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 [Q&A RETIRED 09/09; Outdated]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

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. This file 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/HomeHealthQualityInitiatives/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/HomeHealthQualityInitiatives/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/HomeHealthQualityInitiatives/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/HomeHealthQualityInitiatives/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

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 [Q&A RETIRED 09/09; Outdated]

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.

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

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. M1020/1022/1024/1308/2100/2250/2400) 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]**

**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.

**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]**

Category 4 – OASIS Data Set – Forms and Items 01/10
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]

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.

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 01/10; 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 and through record review 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.
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.

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.

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.
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.

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:

- Can the agency perform the RFA 09 and RFA 01 on the same visit?
- If so, what is the discharge date for the RFA 09 at M0090?
- If so, what is the admission date for RFA 01 at M0090?
- Will recording of the same date for both of these assessments 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.

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 1st and records that date at M0090. On Feb 2nd 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 2nd 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.

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.

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.

Category 4 – OASIS Data Set – Forms and Items 01/10
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.

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”.

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.
**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.
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.

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.

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, Response 1, Yes, used hospital emergency department WITHOUT hospital admission, is the appropriate response for a patient who was held in an emergency department for outpatient observation services without a subsequent qualifying hospital admission. A qualifying hospital admission is an admission to a hospital inpatient bed for 24 hours or longer for reasons other than diagnostic testing. A Transfer OASIS is not required as the patient did not meet the criteria for the RFA 6 or 7.

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 that 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 5th, 2007 (with an end of payment episode date of Sept 2nd), then recertified on Sept 3rd (with an end of episode date November 1st, 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 continue counting to, and including, the first day of the next episode. In the scenario presented,. In this example, November 1st 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 1st), November 2nd 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 1st 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 2nd 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 2nd episode. A partial episode payment will apply to the 2nd 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

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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/hhppsru/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; 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.qtso.com/hhadownload.html; scroll down the list of available resources and click on the link for HHAcorrectionpolicy.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

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 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 data base. If the assessment is not deleted, the patient identifiable data will remain in the data base, 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 01/10]
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 long term nursing facility or 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 proceeding the first day of the new certification period.
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.

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 place 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.

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.

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.
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]

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) data collection time point? 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 data collection time point. 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 that was not due to an improvement in the diagnosis.

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 that was not due to an improvement in their diagnosis. 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.

Q43.1. [Q&A RETIRED 09/09; Outdated]

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
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.

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.
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. 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 & EDITED 01/10; Previously CMS OCCB 04/08 Q&A #6]

Q44.4. 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 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 data set is being used to determine an HH/PPS. M1024 is optional, and may be completed for any assessment which will be used to generate an HH/PPS 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 (HH/PPS). 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.

**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]

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.

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.

Q53.4. 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.

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.

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.

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]

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

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?

A89.2. 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]
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.

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.

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 in the WOCN Guidance Document and at the NPUAP site at www.npuap.org.

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]

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

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.

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 scored as a surgical wound?

A103. Yes.

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.

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.

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 M1340, 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 01/10; 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 M1340, Does this patient have a Surgical Wound and M1350, Skin Lesion or Open Wound.

[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 re-epithelialization has been present for approximately 30 days at which time it becomes 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 & EDITED 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 would be reported as a surgical wound...
wound for M1340 until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

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 re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

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.

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 re-epithelialization has been present for approximately 30 days at which time it becomes a scar) 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]

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 & EDITED 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 M1340. It remains a surgical wound after the drain is pulled until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.
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 re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

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 re-epithelialization has been present for approximately 30 days at which time it becomes a scar) 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 until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

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 and the wound is re-epithelialized for approximately 30 days at which time it becomes a scar.

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.

Q105.17. M1340. Would an enterocutaneous fistula that developed as a result of a surgery be documented as a surgical wound?
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”.

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.

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 re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

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 re-epithelialization has been present for approximately 30 days at which time it becomes a scar. At this point it is no longer considered a current surgical wound, as the VP shunt is neither venous access device nor an infusion device.

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 07/08 Q&A #11]

Q108.01. M1340. When does a surgical wound become “healed” or no longer reportable as a surgical wound on M1340?

A108.01. For the purposes of determining the healing status for this OASIS item, a surgical wound can be considered fully healed and not reportable as a current surgical wound once re-epithelialization has been present for approximately 30 days at which time it becomes a scar. The incision must be clean, dry and completely closed with no signs or symptoms of infection.

[Q&A ADDED 09/09; M number updated 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 once re-epithelialization has been present for approximately 30 days. 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 once re-epithelialization has been present for approximately 30 days (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 1 – Fully granulating 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]

Q111.1. 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.
   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 can be considered fully healed and not reportable as a current surgical wound 4 weeks 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]
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. 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 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 01/10; 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) and a new PEG site (gastrostomy) would be considered a skin lesion or wound at M1350, if they 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.
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.

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.

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.
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).

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.

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.

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]
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]

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.)

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.

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 prosthesis 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.

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.
**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.

**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.

**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 M1820. 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.
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&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&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&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&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 started 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.

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]

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]
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 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 01/10]
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/chair to bed transfer should be considered when responding to the item.

[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?

Category 4 – OASIS Data Set – Forms and Items 01/10
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 09/09; EDITED 01/10; 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 and from the chair back into bed. 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]**

**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]**

**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. 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 01/10; 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 a two-handed device and/or human assistance at times but not constantly (Response 2).

Response 0, Able to independently walk on even and uneven surfaces and negotiate 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.


[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, Toilet 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]
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]

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.
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/overtaining 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]

A167.5. 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.

Q167.5. [Q&A ADDED & EDITED 09/09; Previously CMS OCCB 10/08 Q&A #9]

Category 4 – OASIS Data Set – Forms and Items 01/10
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 the 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.

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.
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.
Q170. [Q&A RETIRED; Outdated]

Q170.1. [Q&A RETIRED; Outdated]

[Q&A EDITED 01/10; 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 as ordered and includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment of supplies, continuous passive motion machine, wheelchair, hoyer lift, etc. 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 09/09 & EDITED 01/10; 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 M2100 e.?

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 safely use equipment as ordered. 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]
Q171.1. [RETIRED 09/09; Outdated]
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 UPDATED 01/10; 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.

See Category 2, Question 37.2 for guidance regarding other options.

**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.