physical Therapist does the discharge comprehensive assessment on Wednesday, then M1750 (at discharge) would not reflect the presence of psychiatric nursing services.

[M item number updated 09/09]

**Q127. M1800-M1900. At OASIS items M1800-M1900, what does IADL mean and what's the difference between IADLs and ADLs?**

A127. ADL stands for 'activities of daily living' while IADL stands for 'instrumental activities of daily living'. ADLs refer to basic self-care activities (e.g., bathing, dressing, toileting, etc.), while IADLs include activities associated with independent living necessary to support the ADLs (e.g., use of telephone, ability to manage medications, etc.).

**Q128.** [Q&A RETIRED 09/09; Outdated]

**Q128.1.** [Q&A RETIRED 09/09; Outdated]

**Q129. M1800. Must I see the patient comb his/her hair or brush his/her teeth in order to respond to this item?**

A129. No, as assessment of the patient’s coordination, manual dexterity, upper-extremity range of motion (hand to head, hand to mouth, etc.), and cognitive/emotional



status will allow the clinician to evaluate the patient's ability to perform grooming activities.

**Q130.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A ADDED 08/07; M item numbers updated 09/09; Previously CMS OCCB 07/06 Q&A #34]

**Q130.1. M01800 & M1830. Is hair washing/shampooing considered a grooming task, a bathing task, or neither?**

A130.1. The task of shampooing hair is not considered a grooming task for M1800. Hair care for M1800 includes combing, brushing, and/or styling the hair. Shampooing is also specifically excluded from the bathing tasks for M1830, therefore the specific task of shampooing the hair is not included in the scoring of either of these ADL items.

**Q131.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[M item number updated 09/09]

**Q132. M1810. What if the patient must dress in stages due to shortness of breath? What response must be marked?**

A132. If the patient is able to dress herself/himself independently, then this is the response that should be marked, even if the activities are done in steps. If the dressing activity occurs in stages because verbal cueing or reminders are necessary for the patient to be able to complete the task, then response 2 is appropriate. (Note that the shortness of breath would be addressed in M1400.)

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #25]

**Q132.1. M1810 & M1820. In the dressing items, how do you answer if a disabled person has everything in their home adapted for them; for instance, closet shelves & hanger racks have been lowered to be accessed from a wheelchair. Is the patient independent with dressing?**

A132.1. M1810 & M1820, Upper and Lower Body Dressing, Response 0 indicates a patient is able to safely access clothes and put them on and remove them (with or without dressing aids). Because in these specific OASIS items, the use of special equipment does not impact the score selection, at the assessment time point, if the patient is able to safely access clothes, and safely dress, then Response 0 would be appropriate even if the patient is using adaptive equipment and/or an adapted environment to promote independence.

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #26]

**Q132.2. M1810 & M1820. For M1810 & M1820, we know you count things like prostheses & TED hose as part of the clothing. But the interpretation is that they have to only be independent with the "majority" of the dressing items & then they are considered independent. Because of the importance of being able to put a prostheses on and for a diabetic being able to put shoes & socks on, clinicians want to mark a patient who can do all their dressing except those items NOT independent. However, does this fit the criteria of "majority"?**

A132.2. Your understanding of the majority rule is correct. If a patient's ability varies among the tasks included in a single OASIS item (like M1810, Upper body dressing or M1820, Lower body dressing), select the response that represents the patient's status in a "majority" of the tasks. The concerns of clinicians focus on critical issues that need to be addressed in the plan of care. It may help to remember that the OASIS is a standardized data set designed to measure patient outcomes. In order to standardize the data collected, there must be objective rules that apply to the data collection (e.g. the percentage of clothing items a patient can independently obtain, put on and take off). Less objective criteria, like which clothing items are more important than others, have limitations in consistency in which a similar situation would likely be interpreted differently between various data collectors from one agency to the next. While these rules may cause the assessing clinician to pick an item response that lacks the detail or specificity that may be observable when assessing a given patient, as long as the clinician is abiding by scoring guidelines, he/she is scoring the OASIS accurately and the agency's outcome data will be a standardized comparison between other agencies. In any situation where the clinician is concerned that the OASIS score does not present as detailed or accurate representation as is possible, the clinician is encouraged to provide explanatory documentation in the patient's clinical record, adding the necessary detail which is required for a comprehensive patient assessment.

[Q&A ADDED 09/09; Previously CMS OCCB 10/08 Q&A #8]

**Q132.3. M1810 & M1820. I have a patient who could not obtain his clothes, but could dress without assistance if clothes were laid out (Response 1). If the environment was adapted (a new "usual" storage place for clothing was selected) so that the patient could obtain, put on and remove the clothing without any assistance, would the patient then be considered independent in dressing?**

A.132.3. When a patient's ability varies on the day of assessment, the clinician reports what was true for a majority of the time. If the patient was unable to access clothing, but could put on and remove the majority of clothing items safely when they were laid out for him, the appropriate score would be a "1". If the environment is modified (e.g., the patient decides to start storing clothing in the dresser instead of hanging in the closet), and the patient can now access clothes from a location without anyone's help, then this new arrangement could now represent the patient's current status (e.g., clothing's new "usual" storage area and patient's ability). The appropriate score would be a "0" if the patient was also able to put on and remove a majority of his clothing items safely.

If however, the patient explained that while he is feeling weak, he will temporarily modify his dressing practice (e.g., place his clothes on the chair by his bed instead of putting them in the usual storage area - the closet), since the clothing lying on the chair is not in its "usual" storage area and the patient does not intend on making the chair his usual storage area for his clothes, then he currently is unable to obtain the clothing from its usual location, and the patient would be scored a "1". The patient could then work to gain independence in accessing clothing from its usual storage location, or decide to make long-term environmental modifications, and possibly achieve improvement in the outcome if successful.

[Q&A ADDED 09/09; M item number updated 09/09; Previously CMS OCCB 04/09 Q&A #10]

**Q132.4. M1810 & M1820. The guidance in M1810 & M1820 states that you assess the patient's ability to obtain, put on and remove the clothing items usually worn.**

**Other guidance states that items such as prosthetics, corsets, cervical collars, hand splints, Teds, etc. are considered dressing apparel. Do we include the other items, like a splint, if the patient doesn't usually wear it? Our patient just injured their wrist and will only be wearing it for a week; he doesn't usually wear a splint.**

A132.4. M1810 & M1820, Upper/Lower Body Dressing, includes all the dressing items the patient usually wears and additionally any device the patient is ordered to wear, e.g. prosthetic, splint, brace, corset, Teds, knee immobilizer, orthotic, AFO, even if they have not routinely worn/used them before. If they are wearing the device/support (or ordered to wear the device/support) on the day of assessment, it is to be included when assessing and scoring M1810 & M1820.

[Q&A ADDED 09/09; M item number updated 09/09; Previously CMS OCCB 04/09 Q&A #11]

**Q132.5. M1810 & M1820. At my agency, we are asked to score M1810 and M1820 as "2 - Someone must help the patient put on upper body clothing" if the patient takes longer than the usual time to dress self even if they live alone and are perfectly capable of dressing themselves. Is this correct?**

A132.5. There is no requirement that a patient dress within a specific amount of time in order to be independent in dressing. A patient may take longer than "usual", but as long as they can safely access their clothing from its usual storage location, put on and take off a majority of their routine clothing items safely, the patient is scored a "0" in Upper and Lower Body Dressing.

[Q&A ADDED 08/07; M item updated 09/09; Previously CMS OCCB 07/06 Q&A #35]

**Q132.6. M1820. 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 M1820?**

A132.6. M1820 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. [

**Q133.** [Q&A RETIRED 09/09; Outdated]

[Q&A EDITED 09/09; M number updated 09/09]

**Q134. M1830. Given the following situations, what would be the appropriate responses to M1830?**

- a) The patient's tub or shower is nonfunctioning or is not safe for use.
- b) The patient is on physician-ordered bed rest.
- c) The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again.
- d) The patient chooses not to navigate the stairs to the tub/shower.

A134. a) The patient's environment can impact his/her ability to complete specific ADL tasks. If the patient's tub or shower is nonfunctioning or not safe, then the patient is currently unable to use the facilities. Response 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities outside the tub/shower.

b) The patient's medical restrictions mean that the patient is unable to bathe in the tub or shower at this time. Select response 4 (unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode), 5 (Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath) or 6 (unable to effectively participate in bathing and is bathed totally by another person), whichever most closely describes the patient's ability at the time of the assessment.

c) If the patient's fear is a realistic barrier to her ability to get in/out of the shower safely, then her ability to bathe in the tub/shower may be affected. If due to fear, she refuses to enter the shower even with the assistance of another person; either response 4, 5, or 6 would apply, depending on the patient's ability at the time of assessment. If she is able to bathe in the shower when another person is present to provide required supervision/assistance, then response 3 would describe her ability.

d) The patient's environment must be considered when responding to the OASIS items. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower. While this may appear to penalize the patient whose tub or shower is on another floor, it is within this same environment that improvement or decline in the specific ability will subsequently be measured.

[Q&A EDITED 09/09]

**Q135. M1830. How should I respond to this item for a patient who is able to bathe in the shower with assistance, but chooses to sponge bathe independently at the sink?**

A135. The item addresses the patient's ability to bathe in the shower or tub, not actual performance, regardless of where or how the patient currently bathes. Willingness and compliance are not the focus of the item. If assistance is needed to bathe in the shower or tub, then the level of assistance needed must be noted, and response 1, 2, or 3 should be selected.

[Q&A EDITED 09/09; ADDED 06/05; M item number updated 09/09; Previously CMS OCCB 08/04 Q&A #12]

**Q136. M1830. Should the clinician consider the patient's ability to perform bathing-related tasks, like gathering supplies, preparing the bath water, shampooing hair, or drying off after the bath in responding to this item?**

Q136. When responding to M1830, the patient's ability to transfer in and out of the tub/shower and then "wash the entire body" should be considered. Bathing-related tasks, such as those mentioned, should not be considered in scoring this item.

[Q&A EDITED 08/07; ADDED 06/05; Previously CMS OCCB 8/04 Q&A #13]

**Q137. M1830. If a patient can perform most of the bathing tasks (i.e. can wash most of his/her body) in the shower or tub, using only devices, but needs help to reach a hard to reach place, would the response be “1” because he/she is independent with devices with a “majority” of bathing tasks? Or is he/she a “2” because he/she requires the assist of another “for washing difficult to reach areas?”**

A137. The correct response for the patient described here would be Response 2 "able to bathe in the shower or tub with the assistance of another person: c) for washing difficult to reach areas," because that response describes that patient's ability at that time.

[Q&A EDITED 09/09; ADDED 06/05; Previously CMS OCCB 10/04 Q&A #6]

**Q138. M1830. Please clarify how the patient's ability to access the tub/shower applies to M1830.**

A138. The intent of the bathing item is to identify the patient's ability to wash the entire body. Guidance for this item indicates that when medical restrictions, environmental or other barriers prevent the patient from accessing the tub/shower, his/her bathing ability will be 'scored' at a lower level. The ability to transfer into and out of the tub/shower is evaluated and also impacts the score when responding to M1830. If the patient requires assistance to transfer into or out of the tub/shower, they would be scored a 2 or 3, based on the amount of human supervision or assistance is required throughout the bath.

**Q139.** [RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q140.** [RETIRED 09/09; Outdated]

**Q141.** [RETIRED 09/09; Outdated]

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #36]

**Q141.1. M1830. 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?**

A141.1. 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.

**Q141.2. [RETIRED 09/09; Outdated]**

[Q&amp;A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&amp;A #27]

**Q141.3. M1830. For M1830 even the normal person requires a long-handled sponge or brush to wash their back. If a patient can do everything except wash their back & requires a long-handled sponge or brush, would they be marked a "1"?**

A141.3. Assistive devices promote greater independence for the user by enabling them to perform tasks they were previously unable to, or had great difficulty safely performing. The intention of the use of the term "devices" in the response 1 for M1830 is to differentiate a patient who is capable of washing his entire body in the tub/shower independently (response 0), from that patient who is capable of washing his entire body in the tub/shower only with the use of (a) device(s). This differentiation allows a level of sensitivity to change to allow outcome measurement to capture when a patient improves from requiring one or more assistive devices for bathing, to a level of independent function without devices. Individuals with typical functional ability (e.g. functional range of motion, strength, balance, etc.) do not "require" special devices to wash their body. An individual may choose to use a device (e.g., a long-handled brush or sponge) to make the task of washing the back or feet easier. If the patient's use of a device is optional (e.g., it is their preference, but not required to complete the task safely), then the score selected should represent the patient's ability to bathe without the device. If the patient requires the use of the device in order to safely bathe, then the need for the device should be considered when selecting the appropriate score. CMS has not identified a specific list of equipment that defines "devices" for the scoring of M1830. The clinician should assess the patient's ability to wash their entire body and use their judgment to determine if a device, assistance, or both is required for safe completion of the included bathing tasks.

[Q&amp;A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&amp;A #28]

**Q141.4. M1830. If a patient uses the tub/shower for storage, is this an environmental barrier? Is the patient marked a 4 or 5 in M1830?**

A141.4. Upon discovering the patient is bathing at the sink, the clinician should evaluate the patient in attempts to determine why he/she is not bathing in the tub/shower. If it is the patient's personal preference to bathe at the sink (e.g. "I don't get that dirty." "I like using the sink."), but they are physically and cognitively able to bathe in the tub/shower; the clinician will pick the response option that best reflects the patient's ability to bathe in the tub/shower. If the patient no longer bathes in the tub/shower due to personal preference and has since begun using the tub/shower as a storage area, the patient would be scored based on their ability to bathe in the tub/shower when it was empty.

If the patient has a physical or cognitive/emotional barrier that prevents them from bathing in the tub/shower and therefore has since starting using the tub/shower as a storage area, the clinician will score the patient either as a response 4, 5, or 6, depending on the patient's ability at the time of assessment. Note that the responses of 4, 5, and 6 are due to the patient's inability to safely bathe in the tub/shower (even with help) due to the physical and/or cognitive barrier, not due to the alternative use of the tub for storage.

[Q&A EDITED 09/09]

**Q142. M1840. If my patient has a urinary catheter, does this mean he is totally dependent in toileting transferring?**

A142. M1840 does not differentiate between patients who have urinary catheters and those who do not. The item simply asks about the patient's ability to get to and from the toilet or bedside commode and their ability to transfer on and off toilet/commode. This ability can be assessed whether or not the patient uses the toilet for urinary elimination.

**Q143. M1840. If the patient can safely get to and from the toilet and transfer independently during the day, but uses a bedside commode independently at night, what is the appropriate response to this item?**

A143. If the patient chooses to use the commode at night (possibly for convenience reasons), but is able to get to the bathroom, then response 0 would be appropriate.

**Q144.** [RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q145.** [RETIRED 09/09; Outdated]

[Q&A EDITED 09/09; ADDED 06/05; Previously CMS OCCB 03/05 Q&A Q #9]

**Q146. M1840. If a patient is able to safely get to and from the toilet and perform the transfer with assistance of another person, but they live alone and have no caregiver so they are using a bedside commode, what should be the response to M1840?**

A146. 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 and transfer with assistance, then response 1 should be selected, as this reflects their ability, regardless of the availability of a consistent caregiver in the home.

**Q147.** [RETIRED 09/09; Outdated]

[Q&A EDITED 09/09; ADDED 06/05; Previously CMS OCCB 03/05 Q&A Q #11]

**Q148. M1840. If a patient uses a bedside commode over the toilet, would this be considered "getting to the toilet" for the purposes of responding to M1840?**

A148. Yes, a patient who is able to safely get to and from the toilet and transfer should be scored at response levels 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.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/08 Q&A Q #21]

**Q148.1. M1840/M1850/M1860. Is it true that when the word "OR" appears in a question and the patient's condition meets both sides of the statement that the patient should automatically be marked at the next level down on the scale? Also, if the patient is marked as a "3" on M1860, Ambulation, can the patient be a "0" independent in toileting transferring?**

A148.1. When scoring the OASIS, clinicians should avoid applying "always", "never", or "automatically" rules. Each item, the response options contained in the item, and additional available guidance in the form of Q&As and from Chapter 3 should be reviewed and the most accurate response should be selected. It is not a universally true statement to say that if conditions on both sides of the word "OR" pertain to the patient, then the patient should be automatically scored at the next level down. For instance, Response "0" for M1830 Bathing says "Able to bathe self in shower or tub independently, including getting in and out of tub/shower". If the patient was able to bathe in the shower independently AND also able to bathe in the tub independently, it would not be appropriate to score them at the next level down simply because conditions on both sides of the word "OR" are met.

When scoring M1860, Ambulation/Locomotion, response 3 is selected when the patient requires human supervision or assistance at all times in order to ambulate safely. Response 0 is selected if the patient requires no human assistance and no assistive devices to ambulate safely on even and uneven surfaces. All other combinations of needing assistance intermittently are reported as a 1 or 2.

For M1850, Transferring, Response 1-Able to transfer with minimal human assistance or with use of an assistive device, it is true that if the patient requires BOTH minimal human assistance AND an assistive device to transfer safely, then the response option 2 should be selected (See CMS OASIS Q&A Category 4b Questions 151.4.)

If a patient requires constant human supervision or assistance in order to ambulate safely, they are scored a "3" for M1860, Ambulation/Locomotion. A patient can only be scored a "0" for M1840, Toileting Transferring, if they can get to and from the toilet and transfer independently with or without a device. It would be possible for a patient to be a "3" for M1860, Ambulation/Locomotion and also be reported as a "0" for M1840, Toilet Transferring, if the patient required assistance at all times to ambulate, but was able to get to and from the toilet and transfer safely and without assistance using a wheelchair.

**Q149.** [RETIRED 09/09; Duplicative of Q151.3]

[Q&A EDITED 09/09]

**Q150. M1850. If other types of transfers are being assessed (e.g., car transfers, floor transfers), should they be considered when responding to M1850?**

A150. Because standardized data are required, only the bed to chair transfer should be considered when responding to the item. Based on the patient's unique needs, home environment, etc., transfer assessment beyond bed to chair transfer may be indicated. Note in the patient's record the specific circumstances and patient's ability to accomplish other types of transfers.

[Q&A EDITED 09/09]

**Q151. M1850. If a patient takes extra time and pushes up with both arms, is this considered using an assistive device?**

A151. Taking extra time and pushing up with both arms can help ensure the patient's stability and safety during the transfer process but does not mean that the patient is dependent. If standby human assistance were necessary to assure safety, then a different response level would apply.



[Q&A ADDED 08/07. M item updated 09/09; Previously CMS OCCB 08/04 Q&A #16]  
**Q151.1. M1850. When scoring M1850, Transferring, response “1” indicates that that patient requires minimal human assistance or the use of an assistive device to safely transfer. What constitutes an “assistive device” for the purposes of differentiating “truly independent” transferring (response “0”) from “modified independent” transferring (response “1”, or transferring with equipment)?**

A151.1. CMS is in the process of defining assistive devices and will provide guidance when the issue is clarified.

[Q&A ADDED 08/07; M item updated 09/09; Previously CMS OCCB 07/06 Q&A #38]  
**Q151.2. M1850. 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 M1850 Transferring be “1” (requires “minimal human assistance”) or a “2” (“unable to transfer self”)?** Both seem to apply.

A151.2. 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.

[Q&A ADDED 08/07; M item updated 09/09; Previously CMS OCCB 05/07 Q&A #29]  
**Q151.3. M1850. A quadriplegic is totally dependent, cannot even turn self in bed, however, he does get up to a gerichair by Hoyer lift. For M1850, is the patient considered bedfast?**

A151.3. A patient who can tolerate being out of bed is not “bedfast.” If a patient is able to be transferred to a chair using a Hoyer lift, response 3 is the option that most closely resembles the patient’s circumstance; the patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast (“confined to the bed”) even though he cannot help with the transfer. Responses 4 and 5 do not apply for the patient who is not bedfast. The frequency of the transfers does not change the response, only the patient’s ability to be transferred and tolerate being out of bed.

Q&A ADDED 08/07; M item number updated 09/09; Previously CMS OCCB 07/07 Q&A #15]

**Q151.4. M1850. How do you select a score for M1850 Transferring, for the patient who is not really safe at response 1, but moving to response 2 seems a bit aggressive? Response 1 uses the word "or" NOT "and". If a patient requires both human assist AND an assistive device, does this move them to a 2, especially if they are not safe? It seems these patients can do more than bear weight and pivot--but it is the next best option. If they require human assist AND an assistive device, should we automatically move the patient to a "2", whether they are safe or not?**

A151.4. If the patient is able to safely transfer with either minimal human assistance (but no device), or with the use of an assistive device (but no human assistance) then they should be reported as a “1-Able to transfer with minimal human assistance or with use of an assistive device”. If they are not safe in transferring with either of the above

circumstances, (e.g., they transfer with only an assistive device but not safely, minimal assistance only is not adequate for safe transferring, or they require both minimal human assistance and an assistive device to transfer safely), then the patient would be scored a "2–Able to bear weight and pivot during the transfer process but unable to transfer self" (assuming the patient could bear weight and pivot). Safety is integral to ability. If the patient is not safe when transferring with just minimal human assistance or with just an assistive device, they cannot be considered functioning at the level of response "1".

For the purposes of Response 1 – Minimal human assistance could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance, where the level of assistance required from someone else is equal to or less than 25% of the total effort to transfer and the patient is able to provide >75% of the total effort to complete the task. Examples of environmental set-up as it relates to transferring would be a patient who requires someone else to position the wheelchair by the bed and apply the wheelchair locks in order to safely transfer from the bed to the chair, or a patient who requires someone else to place the elevated commode seat over the toilet before the patient is able to safely transfer onto the commode.

**Q151.5.** [Q&A RETIRED 09/09; Outdated]

[Q&A ADDED 09/09; M item updated 09/09; Previously CMS OCCB 10/07 Q&A #22]

**Q151.6. M1850. When scoring M1850, Transferring, the assessment revealed difficulty with transfers. The patient was toe-touch, weight bearing on the left lower extremity and had pain in the opposite weight bearing hip. The patient had a history of falls and remained at risk due to medication side effects, balance problems, impaired judgment, weakness, unsteady use of device and required assistance to transfer. The concern is the safety of the transfers considering all of the above. Would "2" or "3" be the appropriate response?**

A151.6. Safety is integral to ability, if your patient requires more than minimal human assistance or they need minimal assistance and an assistive device to safely transfer, and can bear weight and pivot safely, Response 2 should be reported. If you determine the bearing weight and pivoting component of the transfer is not safe even with assistance, then the patient is not able to bear weight or pivot and the appropriate selection would be Response 3 – Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/08 Q&A #15]

**Q151.7. M1850. For M1850, Transferring, does the transfer from bed to chair include evaluation from a seated position in bed to a seated position in a chair or from supine in bed to seated in a chair?**

A151.7. The bed to chair transfer includes the patient's ability to get from the bed to a chair. For most patients, this will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/08 Q&A Q #21]

**Q151.8. M1840/M1850/M1860. Is it true that when the word "OR" appears in a question and the patient's condition meets both sides of the statement that the patient should automatically be marked at the next level down on the scale? Also,**

**if the patient is marked as a "3" on M1860, Ambulation, can the patient be a "0" independent in toileting transferring?**

A151.8. When scoring the OASIS, clinicians should avoid applying "always", "never", or "automatically" rules. Each item, the response options contained in the item, and additional available guidance in the form of Q&As and from Chapter 3 should be reviewed and the most accurate response should be selected. It is not a universally true statement to say that if conditions on both sides of the word "OR" pertain to the patient, then the patient should be automatically scored at the next level down. For instance, Response "0" for M1830 Bathing says "Able to bathe self in shower or tub independently, including getting in and out of tub/shower". If the patient was able to bathe in the shower independently AND also able to bathe in the tub independently, it would not be appropriate to score them at the next level down simply because conditions on both sides of the word "OR" are met.

When scoring M1860, Ambulation/Locomotion, response option 3 is selected when the patient requires human supervision or assistance at all times in order to ambulate safely. Response 0 is selected if the patient requires no human assistance and no assistive devices to ambulate safely on even and uneven surfaces. All other combinations of needing assistance intermittently are reported as a 1 or 2.

For M1850, Transferring, Response 1-Able to transfer with minimal human assistance or with use of an assistive device, it is true that if the patient requires BOTH minimal human assistance AND an assistive device to transfer safely, then the response option 2 should be selected (See CMS OASIS Q&A Category 4b Questions 151.4.)

If a patient requires constant human supervision or assistance in order to ambulate safely, they are scored a "3" for M1860, Ambulation/Locomotion. A patient can only be scored a "0" for M1840, Toileting Transferring, if they can get to and from the toilet and transfer independently with or without a device. It would be possible for a patient to be a "3" for M1860, Ambulation/Locomotion and also be reported as a "0" for M1840, Toilet Transferring, if the patient required assistance at all times to ambulate, but was able to get to and from the toilet and transfer safely and without assistance using a wheelchair.

**Q152. M1860. What if my patient has physician-ordered activity restrictions due to a joint replacement? What they are able to do and what they are allowed to do may be different. How should I respond to this item?**

A152. The patient's medical restrictions must be considered in responding to the item, as the restrictions address what the patient is able to safely accomplish at the time of the assessment.

**Q153.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A EDITED 09/09; ADDED 06/05; Previously CMS OCCB 08/04 Q&A #17]

**Q154. M1860. If a patient uses a wheelchair for 75% of their mobility and walks for 25% of their mobility, then should they be scored based on their wheelchair status because that is their mode of mobility >50% of the time? Or should they be scored based on their ambulatory status, because they do not fit the definition of "chairfast?"**

A154. Item M1860 addresses the patient's ability to ambulate, so that is where the clinician's focus must be. Endurance is not included in this item. The clinician must determine the level of assistance is needed for the patient to ambulate and choose response 0, 1, 2, or 3, whichever is the most appropriate.

**Q155.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A ADDED 08/07; M item number updated 09/09; Previously CMS OCCB 07/06 Q&A #39]

**Q155.1. M1860. 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 M1860?**

A155.1. It sounds as though your assessment findings cause you to believe the patient should have someone with them at all times when walking (Response “3”). When scoring M1860, 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.

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #30]

**Q155.2. M1860. For M1860, does able to walk “on even and uneven surfaces” mean inside the home or outside the home or both? If the patient is scored a 0, does this mean the patient is a safe community ambulator and therefore is not homebound?**

A155.2. “Even and uneven surfaces” refers to the typical variety of surfaces that the particular home care patient would routinely encounter in his environment. Based on the individual residence, this could include evaluating the patient’s ability to navigate carpeting or rugs, bare floors (wood, linoleum, tile, etc.), transitions from one type or level of flooring to another, stairs, sidewalks, and uneven surfaces (such as a graveled area, uneven ground, uneven sidewalk, grass, etc.).

To determine the best response, consider the activities permitted, the patient’s current environment and its impact on the patient’s normal routine activities. If, on the day of assessment, the patient’s ability to safely ambulate varies among the various surfaces he must encounter, determine if the patient needs some level of assistance at all times (Response 3), needs no human assistance or assistive device on any of the encountered surfaces (Response 0), needs a one-handed device but no human assistance, (Response 1) or needs some human assistance and/or equipment at times but not constantly (Response 2).

Response 0, Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e. needs no human assistance or assistive device), is not intended to be used as a definitive indicator of homebound status. Some patients are

homebound due to medical restrictions, behavioral/emotional impairments and other barriers, even though they may be independent in ambulation. Refer to the Medicare Coverage Guidelines for further discussion of homebound criteria at <http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf>.

[Q&A ADDED 09/09; Previously CMS OCCB 01/09 Q&A Q #12]

**Q155.3. M1860. A patient is able to ambulate independently with a walker, but the patient chooses to not use the walker, therefore not being safe. When selecting a response for M1860 Ambulation/Locomotion, should I select Response #2, that the patient is able to ambulate safely with the walker or should I select Response #3 that the patient is only safe when walking with another person at all times, because he chooses to not use his walker?**

A155.3. The OASIS items should report the patient's physical and cognitive ability, not their actual performance, compliance or willingness to perform an activity. You state the patient is able to ambulate independently with a walker, so we will assume you meant that the patient is able to ambulate without human assistance safely with the walker. This would be scored a "2" for M1860 Ambulation/Locomotion. You state the patient's actual performance is that he is unsafe ambulating because he chooses not to use his walker. This patient would still be scored a "2" unless, as you pointed out, the clinician identified some other physical, cognitive or environmental barrier that prevents the patient from utilizing his walker to assist with ambulation, e.g. fear, memory impairment, undisclosed pain associated with walker use, or other emotional, behavioral or physical impairments. If there was a barrier preventing the patient from safely utilizing the walker during ambulation, the clinician would need to determine if the patient needed someone to assist at all times in order to ambulate safely and if so, the appropriate score for M1860 would be a "3". If the patient only needed assistance intermittently, the correct response would be a "2".

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/08 Q&A Q #21]

**Q155.4 . M1840/M1850/M1860. Is it true that when the word "OR" appears in a question and the patient's condition meets both sides of the statement that the patient should automatically be marked at the next level down on the scale? Also, if the patient is marked as a "3" on M1860, Ambulation, can the patient be a "0" independent in toileting transferring?**

A155.4. When scoring the OASIS, clinicians should avoid applying "always", "never", or "automatically" rules. Each item, the response options contained in the item, and additional available guidance in the form of Q&As and from Chapter 3 should be reviewed and the most accurate response should be selected. It is not a universally true statement to say that if conditions on both sides of the word "OR" pertain to the patient, then the patient should be automatically scored at the next level down. For instance, Response "0" for M1830 Bathing says "Able to bathe self in shower or tub independently, including getting in and out of tub/shower". If the patient was able to bathe in the shower independently AND also able to bathe in the tub independently, it would not be appropriate to score them at the next level down simply because conditions on both sides of the word "OR" are met.

When scoring M1860, Ambulation/Locomotion, response option 3 is selected when the patient requires human supervision or assistance at all times in order to ambulate safely. Response 0 is selected if the patient requires no human assistance and no assistive

devices to ambulate safely on even and uneven surfaces. All other combinations of needing assistance intermittently are reported as a 1 or 2.

For M1850, Transferring, Response 1-Able to transfer with minimal human assistance or with use of an assistive device, it is true that if the patient requires BOTH minimal human assistance AND an assistive device to transfer safely, then the response option 2 should be selected (See CMS OASIS Q&A Category 4b Questions 151.4.)

If a patient requires constant human supervision or assistance in order to ambulate safely, they are scored a "3" for M1860, Ambulation/Locomotion. A patient can only be scored a "0" for M1840, Toileting Transferring, if they can get to and from the toilet and transfer independently with or without a device. It would be possible for a patient to be a "3" for M1860, Ambulation/Locomotion and also be reported as a "0" for M1840, Toilet Transferring, if the patient required assistance at all times to ambulate, but was able to get to and from the toilet and transfer safely and without assistance using a wheelchair.

**Q156.** [RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q157.** [RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q157.1 .** [RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A EDITED 08/07; ADDED 06/05; M item number updated 09/09; Previously CMS OCCB 10/04 Q&A #8]

**Q158. M1880. Should a therapeutic diet prescription be considered when assessing the patient's ability to plan and prepare light meals for M1880? 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?**

A158. M1880 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 M1880. Therefore a patient who is able to complete the 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. If the patient with any prescribed diet requirements is unable to plan and prepare a meal that complies with their prescribed diet AND also is unable to plan and prepare "generic" light meals (e.g. heating a frozen dinner in the microwave or making a sandwich), Response 2 – Unable to prepare any light meals or reheat any delivered meals" should be selected. 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.

**Q159.** [Q&A RETIRED 09/09; Outdated]

**Q160.** [Q&A RETIRED 09/09; Outdated]

**Q161.** [RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q162.** [RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A EDITED 08/07]

**Q163. M2020. I have had several patients who use a list of medications to self-administer their meds. Would this be considered a drug diary or chart?**

A163. Yes, this is considered a drug diary or chart. The statement for response 1b (another person develops a drug diary or chart) pertains to someone other than the patient developing the aid. What you need to assess is whether the patient must use this list to take the medications at the correct times. If he/she does require the list and also requires someone else to create it, then response 1 is the appropriate choice.

[M item number updated 09/09]

**Q164. M2020. Some assisted living facilities require that facility staff administer medications to residents. If the patient appears able to take oral medications independently, how would the clinician answer M2020?**

A164. M2020 refers to the patient's ability to take the correct oral medication(s) and proper dosage(s) at the correct times. Your assessment of the patient's vision, strength and manual dexterity in the hands and fingers, as well as cognitive ability, will allow you to evaluate this ability, despite the facility's requirement. You would certainly want to document the requirement in the clinical record.

**Q165.** [Q&A RETIRED 09/09; Outdated]

[Q&A EDITED 09/09; ADDED 06/05; Previously CMS OCCB 08/04 Q&A #19]

**Q166. M2020. When scoring M2020, Management of Oral Medications, should medication management tasks related to filling and reordering/obtaining the medications be considered?**

A166. No.

**Q167.** [RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[M item number updated 09/09]

**Q167.1. M2020. A patient is typically independent in managing her own oral medications. At the time of assessment, the patient's daughter and grandchildren have moved in to help care for the patient, and the daughter has placed the meds out of reach for safety. This now requires someone to assist the patient to retrieve the medications. How should M2020 be answered?**

A167.1. M2020 assesses the patient's ability to prepare and take oral medications reliably and safely. Preparation includes ability to read the label (correct medication), open the container, select the pill/tablet or milliliters of liquid (correct dosage), and orally ingest at the prescribed time (take). In some cases, a patient lives in an environment

where the facility or caregiver may impose a barrier that limits the patient's ability to access or prepare their medications, e.g. an Assisted Living Facility that keeps all medications in a medication room or a family that keeps the medications out of the reach of children for the child's safety - not the patient's. In these cases, the clinician will assess the patient's vision, strength and manual dexterity in the hands and fingers, as well as their cognitive status to determine the patient's ability to prepare and take their oral medications despite access barriers imposed by family or facility caregivers.

[Q&A ADDED 08/07; M item number updated 09/09; Previously CMS OCCB 07/07 Q&A #18]

**Q167.2. M2020. The patient with schizophrenia is not compliant with his medication regimen when he must pour his oral medications from bottles. The nurse discovers that if the pharmacist prepares the medications in bubble packs, the patient is less paranoid, is able to open the pack and will safely and reliably take the majority of his medication doses at the correct time. Since the patient is able to manage the medications once they are in the home in a bubble pack is he considered independent (Response 0) in medication management or is the special packaging requirement considered a type of assistance and is response 1 the correct answer?**

A167.2. M2020 is asking if the patient has the ability to prepare and take oral medications reliably and safely - the correct dosage at the correct times. Preparation includes the ability to read the label (or otherwise identify the medication correctly, e.g. illiterate patients may place a special mark or character on the label to distinguish between medications), open the container, select the pill/tablet or milliliters of liquid and orally ingest it at the correct times. Some patients may require medications to be dispensed in bottles with easy-open lids, while others may not. Arranging to have medications dispensed in bubble packs is an excellent strategy that may enable a patient to become independent in the management of their oral medications. Because a patient utilizes a special method or mechanism in order to take the correct medication, in the correct dose, at the correct time, does not necessarily make them dependent in the management of their oral medications. All patients are dependent on their pharmacist to dispense their medications in containers appropriate to their needs. Once in the home, if the patient requires someone else to prepare individual doses, or fill a pill box or planner, or create a diary or med list in order to take the correct med in the correct dose at the correct time, the patient would be scored a "1" indicating they require someone's else's assistance.

**Q167.3.** [Q&A RETIRED 09/09; Outdated]

**Q167.4.** [Q&A RETIRED 09/09; Outdated]

[Q&A ADDED & EDITED 09/09; M item number updated 09/09; Previously CMS OCCB 10/08 Q&A #9]

**Q167.5. M2020. What is the appropriate response to M2020, Management of Oral Medications, when the nurse sets up a medication dispenser that has a visual alarm (flashing light) and an automated verbal message reminding the patient to take the medication? This medication dispenser also calls to alert a caregiver if the patient does not respond to the alarms by taking the medication from the dispenser.**



A167.5. If the patient requires another person (e.g., nurse, family member, friend, caregiver) to give them daily reminders they are considered a "2". If an automated system is introduced that provides the reminders and after educating the patient on its setup and operation, the patient demonstrates competency at operating the reminder system and no longer needs "another person" to give them the reminders, a "2" response would no longer be appropriate.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 1/09 Q&A #13]

**167.6. M2020/M2030. It is our understanding that if the nurse is ordered to administer a medication, the patient is considered dependent for that (oral or injectable) medication. At SOC, if a patient has been in the hospital where all medications were administered by hospital nursing staff, would this make the patient dependent because the medications over the past 24 hours were administered by the acute care nurse at the hospital?**

A167.6. In the case of an admission to home care following a discharge from an inpatient facility, M2020 and M2030 should be scored based on the orders relevant to medications that will be taken/administered in the home and will not include a reporting of medications that were administered while the patient was an inpatient. Restrictions imposed during a recent hospitalization should not impact the reporting of the patient's current status.

If the patient had been discharged from an inpatient facility on the day of the assessment (24 hours immediately prior to the clinician's visit and the time spent in the home), the clinician would gather information by report regarding the patient's cognitive and physical status prior to the visit and assess the patient's status during the visit and make a determination regarding the patient's ability to manage all the medications ordered to be administered in the home at all times. At the SOC, the clinician has up to five days after the SOC date to complete the comprehensive assessment, including the patient's ability to manage medications.

The intent of M2020 is to identify the patient's ability to take all oral medications reliably and safely at all times. If the patient's ability to manage the home medications varied on the day of the assessment, the clinician would report the patient's ability to manage the medication for which the most assistance was needed.

[Q&A ADDED & EDITED 09/09; M number updated 09/09; Previously CMS OCCB 07/09 Q&A #6]

**Q167.7. M2020, M2100 e., M1030. 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 M1030, M2020, M2100 at SOC?**

Q167.7. M1030, 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.

M2020, Management of Oral Medications, would be NA-no oral medications prescribed.

M2100, Types and Sources of Assistance, e. 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 the level of caregiver ability and willingness to provide assistance with managing the equipment.

[Q&A ADDED 09/09; M item number updated 09/09; Previously CMS OCCB 10/07 Q&A #23]

**Q167.8. M2020. If a patient can't swallow his/her meds but is able to do all the other requirements for oral medication administration, how would you answer M2020, Management of Oral Medications?**

A167.8. M2020 reports the patient's ability to prepare and take (ingest) oral medications reliably and safely at the appropriate dosage and times. On the day of assessment, if the clinician discovers the patient has not been able to swallow prescribed oral medications in the past 24 hours, Response 3 - Unable to take medication unless administered by another person should be selected, as it is the best response option available. The clinician should explain the patient's inability to take their oral medications in the clinical documentation and why Response 3 was selected.

If it is identified that the route of administration of the medications (which may have originally been prescribed as "oral medications") had been changed to administration "per tube" due to the patient's inability to swallow, and this has been the patient's usual status on the day of assessment, then response NA - No oral medications prescribed should be selected.

**Q168.** [Q&A RECALLED 08/07]

[Q&A ADDED 09/09; Previously CMS OCCB 01/08 Q&A #24]

**Q168.1. M2030. The patient has B12 injections ordered monthly which are/will be given in the home. At the SOC/ROC visit, the schedule for the injection does not fall on the day of the SOC/ROC or Discharge visit. Since our assessment should reflect what is true on the day of assessment, Is N/A, No Injectable medications prescribed the correct response to M2030 in this circumstance?**

A168.1. The M2030 response "NA-No injectable medication prescribed" would not be appropriate in the situation described because the patient has an order to receive injectable medication during the episode. Even though the medication will not be injected on the day of the assessment, the clinician would assess and report the patient's ability by following the guidance in the Chapter 3 assessment strategies. It states "If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration."

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/08 Q&A #25]

**Q168.2. M2030. How do I score M2030 if the physician has ordered the RN to administer the medication?**

A168.2. If a physician orders the nurse to administer a prescribed injectable medication, the patient's ability is reported as "3-Unable to take injectable medications unless administered by another person." The order for the nurse to administer the medication

represents a medical restriction against patient self-administration. When a patient is medically restricted from performing an activity, the impact of this medical restriction on the patient's ability must be considered.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 04/08 Q&A #12]

**Q168.3. M2030. I need more clarification regarding what is included and not included in M2030 and what are we assessing. We have a patient that is receiving injections at her physician's office, mainly for financial reasons, do we include those injections.**

A168.3. When a patient is receiving an injectable medication in the physician's office or other setting outside the home; it is not included in the assessment of M2030, Management of Injectable Medications.

M2030, Management of Injectable Medications, reports the patient's ability to prepare and take (inject) all prescribed injectable medications that the patient is receiving in the home while under the home health plan of care. M2030 requires an assessment of the patient's cognitive and physical ability to draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly.

M2030 includes all injectable medications the patient has received or will receive in the home during the home health plan of care. Note that if an injectable medication is given by a nurse, the clinician will need to determine if the administration by the nurse was for convenience, or if administration by the nurse was ordered by the physician which represents a medical restriction inferring that the patient is unsafe/unable to self-inject. If that was the case, the appropriate response for M2030 would be 3-Unable to take injectable medications unless administered by another person.

M2030 would also include one time injections that were ordered to occur in the home as long as the administration occurred during the period of time covered by the plan of care. If the patient administered the medication, the clinician would report the patient's ability to complete the included tasks on the day of the assessment. If the injection was ordered but not to be administered on the clinician's day of assessment, the clinician will use the assessment of the patient's cognitive and physical ability and make an inference regarding what the patient would be able to do.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/08 Q&A #17]

**Q168.4. M2030. Our patient has orders for Vitamin B12 to be injected by the RN once a month and SQ Insulin to be injected by the patient 3 times a day. How would M0800 be reported in this situation?**

A168.4. When completing M2030, Management of Injectable Medications, the clinician must consider all prescribed injectable medications that the patient is receiving in the home. In situations where the patient's ability to inject their various medications varies on the day of assessment, the clinician must report what is true for the medication requiring the most assistance.

In the situation described, the patient self injects insulin 3 times a day and the Vitamin B12 injection is administered by the RN only once a month. Since the order requires the nurse to administer the Vitamin B12, the patient would be considered unable to

administer that medication and would represent the patient's ability for the medication requiring the most assistance. Response 3, Unable to take injectable medications unless administered by another person, would be the appropriate response.

[Q&A ADDED 09/09; M item number updated 09/09; Previously CMS OCCB 1/09 Q&A #14]

**Q168.5 M2030. How would you respond to M2030 if a patient is able to self-inject a pre-filled injectable medication such as Lovenox? Obviously the patient cannot be observed "preparing" a pre-filled injectable. Which response best fits this scenario?**

A168.5. When the medication is supplied by the manufacturer/pharmacy in a pre-filled syringe, the clinician will not include assessment of the patient's ability to fill the syringe. The included tasks in this situation would be handling the syringe using aseptic and safe technique, selecting the correct location in which to inject the medication and injecting it using proper technique and disposing of the needle and syringe appropriately, and the patient could be a "0", "1", "2", or "3".

[Q&A ADDED & EDITED 09/09; M number updated 09/09; Previously CMS OCCB 07/09 Q&A #6]

**Q168.6. M2100 e., M1030, M2020. 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 M1030, M2020, M2100 e. at SOC?**

Q168.6. M1030, 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.

M2020, Management of Oral Medications, would be NA-no oral medications prescribed.

M2100, Types and Sources of Assistance, e. 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 the level of caregiver ability and willingness to provide assistance with managing the equipment.

[Q&A EDITED 09/09]

**Q169. M2100 e. I am unsure how to respond to M2100 e. if my patient has an epidural infusion of pain medication? A subcutaneous infusion?**

A169. Patients receiving epidural infusions or subcutaneous infusions are receiving IV/infusion therapy, therefore, M2100 e. should be answered based on the caregiver's ability and willingness to use associated equipment as ordered. For M2100 e., the caregiver's ability to set up, monitor and change equipment reliably and safely, including adding appropriate fluids or medication, cleaning/storing/disposing of equipment and supplies should be assessed.

[Q&A EDITED 09/09]

**Q170. M2100 e. Does this item include delivery devices for inhaled medications, TENS units, or mechanical compression devices?**

A170. M2100 e. considers management of equipment and supplies only for oxygen, IV/infusion therapy, enteral/parenteral nutrition, and ventilator therapy and do not include the delivery devices or equipment associated with other treatments such as the type listed. (Note that inhaled medications are addressed in M2100 c.)

**Q170.1.** [Q&A RETIRED; Outdated]

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #31]

**Q170.2. M2100 e. Is dialysis thru a central line considered for this question?**

A170.2. Dialysis through a central line is included in M2100 e. as long as the dialysis occurs in the home. M2100 e. reports the caregiver's ability and willingness to manage the equipment used for the delivery of oxygen, IV/infusion therapy, enteral/parenteral nutrition, ventilator equipment or supplies. Dialysis is an infusion therapy.

If the patient were receiving such therapy outside the home, (e.g. at a dialysis center), then M2100 e. would be marked "No assistance needed in this area", assuming the patient care did not include use of any other included services at home (oxygen, enteral nutrition, etc.).

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 07/08 Q&A #18]

**Q170.3. M2100 e. When completing M2100 e., Types and Sources of Assistance; Management of Equipment, is there a consideration for people who use the larger portable oxygen tanks versus the smaller tanks? Some of our patients use liquid oxygen and have the equipment available in the home to refill their tanks. Other patients get the larger oxygen tanks from the DME company. A person may have the ability to fill a larger tank but it is not feasible to have this equipment available in the home. The same question could apply to the various types of IV bags, equipment or solutions used for IV/infusion therapy.**

A170.3. M2100 e., Types and Sources of Assistance; Management of Equipment, reports the caregiver's ability and willingness to set up, monitor and change the equipment that is in the home on the day of the assessment. You do not report what the patient would be able to do if different size tanks or different IV bags or solutions were available. Report the patient's ability on the day of assessment with the equipment they currently have.

[Q&A ADDED & EDITED 09/09; Previously CMS OCCB 01/09 Q&A #15]

**Q170.4. M2100 e. I was wondering on how to handle M2100 e. regarding equipment when we are only performing a flush. I understand from the CMS guidance that a flush is considered an infusion for M1030, as long as it is provided in the home. Would I then consider the syringe as the equipment for M2100e.?**

**Also, we recently had a patient with a fully implanted subcutaneous infusion device. There was no external equipment to assess. Since this was an ongoing infusion, the patient did receive this in the home, and therefore we answered**

**response "1" in M1030- but since there is no equipment to even assess, how do we answer M2100 e.?**

A170.4. M2100 e. assesses the caregiver's ability and willingness to set up, monitor and change the equipment and supplies required for in-home IV/infusion therapy (including flushing), oxygen, and enteral/parenteral nutrition reliably and safely.

If the only equipment utilized to administer an infusion/flush is a needle and syringe, the clinician will assess the caregiver's ability and willingness to select the appropriate syringe and needle, fill the needle with the appropriate solution utilizing safe and appropriate technique, handle the needle and syringe appropriately as they access the port, monitor the administration of the infusion/flush to ensure it is appropriate and safe, change the needles and syringes safely and appropriately and dispose of the needle and syringe safely and appropriately.

In a situation where the infusion is administered via an implanted pump and there is no equipment accessible to the patient or which requires management in the home, the correct response for M2100 e. would be "No assistance needed in this area."

Note that per *Response-Specific Instructions*, if the patient is using more than one type of equipment; consider the equipment for which the most assistance is needed.

**Q171.** [RETIRED 09/09; Outdated]

[Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #32]

**Q171.1. M2100 e. Is it true that nebulizers are not considered when answering M2100 e. unless they are given with oxygen? Are nebulizers considered in these OASIS items?**

A171.1. M2100 e. is restricted to the management of oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment ventilator equipment or supplies. A nebulizer utilizing oxygen in the treatment is considered for these items but a nebulizer without oxygen is not.

**Q171.2.** [RETIRED 09/09; Outdated]

**Q171.3.** [RETIRED 09/09; Outdated]

**Q171.4.** [RETIRED 09/09; Outdated]

**Q171.5.** [RETIRED 09/09; Outdated]

[Q&A ADDED 09/09; M item number updated 09/09; Previously CMS OCCB 10/07 Q&A #10]

**Q171.6 . M2200 & M0110. If we determine that we answered M2200, Therapy Need or M0110, Episode Timing, incorrectly at SOC, ROC or Recert, what actions do we have to take?**

A171.6. In the Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008; Final Rule available at: <http://www.cms.hhs.gov/center/hha.asp> it states:

“The CWF will automatically adjust claims up or down to correct for episode timing (early or later, from M0110) and for therapy need (M0826) when submitted information is found to be incorrect. No canceling and resubmission on the part of HHAs will be required in these instances. Additionally, as the proposed rule noted, providers have the option of using a default answer reflecting an early episode in M0110 in cases where information about episode sequence is not readily available.”

Since medical record documentation standards require a clinician to correct inaccurate information contained in the patient’s medical record, if it comes to the clinician’s attention that the OASIS response for M0110 - Episode Timing is incorrect, the original assessment may be corrected following the agency’s correction policy. Agencies can make this non-key field change to their records and retransmit the corrected assessment to the State system. For example, if the clinician chose “Early” and during the episode, s/he learned that the patient was in a “Later” episode, M0110 may be corrected. Alternatively, in order to maintain compliance with standard medical record accuracy expectations, the clinician or agency could otherwise document the correction in a narrative correction note, or other format, since CMS is not specifically requiring the correction to be made to the OASIS assessment.

It is quite possible that providers may underestimate or overestimate the number of therapy visits M2200 that will be required in the upcoming episode. Because M2200 is an estimation of an exact number of therapy visits the agency expects to provide and the CWF will automatically adjust claims if the estimation is found to be incorrect, there will be no need to go back to the original OASIS assessment and change the M2200 response and resubmit the data.

The clinician cannot be expected to correct what is unknown to them and since in these specific cases the Common Working File (CWF) will automatically adjust claims found to be incorrect, no extraordinary efforts need to be taken after the original data collection to determine the accuracy of the data specific to M0110 and M2200.

[Q&A ADDED 09/09; M item number updated 09/09; Previously CMS OCCB 01/08 Q&A #12]

**Q171.7. M2200 & M0110. How would an agency report M0110 and M2200 when the patient has a HMO/MCO insurance (and is managed by Medicare) when they require a HIPPS code? What if they *don't* require a HIPPS Code?**

A171.7. If the payer requires an HHRG/HIPPS, M0110 should be answered Early, Later or Unknown and M2200 should reflect the number of reasonable and necessary therapy visits planned for the episode. If the payer does not need the HHRG/HIPPS, M0110 and M2200 should be answered NA.

The agency will need to communicate with their non-Medicare Traditional Fee-for-Service (PPS) patient’s payer to determine if they require a HHRG/HIPPS.

[Q&A ADDED 09/09; M item number updated 09/09; Previously CMS OCCB 01/08 Q&A #13]

**Q171.8. M2200 & M0110. I have entered an assessment into HAVEN, it is ready to be locked and exported, but when I try to calculate the HIPPS Code I receive a message that grouper returned blank values. Why is this?**

A171.8. If M0110 or M2200 are marked as 'Not Applicable' then the Grouper will not return a value for the HIPPS Score. To determine how these fields should be completed please contact your state's OASIS Education Coordinator.

Q&A ADDED 09/09; M item numbers updated 09/09; Previously CMS OCCB 01/08 Q&A #26]

**Q171.9. M2200. We are having a huge discussion as to what the meaning of the new M2200 question implies. At present if the admission is done by nursing any rehabilitation service is put on the 485 (plan of care) as a 1 day 1 for evaluation and treatment. Then later the rehabilitation service enters their own orders and frequency as a verbal order after they have completed therapy evaluation. The way the new M2200 reads, some feel the nurse must put on the 485 a total of rehabilitation visits to match the OASIS number placed in the blank even though the rehabilitation service may or may not have made their evaluation visit to the patient by the time the POT and OASIS are to be completed. We realize CMS will adjust the actual number of visits later as the claim is processed but are we expected to put the guess on the 485 at the start of care? Is this a compliance issue?**

A171.9. Chapter 3 of the OASIS-C Guidance Manual states under the Response-Specific Instructions, "Therapy visits must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapist(s); and (b) be reasonable and necessary to the treatment of the patient's illness or injury." It further states under Assessment Strategies "If the number of visits that will be needed is uncertain, provide your best estimate." [

[Q&A ADDED 09/09; Previously CMS OCCB 04/08 Q&A #15]

**Q171.10. M2200. I am uncertain how to answer M2200 in the following situations, please clarify:**

**a. At ROC?**

**b. When patient has multiple payers and some therapy services are covered under the Medicare home health benefit and other therapy services are not (e.g. patient in a long term home health care program (LTHHCP) or one who pays privately for therapy beyond what is considered reasonable and necessary)?**

**c. When I add therapy services mid-episode?**

A171.10.

**a. At ROC** M2200 is an OASIS item with a single use of facilitating payment under the Home Health Prospective Payment System. Typically, at the SOC (RFA 1) and Recertification (RFA 4), data from M2200 (along with other relevant OASIS items) are used to determine the payment under PPS for the current or upcoming episodes respectively. In addition to SOC and Recert, M2200 is also collected at the ROC (RFA3) time point. Typically, data from this ROC is not used for PPS payment determination, and in cases where the data is not needed for payment, response NA - Not Applicable: No case mix group defined by this assessment could be reported on M2200.

Alternatively, providers may choose to report the total of therapy visits that have been provided during the episode to date, added to the number of therapy visits planned to be provided during the remainder of the current episode. If the ROC assessment will not be used to determine payment, then it does not matter which of the above approaches an agency chooses.



While data from the ROC time point does not usually affect PPS payment, there is a specific situation in which it does; that is when a patient under an active home health plan of care is discharged from an inpatient facility back to the care of the home health agency in the last five days of the certification period. In that situation, CMS allows the agency to complete a single ROC assessment to meet the requirements of both the resumption of care and of the pending recertification. When a ROC assessment will be "used as a recert" (i.e., used to determine payment for the upcoming 60 day episode), then the ROC data will be necessary to define a case mix (payment) group, in which case the total number of therapy visits planned for the upcoming 60 day episode should be reported.

**b. Therapy services that are not covered by the Medicare HH benefit:** M2200 should reflect the total number of reasonable and necessary therapy visits (e.g. therapy visits that meet the Medicare home health coverage criteria) that the agency plans to provide during the payment episode. If the agency intends on providing therapy visits that do not meet the Medicare home health coverage criteria (e.g. more frequent than necessary, custodial or repetitive in nature), including those which the agency intends to bill to another (non Medicare PPS) payer, only those visits that meet the Medicare home health benefit coverage should be reported in M2200.

**c. Therapy services added mid-episode:** When therapy services are ordered within the episode, the RFA 5 (other follow up) assessment may be required, depending on your agency's established policy and practice. The number of visits reported in M2200 on the RFA 5 assessment will in no way impact the episode payment under Medicare PPS. Upon submission of the final claim (which will indicate the number of therapy visits provided) the claims processing system will autocorrect the payment to reflect the actual number of therapy visits provided and reimburse the agency accordingly, even if more therapy visits were provided during the episode than were projected at any of the OASIS data collection time points that capture M2200. The agency does not have to go back and make any changes or corrections to M2200 at the SOC or other time points.

**Q172.** [Q&A RETIRED 09/09; Outdated]

[Q&A EDITED 08/07]

**Q173. M2300. The patient was held in the ER suite for observation for 36 hours. Was this a hospital admission or emergent care?**

A173. If the patient were never admitted to the inpatient facility, this encounter would be considered emergent care. The time period that a patient can be 'held' without admission can vary from location to location, so the clinician will want to verify that the patient was never actually admitted to the hospital as an inpatient.

**Q174.** [Q&A RETIRED 09/09; Outdated]

**Q175.** [Q&A RECALLED 08/07]

**Q176.** [Q&A RETIRED 09/09; Outdated]

**Q177.** [Q&A RETIRED 09/09; Outdated]

**Q178.** [Q&A RETIRED 09/09; Outdated]

[Q&A ADDED 06/05; Previously CMS OCCB 10/04 Q&A #11]

**Q179. M2300.** If a patient is admitted to an inpatient facility after initial access in the emergency room, can there be a situation in which that emergent care would NOT be reported on M2300, (i.e., patient is only briefly triaged in ER with immediate and direct admit to the hospital)?

A179. The item-by-item response specific instructions in Chapter 3 of the OASIS-C Guidance Manual clarify that responses to M2300 – 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 M2300 if it occurred since the last time OASIS data were collected.

[Q&A ADDED 06/05; M item numbers updated 09/09]

**Q180. M2300.** A patient whose Start of Care is January 9, has an emergent care visit on January 13 that does not result in hospitalization. The patient is subsequently recertified and discharged on March 17. M2300, which appears on the transfer and discharge assessments, specifies the response should be based on the “last time OASIS data was collected.” Should the response to M2300 regarding emergent care be based on the last time any OASIS assessment was completed, or should it be based on the last assessment where M2300 appears. In this scenario, the item is being asked at the time of discharge where the recertification OASIS was “the last time OASIS data was collected.” Since the emergent care visit occurred before the recertification, it would not have been identified at that time because it is not a required item.

A180. The above scenario does not tell us when recertification assessment was completed. According to the Conditions of Participation for HHA, the recertification visit should have occurred during a five-day period prior to the end of the episode, which should be March 5-9. The OASIS item M2300. Emergent Care, asks for responses to include the entire period since the last time OASIS data were collected, including current events. Since the last time OASIS data were collected was at the recertification assessment, the emergent care visit occurred prior to that date. The correct response to M2300 is 0-no emergent care services were provided.

**Q181.** [Q&A RETIRED 09/09; Outdated]

**Q181.1.** [Q&A RETIRED 09/09; Outdated]

**Q181.2.** [Q&A RETIRED 09/09; Outdated]

[Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #47]

**Q181.3. M2300.** 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?**

A181.3. 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.

**Q181.4.** [Q&A RETIRED 09/09; Outdated]

[Q&A ADDED 09/09; M item number updated 09/09; Previously CMS OCCB 10/08 Q&A #11]

**Q181.5. M2310. We had a patient who attempted suicide using Coumadin. He was sent to the Emergency Room and then admitted to the hospital. When completing the Transfer OASIS data collection, we reported Response 1 - Improper medication administration, side effects, etc. as a reason for emergent care on M2310. Was Response 1 the correct answer, since it was a deliberate action chosen by the patient?**

A181.5. The appropriate response for M2310 would be #1 (improper medication administration, medication side effects, toxicity, anaphylaxis) whenever the patient sought emergent care as a result of improper medication administration, regardless of who (patient, caregiver, or medical staff) administered the medication improperly.

**Q182.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

[Q&A ADDED 06/05; M item number updated 09/09]

**Q183. M2410. A patient receiving skilled nursing care from an HHA under Medicare is periodically placed in a local hospital under a private pay arrangement for family respite. The hospital describes this bed as a purely private arrangement to house a person with no skilled services. This hospital has acute care, swing bed, and nursing care units. The unit where the patient stays is not Medicare certified. Should the agency do a transfer and resumption of care OASIS? How should the agency respond to M0100 and M2410?**

A183. Yes, if the patient was admitted to an inpatient facility, the agency will need to contact the inpatient facility to verify the type of care that the patient is receiving at the inpatient facility and determine the appropriate response to M2410. If the patient is using a hospital bed, response 1 applies; if the patient is using a nursing home bed, response 3 applies. If the patient is using a swing-bed it is necessary to determine whether the patient was occupying a designated hospital bed (response 1 would apply) or a nursing home bed

(response 3 would apply). The hospital utilization department should be able to advise the agency of the type of bed and services the patient utilized.

**Q183.1.** [Q&A RETIRED 09/09; Duplicative of OASIS-C Guidance Manual]

**Q184. M2420. My patient was admitted to the hospital, and I completed the assessment information for Transfer to the Inpatient Facility. His family informed me that he will be going to a nursing home rather than returning home, so my agency will discharge him. How should I complete these items on the discharge assessment?**

A184. Once the transfer information was completed for this patient, no additional OASIS data would be required. Your agency will complete a discharge summary that reports what happened to the patient for the agency clinical record; however, no discharge OASIS assessment is required in this case. The principle that applies to this situation is that the patient has not been under the care of your agency since the inpatient facility admission. Because the agency has not had responsibility for the patient, no additional assessments or OASIS data are necessary.

**Q185.** [Q&A RETIRED 09/09; Outdated]

**Q186.** [Q&A RETIRED 09/09; Outdated]

**Q187.** [Q&A RETIRED 09/09; Outdated]

[Q&A EDITED 09/09]

**Q188. M0903. Do the dates in M0903 and M0090 always need to be the same? What situations might cause them to differ?**

A188. When a patient is discharged from the agency with goals met, the date of the assessment (M0090) and the date of the last home visit (M0903) are likely to be the same. Under three situations, however, these dates are likely to be different. These situations are: (1) transfer to an inpatient facility; (2) patient death at home; and (3) the situation of an “unexpected discharge.” In these situations, the M0090 date is the date the agency learns of the event and completes the required assessment, which is not necessarily associated with a home visit. M0903 must be the date of an actual home visit. See M0100 Q&As for additional guidance on “unexpected discharges.”

[Q&A ADDED 06/05]

**Q189. M0903. What constitutes a “home visit” when responding to OASIS Item M0903? Medicaid programs pay for some home health services provided outside of the home. If these patients receive all their skilled care outside the home, must OASIS data be collected and transmitted? If some of the visits are provided outside of the home should a visit provided outside the home be considered the last visit for M0903, or should M0903 be the last visit at the patient’s home?**

A189. The date of the last (most recent) home visit (for responding to M0903) is the last visit occurring under the plan of treatment. The HHA must conduct the comprehensive assessment and collect and transmit OASIS items for Medicaid patients receiving skilled care.

[Q&A ADDED 06/05]

**Q190. M0903/M0906. When a speech therapist is the last service in a patient's home, our agency has chosen to use an RN to complete the discharge assessment (with OASIS) as a non-billable visit. If the patient meets the speech therapist's goals on day 50 of the episode, but we cannot schedule an RN until day 51 of the episode, how do we respond to M0903 and M0906?**

A190. If the agency policy is to have an RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge assessment after the last visit by the SLP. This planned visit should be documented on the Plan of Care. The RN visit to conduct the discharge assessment is a non-billable visit. M0903 (Date of Last/Most Recent Home Visit) would be the date of the last visit by the agency; in this case it would be the date of the RN visit. The date for M0906 (Discharge/Transfer/Death Date) would be determined by agency policy. The date of the actual agency discharge date would be entered here. When the agency establishes its policy regarding the date of discharge, it should be noted that a date for M0906 (Discharge/Transfer/Death Date) that precedes the date in M0903 (Date of Last/Most Recent Home Visit) would result in a fatal error, preventing the assessment from being transmitted.

[Q&A EDITED 08/07]

**Q191. M0906. My patient died at home 12/01 after the last visit of 11/30. I did not learn of her death until 12/04. How do I complete M0903 and M0906? What about M0090?**

A191. You will complete an agency discharge for the reason of death at home (RFA 8 for M0100). M0090 would be 12/04 -- the date you learned of her death and completed the assessment. M0903 (date of last home visit) would be 11/30, and M0906 (death date) would be 12/01.

[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #36]

**Q191.1. M0906. How do you answer M0906 on a Transfer OASIS when a patient is transferred to an inpatient facility (hospital) during the evening of 1/24/07 but doesn't get admitted to the inpatient facility until 1/25/07?**

A191.1. Transfer is not defined as the date the patient was transported to the inpatient facility, or the date that the patient was transported and/or treated in the emergency department. Assuming the patient's inpatient admission lasted 24 or more hours, and included care/services other than diagnostic testing, the Transfer date would be the actual date the patient was admitted to the inpatient facility. If, as in your example, the transportation occurred during the evening of 1/24/07, but the inpatient facility admission did not occur until 1/25/07, M0906 Transfer/Discharge/Death Date would be 1/25/07.

