CATEGORY 4 - OASIS DATA SET: FORMS and ITEMS

Category 4A - General OASIS forms questions.

Q1. Will there be any further revisions to the OASIS-B1 data set currently posted on the OASIS website?

A1. The most current version of the OASIS data set will always be available on the OASIS website http://www.cms.hhs.gov/oasis/oasisdat.asp. When revisions are necessary in the future, we will post them on the website well in advance of their effective dates.

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 provide the proper instructions. 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/datasubm.asp. This file that contains the OASIS data items in the same order as contained on the OASIS data set.

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 User's Manual*, Chapter 12 available at http://www.cms.hhs.gov/oasis/usermanu.asp.

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

A5. We have posted 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/oasis/oasisdat.asp.

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 M0xxx numbers when integrating to alert clinicians that the M0xxx labeled items MUST be assessed and completed. Ultimately this will minimize delays in encoding due to uncompleted OASIS data items. Please refer to Appendix C of the *OASIS User's Manual* (available at http://www.cms.hhs.gov/oasis/usermanu.asp) for examples of a comprehensive assessment (sample clinical records) showing an integration of the OASIS data items with other agency assessment items for each time point. The OASIS data sets are available in Appendix B in the *OASIS User's Manual* or on the OASIS Data Sets page at http://www.cms.hhs.gov/oasis/oasisdat.asp.

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

A7. The sample assessment forms (incorporating OASIS items) found on the OASIS Data Sets page (http://www.cms.hhs.gov/oasis/oasisdat.asp) most closely resemble nursing assessments. 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 Chapters 4 and 7 of the *OASIS User's Manual* available at http://www.cms.hhs.gov/oasis/usermanu.asp.

Q8. The start of care (SOC) version of OASIS posted on the OASIS web site shows the description of M0550 with two definers, a) and b). However, the Discharge and Transfer versions do not show both definers. Should the definers be included at all assessment time points?

A8. The a) definer (related to an inpatient stay) is specific to SOC (or resumption of care after an inpatient stay). It is not appropriate for the Discharge and Follow-up and therefore is omitted from those time point versions. This data item also is not included in the Transfer assessment.

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/providers/hha/#oasis, 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 http://www.cms.hhs.gov/providers/hha/#oasis, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

Q11. Our agency completes the Reduced Burden Recertification assessment that has only 26 items. Is this sufficient to meet the CoP for the follow-up assessment?

A11. The twenty-six OASIS items are not a complete comprehensive assessment and must also have either the agency-determined components of the Follow-Up assessment or a clinical note describing the health status of the patient. Please refer to Appendix C of the *OASIS User's Manual* (available at http://www.cms.hhs.gov/oasis/usermanu.asp) for sample clinical forms demonstrating the integration of OASIS items into comprehensive assessments, one for each time point.

Q12. In some places in the OASIS User's Manual, the prior 14 days is referred to as being a 'point in time' and in other places, it is referred to as a 'period of time'. Are the '14 days prior' assessment items to be based on what the patient was doing on the 14th day prior to the assessment or on what the patient could usually do the majority of the time during the 14-day period prior to the assessment?

A12. In the ADL/IADL data items (M0640 through M0800), the patient's ability 14 days prior to the start (or resumption) of care is addressed. In these items, 'prior' indicates the patient's status on the 14th day before the start (or resumption) of care. Adhere strictly to this 14-day time point. If the patient was in a hospital at that time, describe the status that day. Several other OASIS items (e.g., M0170, M0200, etc.) address events that may have occurred within the last 14 days. In responding to those items, the entire 14-day period should be considered. For example, was the patient discharged from an inpatient facility during that time?

Q13. There seems to be a discrepancy between the instructions in the OASIS User's Manual regarding M0890, M0895, and M0900. In Appendix B, these three items are omitted from the discharge assessment, yet the items are included in the Inpatient Transfer with Discharge grouping. Should these items be included in the discharge assessment?

A13. The answer to this question depends on whether your agency uses separate assessment forms for Transfer to an Inpatient Facility and for Discharge (not to an inpatient facility). If it has separate forms, these three data items should be included in the assessment for Transfer to Inpatient Facility and not included in the Discharge assessment. On the Transfer to an Inpatient Facility, these items are included in the list of assessment items to be completed. Under Discharge from Agency - Not to an Inpatient Facility, these items are correctly not included. If your agency uses only one form that includes both Transfer and Discharge, however, these items should be included.

Q14. Our agency has created separate clinical documentation forms for Transfer to Inpatient Facility and for Discharge. On our Discharge form, we omitted M0890, M0895, and M0900 according to the web site information. Yet, when a clinician answers 'hospital' for M0855 on the Discharge form, she is directed to skip to M0890 (which is not included). What should happen in this scenario?

A14. Because your agency has a separate clinical form for Transfer to Inpatient Facility, the clinician should NOT be marking 'hospital' on the Discharge form (for M0855) because a discharge assessment is not correct at the time of transfer. Instead, the clinician should be using the Transfer form, which will direct her/him from M0855 to M0890 when 'hospital' is marked on that form. (M0890, M0895, and M0900 are all included in the Transfer data items.) For HHAs with separate Transfer and Discharge forms, the only correct response to M0855 on the Discharge form is 'NA - No inpatient facility admission.' This is an excellent training reminder to share with your staff.

Q15. Was OASIS item M0160 (Financial Factors) eliminated? If so, does this mean that this item was not weighted heavily in the risk adjustment formulas? It appears that financial factors would seriously affect outcomes.

A15. M0160 was required to be collected since OASIS was implemented, but the responses to this item never have been transmitted to the State. Because the data have never been transmitted, there was no way that they could enter into the data analysis and risk adjustment processes. Therefore, a CMS decision was made to eliminate the item effective December 2002. Eliminating the item from OASIS does not mean it is not important information to consider in care planning; agencies may choose to include information about financial factors in their agency-specific comprehensive assessment.

Q16. Please explain the skip patterns related to pressure ulcers and stasis ulcers for OASIS items M0460, M0478, M0488, and M0530 at follow-up (RFA 4,5). What do you fill in and what do you skip?

A16. The skip patterns were modified only for the follow-up/recertification time points (RFAs 4 and 5), due to the changes in the required data items for those assessments based on industry requests, effective December 2002. There were no changes to the skip patterns associated with these items for Reason for Assessments (RFAs) 1, 3, 6, 7, 8, and 9. At the recertification or other follow-up time points, M0460 can be skipped if the patient has no pressure ulcer, M0476 can be skipped if the patient has no stasis ulcer, M0488 can be skipped if the patient has no surgical wound, and M0530 can be skipped if the patient has no urinary incontinence or has a urinary catheter. In designing their clinical documentation for these time points, agencies should pay very close attention to these skip patterns. Agencies may choose to retain all of the wound and urinary continence items in their forms. Non-required items submitted will not be stored on the State's database.

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. 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.
[Q&A added 06/05]

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 "M000" numbers stand for?

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

Q5. M0016. What do I enter in M0016 Branch ID after January 1, 2004 if I am an HHA with no branches, a parent, a subunit, or a branch?

A5. If you are a HHA with no branches, please enter "N" followed by 9 spaces. If you are a parent HHA that has branches, please enter "P" followed by 9 spaces. If you are a subunit with no branches, please enter "P" followed by 9 spaces. If you are a branch, enter the Branch ID number assigned by the Regional Office (RO). The Branch identifier consists of 10 digits – the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS assigned branch number.

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 when the patient was admitted to the agency and continues 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.

Q8. M0032. How should resumption of care (ROC) be documented if it occurred in a previous 60-day episode/ certification period? What if the latest resumption of care (ROC) was in a previous 60-day episode?

A8. The most recent ROC should be documented, even if it was in a previous 60-day payment episode, as long as the patient has not been discharged from the agency since the most recent ROC.

Q9. M0040. On M0040, the manual lists the name requirement as 'First, MI, Last, Suffix' but the HAVEN software requires 'Last, First, MI, Suffix.' Can we change the order on our forms to match the software?

A9. Yes.

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.

Q11. M0072. With regard to M0072, what is the Primary Referring Physician ID?

A11. For item M0072, we are requesting the current UPIN number for now; however, we have allowed for the new national provider number (NPI) that will be assigned in the future. When the NPI number is finalized and published, we will provide additional guidance.

Q12. M0072. For M0072, are you requesting the ID of the physician who sent the referral or the ID of the primary physician responsible for the patient and who will sign the Plan of Care? They may be different.

A12. If these are different, you should use the same physician information used for filing Medicare (or other) claims to complete M0072. This should be the ID of the physician who signs the plan of care.

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 are able to complete the assessment. Social workers are not able to initiate a qualifying Medicare home health benefit, 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/providers/hha/#oasis, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category.

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 a clinical data item, M0090 should reflect that date.

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 locked and 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. 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 coincide with a home visit. The transfer or death at home assessments (RFAs 6, 7, or 8 for M0100) will have the date the agency learns of the event recorded at M0090. However, in the rare instance that 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 was 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 code based upon the written diagnosis. 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.
[Q&A added 06/05]

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 date the actual assessment of the patient was completed.

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

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

A19. Under normal business practices, one home health visit should not include two types of assessments and be billed to two payer sources. The discharge date for the (RFA 09) Discharge from Agency should be the last date of service for the payer being terminated. The admission date for the new Start of Care (RFA 01) assessment should be the next scheduled visit, according to the plan of care. The agency may send a batch including both assessments to the state system. An edit is in place at the state system to sort for an assessment to close an open patient episode prior to opening a new episode.
[Q&A added 06/05]

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. Note that the text of the item indicates that it means transfer to an inpatient facility.

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. You are correct that RFA 1 is the appropriate response on M0100 for a one-visit Medicare PPS patient. The OASIS data should be encoded (data entered) to generate a Health Insurance Prospective Payment System (HIPPS) code and transmitted to the State system. No discharge assessment is required, as the patient received only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent discharge information must be collected or submitted, but the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the name will be dropped. 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. M0100. Which reason for assessment (RFA) should be used when a patient is transferred to another agency?

A22. When a patient is transferred from one agency to another, the patient must be discharged using RFA 9 to enable the new agency to bill for the patient's care.

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 M0855?

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 M0855. If the patient is using a hospital bed, response 1 applies; if the patient is using a nursing home bed, response 3 applies. If the patient is using a swing-bed it is necessary to determine whether the patient was occupying a designated hospital bed, response 1 applies; or a nursing home bed, response 3 applies. The hospital utilization department should be able to advise the agency of the type of bed and services the patient utilized.
[Q&A added 06/05]

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) for the home care episode. Note that the text of M0150 asks for the "current payment source**s**" (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 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, Medicare is always a likely 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. M0150. Is M0150 (Current Payment Sources for Home Care) limited to payment for home care services? If a patient had out-of-pocket expenses for DME or for prescription or over-the-counter medications, should Response "10" – Self-pay be marked?

A26. If equipment or medications essential or integral to the home care episode are being paid by the patient, in part or full, then Response 10 – Self Pay should be marked. [Q&A added 06/05]

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 added 06/05]

Q28. 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. There is a discussion of payer source change in Chapter 8, Section E, of the *OASIS User's Manual.* 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 page 89 of the document to read "Section 80 - special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your RHHI.

Q29. M0150. Which pay sources should be noted when responding to M0150, current payment sources for home care?

A29. All current pay sources should be noted when responding to this item regardless of whether the pay source is primary or secondary. If Medicare and other pay source(s) are paying for care provided by a single agency, all the relevant pay sources should be noted. Note that the text of M0150 contains the instruction, "Mark all that apply."

Q30. M0175. If the patient has outpatient surgery within the 14-day time frame described in M0175, should 1 or NA be marked?

A30. The correct response would be 'NA' for M0175 because the patient's status would have been an outpatient for this situation.

Q31. M0175. For M0175, what is the difference between response 3 (skilled nursing facility) and response 4 (other nursing home)?

A31. A skilled nursing facility (response 3) means a Medicare-certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit. Other nursing facilities (response 4) include intermediate care facilities for persons with mental retardation (ICF/MR) and nursing facilities (NF).

Q32. M0175. M0175 refers to the inpatient facility from which the patient was discharged within the last 14 days. Please define 14 days.

A32. "During the past 14 days" refers to the two-week period immediately preceding the start of care/resumption of care (SOC/ROC) date or the first day of the new certification period at follow-up. The easiest way to determine this is to refer to a calendar. For example, if the SOC/ROC is Wednesday, August 20, look at a calendar to refer to the same day of the week two weeks ago, which in this case is August 6. For follow-up assessments, count fourteen days before the first day of the new certification period. For more information please refer to *Medicare Resources for Researching Inpatient Discharges within 14 Days of a Home Health Admission* found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0410.pdf.
[Q&A edited 06/05]

Q33. M0180. In OASIS field M0180, if there is no date, do you just fill in zeros?

A33. As noted in the skip instructions for item M0175, if the patient was not discharged from an inpatient facility within the past 14 days, (i.e., M0175 has a response of NA), M0180 and M0190 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 M0180 and leave the date blank.

Q34. M0190. How would additional inpatient facility diagnoses and ICD-9-CM codes be entered into M0190 since the field only allows for two sets of codes? When we include this item in our clinical forms, can we add more lines?

A34. M0190 requests the two primary diagnoses that were actively treated during the inpatient facility stay, not all diagnoses that the patient may have. Agencies should carefully consider whether additional information is needed and, if so, how only the most relevant information is listed in "a" and "b" of M0190. 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 M0190.

Q35. M0190. 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.

Q36. M0190. 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 severity indices. The clinician should write-in the medical diagnosis requested in M0210, M0230/M0240, and M0245, if applicable. A coding specialist in the agency may enter the actual ICD 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. M0190/M0210. What is the difference between M0190 and M0210?

A37. M0190 and M0210 refer to two separate situations. M0190 relates to a patient who has been discharged from an inpatient facility within the past 14 days and reports the diagnoses for conditions that were treated during the inpatient facility stay. M0210 relates to a change in the patient's medical or treatment regimen during the same past 14 days. The diagnoses in the two items may be the same, but there is no requirement that they be identical. For a patient who was not discharged from an inpatient facility during the past 14 days, M0190 would be skipped.

Q38. M0200/M0210. Please clarify M0200 - Medical or Treatment Regimen Change within past 14 days and M0210 - Medical Diagnoses (for conditions requiring the change).

A38. For M0200, identify whether any change has occurred in the patient's medical or treatment regimen in the past 14 days. Is there a new diagnosis or an exacerbation of an old diagnosis that necessitates a change in the treatment regimen? For example, has there been a medication dosage change? Are therapy services newly ordered as a treatment regimen change? Has a regimen change occurred in response to a change in patient health status? M0210 then asks what medical diagnosis has necessitated this change in regimen? Was the diuretic increased due to an exacerbation of congestive heart failure? Was the patient started on insulin due to a new diagnosis of diabetes?

Q39. M0200. Must the "new or changed diagnosis" have occurred in the last 14 days?

A39. M0200 asks about a change in the patient's medical or treatment regimen, not about a "new or changed diagnosis." It is possible that the treatment regimen change occurred because of a new or changed diagnosis, but the item only asks about the medical or treatment regimen change occurring within the past 14 days. The change may have occurred because of an exacerbation of an existing diagnosis.

Q40. M0200. 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. M0200. 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. Does the patient's referral and admission to the home health agency "count" as a medical or treatment change within the past 14 days?

A42. No.

Q43. M0210. For the medical diagnosis in the changed medication section at OASIS item M0210, 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 M0210 identifies the diagnosis(es) causing a change to the patient's treatment regimen, health care services, or medication within the past 14 days. The ICD 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.

Q44. M0230/M0240/M0245. It is difficult to understand when an ICD-9-CM code must be entered at M0245. Where can we find help?

A44. For Clarification of OASIS items M0230, M0240, and M0245 please refer to the *OASIS User's Manual*, Attachment D to Chapter 8, at: http://www.cms.hhs.gov/oasis/usermanu.asp. Additionally, the "Correct Diagnosis Coding Practices" document originally posted by CMS in 2001 has been updated and is posted at http://www.cms.hhs.gov/providers/hhapps/#home. It is titled, "OASIS Diagnosis Reporting: Case Examples."

Q45. M0250. Does M0250 refer to the therapies the patient is receiving when the staff member walks in to do the OASIS assessment? What if the patient is known to need enteral feedings and is scheduled for setup post-OASIS assessment? Please clarify.

A45. M0250 refers to therapies the patient is receiving at the time of the assessment visit or which the patient is ordered to receive as a result of the assessment visit. For example, if the assessment reveals the existence of dehydration, and the clinician's communication results in an order for IV therapy, response 1 would be marked.

Q46. M0250. Does a central line (OR subcutaneous infusion OR epidural infusion OR intrathecal infusion OR an insulin pump OR home dialysis, including peritoneal dialysis) "count" in responding to M0250?

A46. Only one question must be answered to determine whether these examples "count" as IV or infusion therapy -- is the patient receiving such therapy at home? If the patient were receiving such therapy at home, then response 1 for M0250 would be appropriate. If the infusion therapy is administered in the physician's office or outpatient center or dialysis center, response 4 would be marked.
[Q&A edited 06/05]

Q47. M0250. 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.

Q48. M0250. If the patient refuses tube feedings, does this "count" as enteral nutrition?

A48. Because the patient is not currently receiving enteral nutrition, 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. M0250. If the caregiver provides the enteral nutrition independently, should response 3 be marked, or does the HHA need to provide the care?

A49. M0250 simply asks about therapies the patient is receiving at home. Since this patient is receiving enteral nutrition at home, response 3 should be marked.

Q50. M0250. 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 M0250 (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."

Q51. M0250. Does M0250 relate to other OASIS items?

A51. Note the subsequent items of M0810 (Patient Management of Equipment) and M0820 (Caregiver Management of Equipment), which address IV/infusion therapy and enteral/parenteral equipment or supplies.

Q52. M0250. If the discharge visit includes discontinuing IV or infusion therapy, should the OASIS item (M0250) reflect the presence of these services on the discharge assessment?

A52. Yes, if the IV is being discontinued the day of the assessment visit, then those respective services can be marked as "present" at the assessment.
[Q&A added 06/05]

Q53. M0250. A patient has an order on admission for an IV infusion to be given prn, if specific parameters are present. None of the parameters exist at SOC, and no IV line is inserted. What is the appropriate response to M0250?

A53. If the patient receives an IV infusion as a result of the SOC assessment (i.e., the predetermined parameters are met), then response 1 is appropriate. If the parameters are not met at the SOC assessment, then response 1 does NOT apply. Also note, that since there are physician orders for IV therapy based on potential changes in the patient's condition, no Significant Change in Condition (SCIC) would result if the parameters were met later in the episode.
[Q&A added 06/05]

Q54. M0260. Does Overall Prognosis, M0260, refer to the prognosis of the primary diagnosis or the overall prognosis? For instance, if a patient had a primary diagnosis of fractured hip from which he would recover and a secondary diagnosis of cancer for which gradual deterioration was expected, would the prognosis be "good" because it refers only to the hip fracture?

A54. The focus of M0260 is the overall prognosis for recovery from this episode of illness (for which the home care is being provided). In the example, if the patient's recovery from the hip fracture is complicated by metastasis of the cancer to the bone, then the patient's condition might be noted as response 0-Poor, according to the clinician's assessment. Patient prognosis is also required for the Plan of Treatment.

Q55. M0280. Life Expectancy is assessed at the Start of Care, Resumption of Care, and at Discharge. We don't have the opportunity to change this response if there is a change in the patient and there is no intervening inpatient stay. What should we do?

A55. The reduced burden OASIS did remove the opportunity to update this item with another assessment (RFA4/5). Please document any changes in your patient in the patient's clinical record when there is a change in his/her status.

Q56. M0340. How should we respond to M0340 for patients living in an Assisted Living Facility (ALF)?

A56. Rules for licensing Assisted Living Facilities vary from State to State, and the actual physical structural arrangements vary from one facility to another, so the answer must be selected that is most appropriate for the individual situation. This item simply asks who the patient lives with, not about the type of assistance that the patient receives. For example: a patient living in his/her own room would be response #1, Lives alone, while a patient sharing a room or studio apartment with someone would be response #2 (With spouse or significant other) or #4 (With a friend).

Q57. M0340. My patient lives alone Monday through Friday but has hired help to stay with her on the weekend; how should I respond to this item?

A57. Weekend help would be considered "intermittent' help according to the item-by-item tips found in Chapter 8 of the *OASIS User's Manual*. Therefore, the correct response in this situation would be "1 - Lives alone."

Q58. M0350. How should we respond to M0350 for patients living in an Assisted Living Facility (ALF)?

A58. Rules for licensing Assisted Living Facilities (ALFs) vary from State to State, and the actual physical structural arrangements vary from one facility to another, so the answer must be selected that is most appropriate for the individual situation. Most patients in an ALF are receiving paid help, at least (#3 under M0350), although they may also be receiving help from others listed. We cannot think of any instances in which a resident of an ALF would be receiving help classified as 'None of the above' (#4 under M0350). Refer to the explanation for this item in the *OASIS User's Manual*, Chapter 8, available at http://www.cms.hhs.gov/oasis/usermanu.asp.

Q59. M0350. Is Meals-on-Wheels considered assistance for M0350?

A59. M0350 is asking the clinician to identify assisting person(s) other than home care agency staff. Response 3, paid help, includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family or a specific program. Meals-on-Wheels is a community-based service that assists the homebound by delivering meals and would be included in responding to M0350.
[Q&A added 06/05]

Q60. M0360. How should we respond to OASIS item M0360 for patients living in an Assisted Living Facility (ALF)?

A60. Rules for licensing ALFs vary from State to State, and the actual physical structural arrangements vary from one facility to another, so the answer must be selected that is most appropriate for the individual situation. The clinician making the assessment will need to determine who the primary caregiver is, and mark the appropriate response under M0360 and continue through the remaining items pertaining

to the assistance provided by the primary caregiver. Refer to the explanations for these items in the *OASIS User's Manual*, Chapter 8, available at http://www.cms.hhs.gov/oasis/usermanu.asp.

Q61. M0360. How should the item be answered if one person takes the lead responsibility, but another individual helps out most frequently?

A61. The clinician should assess further to determine whether one of these individuals should be designated as the primary caregiver or whether response 0 (No one person) is the most appropriate description of the situation.

Q62. M0390. Are reading glasses bought at the grocery store considered corrective lenses? What about a patient who uses a magnifying glass to read the paper -- is this a corrective lens?

A62. Reading glasses are considered corrective lenses. A magnifying glass is not considered an example of corrective lenses.

Q63. M0390. How is vision evaluated for the patient who is too disoriented and cognitively impaired for the clinician to assess?

A63. A caregiver may be able to assist by demonstrating the patient's response to an object that is familiar to him/her. Alternatively, this could be a situation where the patient is not able to respond, thus is nonresponsive (response 2).

Q64. M0390. 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.

Q65. M0400. Our agency would like clarification concerning M0400 - Hearing and Ability to Understand Spoken language 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 'No observable impairment' (0) and 'Unable to hear and understand familiar words or common expressions consistently, or patient nonresponsive' (4) 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. M0400. Is it correct that both auditory and receptive language functions are included in responding to this item? Therefore a deaf patient who processes spoken language effectively using lip reading strategies is scored at response

level 4 (Unable to hear and understand) because the item measures the combination of BOTH hearing and comprehension?

A66. Yes, M0400 does include assessment of both hearing AND understanding spoken language. A patient unable to hear (even with the use of hearing aids if the patient usually uses them) would be scored at response level 4.
[Q&A added 06/05]

Q67. M0410. How do I respond to this item if the patient uses sign language? What about a patient who communicates by writing?

A67. This item addresses the patient's ability to speak and orally (verbally) express himself/herself, not general communication ability. If the patient depends entirely on sign language or writing and is unable to speak, response 5 applies. The clinician would want to document the patient's general communication ability in another location in the clinical record, as this is important for care provision.

Q68. M0410. Can this item be answered if a patient is trained in esophageal speaking or uses an electrolarynx?

A68. Augmented speech (through the use of esophageal speech or an electrolarynx) is considered oral/verbal expression of language.

Q69. M0420. How can you assess pain in a nonverbal patient? A nonresponsive patient?

A69. Nonverbal or nonresponsive patients experience pain, and careful observation establishes its presence and an estimation of its severity. The clinician should observe facial expression (frowning, gritting teeth), note changes in pulse rate, respiratory rate, perspiration, pallor, pupil size, or irritability. A nonverbal (but responsive) patient could also utilize a visual analog scale to describe the pain being experienced.

Q70. M0420. For pain to "interfere," does it have to prevent that activity from occurring? Or just alter or affect the frequency or method with which the patient carries out the activity?

A70. For pain to interfere with activity, it does not have to totally prevent the activity. Examples of how pain can interfere with activity without preventing it include: if pain causes the activity to take longer to complete, results in the activity being performed less often than otherwise desired by the patient, or requires the patient to have additional assistance.
[Q&A added 06/05]

Q71. M0420. 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 considers as “affected” or “interfered with” by pain, and the frequency of such interference should be assessed when responding to M0420.
[Q&A added 06/05]

Q72. M0420. 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 M0420 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 M0420 reports the frequency that pain interferes with activity (not the presence of pain itself), then M0420 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]

Q73. M0420. 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. M0420 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, M0420 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 M0420 and, given the information in the scenario, pain apparently is not interfering with the patient's activity. .
[Q&A added 06/05]

Q74. M0430. Our agency would like clarification of the question concerning how M0430, Intractable pain, is assessed. In our agency, intractable pain is often interpreted as cancer pain. However, the term used in the question, 'not easily relieved' opens the door to very wide interpretation.

A74. In this data item, we are assessing the presence of intractable pain as defined in Chapter 8 of the *OASIS User's Manual*. Intractable pain refers not only to cancer pain but also to pain that is ever present, which may affect the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, or ability or desire to perform activity. This type of pain likely interferes with the patient's activities and needs to be considered when developing the plan of care.

Q75. M0430. 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. Based on the information provided, would this patient be considered to have intractable pain?

A75. Intractable pain refers to pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, or ability or desire to perform activity. Intractable pain is ever present. The clinician making the assessment will determine if the patient's pain meets the components of the definition of intractable pain. If the pain is well controlled by round-the-clock pharmacologic interventions, then the pain may not occur daily, and therefore would not be considered intractable. The assessing clinician, with input from the patient, will determine if the pain is easily relieved and will identify the effects of the pain on the patient's activities and life. Note that M0420 and M0430 are separate items and should be assessed and considered separately. There is not an "if response … on M0420, then response … on M0430" algorithm that is appropriate to follow in responding to these items.
[Q&A added 06/05]

Q76. M0430. For intractable pain, must the pain meet all three criteria listed in the item (i.e. (1) be not easily relieved, (2) occur at least daily, and (3) affect the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity) in order to be considered "intractable?"

A76. Yes, the pain must be not easily relieved, be present at least daily, and affect the patient's quality of life as outlined in the item wording.
[Q&A added 06/05]

Q77. M0430. The Chapter 8 assessment strategies describe intractable pain as "ever present." Does this mean that if pain occurs daily, but not constantly, that it could not be considered "intractable?"

A77. Intractable pain, refers to pain that is not easily relieved, occurs at least daily and, affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, or ability or desire to perform activity. While the pain does not need to be constant to be considered intractable, the combination of the pain, its effects on the patient's quality of life and activities, and the effort to manage the pain must be involved, or "ever present."
[Q&A added 06/05]

Q78. M0440. For M0440, Integumentary Status, please clarify CMS's interpretation of a skin lesion.

A78. 'Lesion' is a broad term used to describe an area of pathologically altered tissue. Wounds, sores, ulcers, rashes, crusts, etc. are all considered lesions. So are bruises or scars. In responding to the item, the only 'lesions' that should be disregarded are those that end in 'ostomy' (e.g., tracheostomy, gastrostomy, etc.) or peripheral IV sites (central line sites are considered to be surgical wounds). For additional types of skin lesions, please consult a physical assessment text.

Q79. M0440. How many different types of skin lesions are there anyway?

A79. 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).

Q80. M0440. Is a pacemaker considered a skin lesion?

A80. A pacemaker itself is an implanted device but is not an implanted infusion or venous access device. The (current) surgical wound or (healed) scar created when the pacemaker was implanted is considered a skin lesion.

Q81. M0440. How should M0440 be answered if the wound is not observable?

A81. For the OASIS items, a "nonobservable" wound is one that is covered by a nonremovable dressing (or in the case of pressure ulcers, an ulcer that is partially or entirely covered by eschar). If you know from referral information, communication with the physician, etc. that a wound exists under a nonremovable dressing, then the wound is considered to be present, and M0440 would be answered "Yes."

Q82. M0440. Is a new suprapubic catheter, new PEG site, or a new colostomy considered a wound or lesion?

A82. A new suprapubic catheter site (cystostomy), new PEG site (gastrostomy) and a new colostomy have one thing in common -- they all end in "-ostomy." All ostomies, whether new or long-standing are excluded from consideration in responding to M0440. Therefore, none of these would be considered as a wound or lesion.

Q83. M0440. How should M0440 be answered if the wound/lesion is a burn?

A83. M0440 should be answered, "yes," since a lesion is present. Additional documentation that describes the burn should be included in the clinical record, but burns are not addressed in the OASIS items. The appropriate ICD-9-CM code for the burn should be entered in M0230 Primary Diagnosis for accurate documentation.

Q84. M0440. Do all scars qualify as skin lesions?

A84. Yes, a scar meets the definition of an "area of pathologically altered tissue." [Q&A added 06/05]

Q85. M0440. If the patient had a port-a-cath, but the agency was not providing any services related to the cath and not accessing it, would this be coded as a skin lesion at M0440?

A85. For M0440 you would answer YES for a lesion and continue answering the questions until you come to M0482 - Does this patient have a surgical wound? Respond Yes - #1. The port-a-cath or mediport site is considered a surgical wound even if healed over. The presence of a wound or lesion should be documented regardless of whether the home care agency is providing services related to the wound or lesion.

Q86. M0440. Are implanted infusion devices or venous access devices considered surgical wounds at M0440?

A86. Yes, the surgical sites where such devices were implanted would be considered lesions at M0440 and would be included in the total number of surgical wounds (M0484). It does not matter whether the device is accessed at a particular frequency or not.

Q87. M0440. How do we document other wounds that are not surgical, pressure ulcers, or stasis ulcers at M0440?

A87. Remember that OASIS items are only PART of a comprehensive assessment and include only those items that have proven useful for outcome measurement and risk factor adjustment. During the early stages of the research on which OASIS items are based, the status of many such lesions were tested for their utility as outcome measures. Only the types of wounds that 'worked' for outcome measurement or risk factor adjustment have been carried forward in OASIS, though other types of wounds are extremely important to document in the clinical record. The presence of ANY wound or lesion (other than ostomies) should be noted by a 'yes' response to M0440.

Q88. M0440/M0482. Does a cataract surgery or a gynecological surgical procedure by a vaginal approach result in a skin lesion for M0440 and a surgical wound for M0482?

A88. No. Cataract surgery and gynecological surgical procedures by a vaginal approach are not included in M0440 or M0482. M0440 captures skin lesions or an open wound to the integumentary system. Only certain types of wounds are described by OASIS. We would expect that any discharge, swelling, pain, etc. from either procedure would be reported in the agency's clinical documentation.
[Q&A added 06/05]

Q89. M0440/M0445/M0468. Are diabetic foot ulcers classified as pressure ulcers, stasis ulcers, or simply as wound/lesions at M0440 and M0445?

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 M0440), but it would not be considered a pressure ulcer or a stasis ulcer.

Q90. M0450. When staging pressure ulcers, are we to keep the stage the same throughout all assessment time points even though the ulcer is healing? According to AHCPR guidelines for pressure ulcers we should keep the staging the same (once a stage 4 it stays a stage 4 but we document if healing is occurring). Are we to show that a Stage 4 went to a Stage 3 if this occurred at two different time points?

A90. Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel (NPUAP). If a

pressure ulcer is stage 4 at Start of Care and is granulating at the follow-up visit, the pressure ulcer remains a stage 4 ulcer. Your clinical documentation will reflect the healing process. The NPUAP web site (http://www.npuap.org/) has valuable information and teaching tools regarding pressure ulcers, documenting healing, treatment, etc.

Q91. M0450-M0464. At M0450-M0464, should we document a pressure ulcer when its stage or status worsens?

A91. Absolutely. If a pressure ulcer worsens in stage (or if its status worsens), this information should be noted in M0450 through M0464.

Q92. M0450-M0464. How can one OASIS tell whether a pressure ulcer has improved?

A92. The OASIS items are used for outcome measurement and risk factor adjustment. There are NO outcome measures computed for pressure ulcer improvement. Descriptive documentation in the patient's clinical record should address changes in pressure ulcer size and status that show improvement. The National Pressure Ulcer Advisory Panel web site (http://www.npuap.org/) has valuable information and teaching tools regarding pressure ulcers, documenting healing, treatment, etc.

Q93. M0445-M0464. How should these items be answered if a pressure ulcer is completely healed?

A93. The healing of a pressure ulcer is never indicated by "reverse staging" of the ulcer. If this were the only ulcer the patient had, the appropriate responses would be M0440 = yes and M0445 = yes. M0450 would be answered by indicating the stage of the healed pressure ulcer at its worst, with M0460 answered accordingly. On OASIS item M0464, the "best possible" answer for a healed pressure ulcer would be "fully granulating."

Q94. M0445-M0464. 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. M0445-M0464. 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. M0445-M0464. 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. The healing status of the pressure ulcer (for M0464) can be described by applying the *OASIS Guidance Document,* developed with CMS by the Wound, Ostomy, and Continence Nurses Society (WOCN), found at http://www.wocn.org/. Other objective parameters such as size, depth, drainage, etc. should also be documented in the clinical record. The National Pressure Ulcer Advisory Panel web site (http://www.npuap.org/) has valuable information and teaching tools regarding pressure ulcers, documenting healing, treatment, etc.

Q97. M0445 - M0464. We have been advised that a pressure ulcer is always a pressure ulcer and should be staged as it was at its worst. Does this apply to stage 1 and stage 2 pressure ulcers?

A97. Based on current advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), CMS has modified its policy for coding the healing status of Stage 1 and Stage 2 pressure ulcers. This policy became effective September 1, 2004.

Stage 1 pressure ulcers heal to normal appearing skin and are not at increased risk for future ulcer development. Stage 2 ulcers generally heal to nearly normal appearing skin, but may result in scar tissue formation. Healed stage 2 pressure ulcers only minimally increase the future risk of pressure ulcers at that location. The complete guidance on this topic is provided at www.cms.hhs.gov/oasis/training.

During the SOC or subsequent comprehensive assessments of the patient, if it is found that a patient has a healed Stage 1 or 2 pressure ulcer, the responses for OASIS data items are as follows:

(M0440) Does this patient have a Skin Lesion or Open Wound?

- If the patient has a healed Stage 1 pressure ulcer (and no other pressure ulcers OR skin lesions/wounds), the response would be 'No'.
- If the patient has a healed Stage 2 pressure ulcer (and no other pressure ulcers OR skin lesions/wounds), the response may be either 'No' or 'Yes' depending on the clinician's physical assessment of the healed wound site.
  - If the patient has no scar tissue formation from the healed Stage 2 pressure ulcer, the accurate response is 'No'.
  - If the patient has some residual scar tissue formation, the response is 'Yes'.

(M0445) Does this patient have a Pressure Ulcer?

- If the patient has a healed Stage 1 or 2 pressure ulcer (and no other pressure ulcers), the accurate response is 'No', following the skip pattern as indicated.

[Q&A added 06/05]

Q98. N0445-N0464. 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.

[Q&A added 06/05]

Q99. M0445-M0464. If a wound heals and breaks down again should it be staged at its prior level or should it be staged on the current level of breakdown?

A99. The type of wound is not identified here, but this response pertains to a healed pressure ulcer. This is the only type of wound that clinicians can stage. The appropriate response to this question for pressure ulcers will depend on the stage of the pressure ulcer at its worst prior to healing. If the ulcer was a Stage 1 or 2 prior to healing, then the updated guidance included in the response to Q97 (above) should be followed. The stage of this (newly deteriorated) pressure ulcer must be determined based on the current visual assessment by a clinician skilled in this clinical practice. If the ulcer was a Stage 3 or 4 at its worst prior to healing, then the ulcer's stage will be reported according to what it was at its worst. If the ulcer is worse now, the ulcer's stage at its worst (i.e., its current stage) also is what will be reported.
[Q&A added 06/05]

Q100. M0468-M0476. Would an arterial ulcer be considered a stasis ulcer?

A100. No, because venous stasis ulcers and arterial ulcers are unique disease entities. Refer to the WOCN web site (http://www.wocn.org/) for Clinical Fact Sheets regarding the assessment of leg ulcers, information on arterial insufficiency, and information on venous insufficiency (stasis).

Q101. M0468-M0476. How can I determine whether the patient's ulcer is a stasis ulcer or not?

A101. The patient's physician is the best information source regarding the root cause of the ulcer. Refer to the WOCN web site (http://www.wocn.org/) for Clinical Fact Sheets regarding the assessment of leg ulcers, information on arterial insufficiency, and information on venous insufficiency (stasis).

Q102. M0482-M0488. 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 wound or lesion (M0440), meaning that it could not be considered as a surgical wound. However, the "take-down" of an ostomy done as a surgical procedure would result in both a wound/lesion ("yes" to M0440) and a surgical wound ("yes" to M0482).

Q103. M0482. If the patient had a port-a-cath, but the agency was not providing any services related to the cath and not accessing it, would this be coded as a skin lesion?

A103. For M0440 you would answer YES for a lesion. At M0482, response 1-Yes is appropriate. The port-a-cath or mediport site is considered a surgical wound even if healed over. The presence of a wound or lesion should be documented regardless of whether the home care agency is providing services related to the wound or lesion.

Q104. M0482. Are implanted infusion devices or venous access devices considered surgical wounds? Are these included in the "count" of 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 and included in the total number of surgical wounds at M0484. It does not matter whether the device is accessed at a particular frequency or not.

Q105. M0482. If debridement is required to remove debris or foreign matter from a traumatic wound, is the wound considered a surgical wound?

A105. No. Debridement is a treatment to a wound, and the traumatic wound does not become a surgical wound.
[Q&A added 06/05]

Q106. M0482-M0488. Is a peritoneal dialysis catheter considered a surgical wound? If it is, how can the healing status of this site be determined?

A106. Both M0440 and M0482 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). To answer M0488, the healing status of a wound can only be determined by a skilled assessment (in person). It is possible for such a wound to be considered "fully granulating" (the best level the wound could attain on this particular item) for long periods of time, but it is also possible for such wounds to be considered "early/partial granulation," or "not healing" if the site becomes infected. These sites would not be considered as "non-healing" unless the signs of not healing are apparent. Such a site, because it is being held open by the line itself, may not reach a "fully granulating" state. Assessing the healing status of such a wound is slightly more difficult than a 'typical' surgical site. As long as a device is present, the wound will be classified as a surgical wound. Follow the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document)* found at http://www.wocn.org/ to determine when healing has occurred.

Q107. M0482-M0488. When does a wound no longer qualify as a surgical wound? When does CMS officially consider a wound to be healed?

A107. A wound no longer qualifies as a surgical wound when it is completely healed (thus becoming a scar). Utilizing skilled observation and assessment of the wound, follow the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document*) found at http://www.wocn.org/ to determine when healing has occurred. CMS does not follow time intervals in determining when a wound has healed, since the healing status of the wound can only be determined by a skilled assessment and the time for healing varies widely between patients.

Q108. M0482-M0488. How should these items be marked when the patient's surgical wound is completely healed?

A108. If the patient's surgical wound has healed completely, it is no longer considered a current surgical wound. The resulting scar would be noted as a "yes" response to M0440, but M0482 would be marked "no."

Q109. M0482-M0488. Is a mediport "nonobservable" because it is under the skin?

A109. Please refer to the definition of "nonobservable" used in the OASIS surgical wound items in the *OASIS User's Manual* – "nonobservable" is an appropriate response ONLY when a nonremovable 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. If needed, the manual can be downloaded from http://www.cms.hhs.gov/oasis/usermanu.asp.

Q110. M0482-M0488. I've never seen a nonobservable surgical wound in my agency. Why is this item even included?

A110. There are situations where surgeons do not want others to remove the dressings that they have placed. In such situations, agencies know there is a surgical wound present, but they are unable to describe the wound status because they cannot observe the wound. Without M0486, the responses to the surgical wound item responses might be difficult to evaluate. In the national repository data, nearly 10% (i.e., 9.8%) of patients with surgical wounds at SOC/ROC had nonobservable wounds.

Q111. M0482-M0488. Following the WOCN guidance, is it correct to say that a surgical wound healing by primary intention would be healed when the healing ridge is no longer palpable? Only fine pink collagen tissue (the beginning of a scar) is visible.

A111. Yes. CMS collaborated with the WOCN Association to publish guidelines named the *OASIS Guidance Document* in August 2001. The WOCN document was developed by consensus among the WOCN panel of experts. This guidance documents that a surgical wound closed by primary intention would be fully granulating if the incision is well approximated with complete epithelialization of the incision, if there is no avascular tissue, if there is no sign of infection, and if the healing ridge is well defined. Once the healing ridge has resolved (a positive change), the site would no longer be considered a surgical wound and should be considered a scar (lesion).

For surgical wounds closed by secondary intention, if the wound is completely covered with epithelial tissue, has no avascular tissue or sign of infection, the site would no longer be considered a surgical wound and should be considered a scar (lesion).
[Q&A added 06/05]

Q112. M0482. Does a cataract surgery or a gynecological surgical procedure by a vaginal approach result in a skin lesion for M0440, and a surgical wound for M0482?

A112. No. Cataract surgery and gynecological surgical procedures by a vaginal approach are not included in M0440 or M0482. M0440 captures skin lesions or an open wound to the integumentary system. Only certain types of wounds are described by OASIS. We would expect that any discharge, swelling, pain, etc. from either procedure would be reported in the agency's clinical documentation.
[Q&A added 06/05]

Q113. M0490. How should I best evaluate dyspnea for a chairfast (wheelchair-bound) patient? For a bedbound patient?

A113. M0490 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 never short of breath, 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. Response 1 would be most appropriate if demanding bed-mobility activities produce dyspnea.

Q114. M0500. How should I respond to M0500 for the patient receiving Bi-PAP (not CPAP, as included in response 3)?

A114. If the patient's only respiratory treatment is Bi-PAP, the appropriate response is 4, "None of the above." Note that the Response-specific Instructions for M0500 direct you to exclude any respiratory treatments that are not specifically listed in the item. If the patient uses any of the listed treatments, the appropriate response(s) should be noted. The use of Bi-PAP would be documented in the patient's clinical record.

Q115. M0510. If a patient develops a UTI while on a prophylactic antibiotic, how should I respond to M0510?

A115. In that circumstance, “yes” would be the most appropriate response.

Q116. M0510. If a patient had signs and symptoms of a UTI but no prescribed treatment or the treatment ended more than 14 days prior to the assessment, what would be the best response for M0510?

A116. In either of these situations, the appropriate response would be “no.”

Q117. M0520. 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. M0520. A new urologist has just started referring patients who have a urostomy or ureterostomy. What should I mark for M0520?

A118. A urostomy or ureterostomy is considered an ostomy for urinary drainage. The appropriate response therefore is “0 - no incontinence or catheter.” The appropriate skip pattern should then be followed.

Q119. M0520. 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 M0520, 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 M0520.

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 M0520 would be 1 (patient is incontinent), followed by response 0 to M0530 (timed-voiding defers incontinence. [Q&A added 06/05]

Q120. M0530. How should I respond to M0530 for the patient with an ureterostomy?

A120. If the patient had an ureterostomy, M0520 should have been answered with response 0 (no incontinence or catheter). From response 0, directions are to skip M0530. You should not be responding to M0530 if the patient has an ureterostomy.

Q121. M0530. If patient had stress incontinence during the day that was not deferred by timed-voiding, how would M0530 be completed?

A121. Response 2 at M0530 is the only response that includes the time period of 'day'. Therefore, that response would be the appropriate one to mark. If there were a caregiver, he/she might consider timed-voiding measures to assist in deferring the patient's incontinence during the day.

Q122. M0540. 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.

Q123. M0550. If a patient with an ostomy was hospitalized with diarrhea in the past 14 days, does one mark Response 2 to M0550?

A123. Response #2 is the appropriate response to mark for M0550 in this situation. By description of the purpose of the hospitalization, the ostomy was related to the inpatient stay.

Q124. M0570. If a patient has experienced episodes of recent confusion, but does not demonstrate or report any episodes of confusion today (the date of the assessment), would the patient be considered "never" confused? Or should the recent history of confusion be considered when responding to M0570?

A124. Information collected from patient or caregiver report can be utilized in responding to M0570. This includes reports that extend beyond the day of the assessment into the recent past. Therefore, if the patient or family reported that the patient has experienced periods of confusion on awakening a few mornings over the last week, it would be appropriate to mark "2" on awakening or at night only for M0570, even if no confusion was experienced *today*. This same strategy (of utilizing reported information from the recent past) also applies to the scoring of anxiety in M0580 and depressive feelings in M0590.
[Q&A added 06/05]

Q125. M0620. Are the behaviors to be considered in responding to this item limited to only those listed in M0610?

A125. No, there are behaviors other than those listed in M0610 that can be indications of alterations in a patient's cognitive or neuro/emotional status. Other behaviors such as wandering can interfere with the patient's ability to reach optimal level of function, and the frequency of these should be considered in responding to the item.

Q126. M0630. At discharge, does M0630 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 a specified time point is noted, such as 14 days ago). 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 M0630 (at discharge) would not reflect the presence of psychiatric nursing services.
[Q&A edited 06/05]

NOTE: For OASIS items M0640-M0820, the patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies, chose the response describing the patient's ability more than 50% of the time. See the *OASIS User's Manual* page 8.89 for more details.

Q127. M0640-M0800. At OASIS items M0640-M0800, 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 do laundry, shopping,

etc.). There is a more complete discussion of this topic in the *OASIS User's Manual*, Chapter 8, Item-by-Item tips, on the page preceding the tips for items M0640-M0800.

Q128. M0640-M0800. With regard to the start of care data set, what time frame do we select for IADL's/ADL's if we are to complete 'prior' 14 days before start of home care and the patient was in the hospital at that time? Is this 14 days prior to the hospitalization or 14 days before start of care, which would be while the patient was in the hospital?

A128. For M0640 - M0800, the time frame for the 'prior' ADL/IADLs should reflect the 14th day directly before start of home care, which would be while the patient was in the hospital.

Q129. M0640. 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. M0640. Is toileting hygiene part of this item?

A130. The term "toileting hygiene" typically is used to refer to the activities of managing clothing before and after elimination and of wiping oneself after elimination. If these are the activities implied by this question, the response is "no, toileting hygiene is not part of this item." If the question refers to the patient's ability to wash his/her hands, this activity is considered part of grooming.

Q131. M0650. If the patient is wearing a housecoat, should I evaluate her ability to dress in the housecoat or in another style of clothing?

A131. The appropriate response should indicate the patient's ability to dress herself (or the level of assistance needed to dress) in whatever clothing she would routinely wear. If the patient routinely wears another style of clothing, the assessment should include the skills necessary to manage zippers, buttons, hooks, etc. associated with this clothing style.

Q132. M0650. 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 M0490.)

Q133. M0670. For patients whose regular habit is to sponge bathe themselves at the lavatory, what should be marked for M0670?

A133. As noted in the Item-by-Item Tips found in Chapter 8 of the *OASIS User's Manual*, the patient who regularly bathes at the sink or lavatory must be assessed in relation to his/her ability to bathe in the tub or shower. What assistance would be needed for the patient to be able to bathe in the tub or shower? For example, if it is determined that the patient would be able to shower or bathe in the tub if stand-by assistance of another person was always available, response #2 would be marked.

Q134. M0670. Given the following situations, what would be the appropriate responses to M0670?

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 or 5 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 bathe in shower or tub and is bathed in bed or bedside chair) or 5 (unable to effectively participate in bathing and is totally bathed 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 she is unable to bathe in the tub/shower. If she refuses to enter the shower even with another person present, either response 4 or 5 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, 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.

Q135. M0670. 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, regardless of where or how the patient currently bathes. 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.

Q136. M0670. 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 M0670, only the patient's ability to "wash the entire body" should be considered. Bathing-related tasks, such as those mentioned, should not be considered in scoring this item.
[Q&A added 06/05]

Q137. M0670. 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. The general instructions on the page preceding the ADL/IADL items in Chapter 8 of the *OASIS User's Manual* state that the patient's ability **on the day of the assessment** should be recorded and that if the patient's ability varies (on that day), the clinician should choose the response that describes the patient's ability more than 50% of the time (not the patient's ability to perform more than 50% of the tasks).
[Q&A added 06/05]

Q138. M0670. Please clarify how the patient's ability to access the tub/shower applies to M0670.

A138. M0670 defines the bathing item to identify the patient's ability to wash the entire body. Guidance for this item also indicates that when medical restrictions prevent the patient from accessing the tub/shower, his/her bathing ability will be 'scored' at a lower level. Tasks related to transferring in and out of the tub or shower are evaluated and scored when responding to M0690 – Transferring, and they are not considered part of the bathing tasks for M0670.
[Q&A added 06/05]

Q139. M0670. A patient is unable to participate in the bathing tasks and is totally bathed by a caregiver, but the caregiver bathes the patient in the shower (i.e., lifts the patient into a shower chair, rolls patient to the shower, and bathes the otherwise passive patient). Response 5 states that the patient is unable to effectively participate in bathing and is totally bathed by another person. Please clarify if this patient would be noted to be at response level 5 because they are unable to effectively participate in bathing and are totally bathed by another person or at level 3 because the patient requires the presence and assistance of another person to bathe in the shower?

A139. If the patient truly is unable to effectively participate in any part of the bathing tasks in the shower, response 5 is appropriate. If the patient is able to participate at all in the bathing tasks in the shower, then response 3 is appropriate.
[Q&A added 06/05]

Q140. M0670. If the only reason the patient can't bathe in the tub is because they can't perform the transfer safely, even with equipment and assistance, should they be at response level 4 or 5 (Unable to use the shower or tub) even though the

only reason is the transfer status, and transferring is not supposed to be considered in responding to M0670?

A140. The tub transfer should not be considered when responding to M0670. However, the response for M0670 should differentiate patients who are able to bathe in the tub or shower (i.e., responses 0, 1, 2, or 3) from those who are unable to bathe in the tub or shower (e.g., response 4) regardless of the specific cause or barrier preventing the patient from bathing in the shower or tub.
[Q&A added 06/05]

Q141. M0670. Since the transfer into/out of the tub/shower should not be considered when responding to M0670, is it acceptable for assessing clinicians to ignore Response 2(b) from the item wording?

A141. The tub or shower transfer should not be considered when responding to M0670, and if the transfer is the only bathing task for which a patient requires help to bathe safely in the tub/shower, then the patient should be scored a 0 or 1, depending on his/her need for devices to safely perform all the included bathing tasks independently.
[Q&A added 06/05]

Q142. M0680. If my patient has a urinary catheter, does this mean he is totally dependent in toileting?

A142. M0680 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. This ability can be assessed whether or not the patient uses the toilet for urinary elimination.

Q143. M0680. If the patient can safely get to and from the toilet 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. M0680. If a patient is unable to get to the toilet or bedside commode and uses a bedpan for elimination, what response applies if the patient is able to safely and independently complete all tasks except removing and emptying the bedpan/urinal?

A144. In M0680, the patient does not need to empty the bedpan or urinal to be considered independent. If the patient required assistance to use the bedpan/urinal (i.e., get on or off the bedpan or position the urinal), Response 4 would be the best response. If the patient could position the urinal or get on/off the bedpan independently, Response 3 would be appropriate.
[Q&A added 06/05]

Q145. M0680. The Item-by-Item pages in Chapter 8 state that personal hygiene and management of clothing are not included in scoring, so could "independent use of bedpan" as indicated by response "3" allow someone to help with clothing management and hygiene and still be considered "independent?"

A145. Tasks related to personal hygiene and management of clothing should not be considered when responding to M0680.
[Q&A added 06/05]

Q146. M0680. If a patient is able to safely get to and from the toilet 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 M0680?

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 with assistance, then response 1 should be selected, as this reflects their ability, regardless of the availability of a consistent caregiver in the home.
[Q&A added 06/05]

Q147. M0680. Is the transfer on/off the toilet included in responding to M0680? What about the transfer on/off the bedside commode? What about the transfer on/off the bed pan?

A147. M0680 does not include the transfer on and off the toilet (for response levels 0 and 1) or on/off the bedside commode (for response 2), as both these transfers are specifically addressed in responding to M0690 - Transferring. The transfer on and off the bedpan *is* considered for M0680 response level 3. If the patient requires assistance to get on/off the bedpan, then he/she would not be considered independent in using the bedpan and response 4 would be the best response.
[Q&A added 06/05]

Q148. M0680. If a patient uses a bedside commode over the toilet, would this be considered "getting to the toilet" for the purposes of responding to M0680?

A148. Yes, a patient who is able to safely get to and from the toilet 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 06/05]

Q149. M0690. My patient must be lifted from the bed to a chair. He cannot turn himself in bed and is unable to bear weight or pivot. How would I respond to M0690?

A149. Response 3 is the option that most closely resembles the patient's circumstance you describe. 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.

Q150. M0690. If other types of transfers are being assessed (e.g., car transfers, floor transfers), should they be considered when responding to M0690?

A150. Because standardized data are required, only the specific transfer tasks listed in M0690 should be considered when responding to the item. Based on the patient's unique needs, home environment, etc., transfer assessment beyond bed to chair, toilet/commode, or tub/shower transfers may be indicated. Note in the patient's record the specific circumstances and patient's ability to accomplish other types of transfers.

Q151. M0690. If a patient takes extra time and pushes up with both arms, is this considered using an assistive device?

A151. You appear to be asking about a patient who is not bedfast. Remember that M0690 evaluates the patient's ability to safely perform three types of transfers: bed to chair, on and off toilet or commode, and into and out of tub or shower. "Pushing up with both arms" could apply to two of these transfer types -- bed to chair and on/off toilet or commode. 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 not independent. If standby human assistance were necessary to assure safety, then a different response level would apply to these types of transfers. Remember that transfer ability can vary across these three activities. The level of ability applicable to the majority of the activities should be recorded.

Q152. M0700. What if my patient has physician-ordered activity restrictions due to a joint replacement? What they are <u>able</u> to do and what they are <u>allowed</u> 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 <u>safely</u> accomplish at the time of the assessment.

Q153. M0700. Does M0700 include the ability to use a powered wheelchair or only a manual one?

A153. The OASIS item does not differentiate between the ability to use a powered wheelchair or a manual one.

Q154. M0700. 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 M0700 addresses the patient's <u>ability</u> 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, or 2, whichever is the most appropriate.
[Q&A added 06/05]

Q155. M0700. How would I score a patient who does not use an assistive device, but does sometimes need help on level/even surfaces?

A155. A patient who needs intermittent assistance (including any combination of hands-on assistance, supervision, and /or verbal cueing) to ambulate safely would be scored as

a "1" on M0700. A patient who needs continuous assistance (including any combination of hands-on assistance, supervision, and/or verbal cueing) to ambulate safely would be scored as a "2" -- "able to walk only with the supervision or assistance of another person at all times."
[Q&A added 06/05]

Q156. M0710. How should M0710 be answered if the patient is being weaned from a feeding tube? The tube is still present but is not being used for nutrition.

A156. If the tube is being used to provide all or some nutrition, responses 3-5 apply. Once the tube is no longer used for nutrition, even if it remains in place, the patient's ability to feed himself/herself should be reported using response 0, 1, or 2. The presence of the feeding tube and diet information should be detailed elsewhere in the clinical documentation.

Q157. M0710. What if the patient cannot carry his food to the table? He is able to feed himself, to chew, and to swallow.

A157. You should respond to this item based on the assistance needed by the patient to feed himself once the food is placed in front of him. If no assistance is needed, then response 0 applies. If some assistance is required, response 1 applies. Because you indicate that the patient is able to feed himself, response 2 would not be appropriate.

Q158. M0720. Should a therapeutic diet prescription be considered when assessing the patient's ability to plan and prepare light meals for M0720? For example, if a patient is able to heat a frozen dinner in the microwave or make a sandwich – but is NOT able to plan and prepare a simple meal within the currently prescribed diet (until teaching has been accomplished for THAT diet, or until physical or cognitive deficits have been resolved), would the patient be considered *able* or *unable* to plan and prepare light meals?

A158. M0720 identifies the patient's cognitive and physical ability to plan and prepare light meals or reheat delivered meals. While the nutritional appropriateness of the patient's food selections is not the focus of this item, any prescribed diet requirements (and related planning/preparation) should be considered when scoring M0720. Therefore a patient who is able to 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. 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.
[Q&A added 06/05]

Q159. M0730. My patient's son drives her to doctor's appointments, because she has not driven for years. The patient prefers her son do this, rather than taking public transportation. How would I respond to M0730?

A159. Remember that the item addresses what the patient is able to do, not what she prefers. A person who has not driven for years is not likely to be able to safely and independently drive a car at the time of the assessment. However, if the patient were able to use a regular or handicap-accessible public bus, response level 0 would be appropriate.

Q160. M0760. If I select response 0 or response 1, will the patient's homebound status be questioned?

A160. For all the ADL/IADL OASIS items, the patient's ability to perform the tasks is the focus of the assessment. The frequency of leaving the home to shop or the amount of effort needed, two criteria often associated with homebound status, are not the assessment focus here. You should provide information in the clinical record to document homebound status, regardless of your response to the OASIS items.

Q161. M0780. Do you consider medications given through a gastrostomy tube (M0780) oral medications?

A161. Item M0780 is assessing the patient's ability to take all oral medicines. The route of administration for medications given/taken by G-tube is 'per G-tube', not 'po'. Therefore, medications whose route is listed as per G-tube are NOT oral medications.

Q162. M0780. My patient sets up her own pill planner. How would I answer M0780?

A162. If your patient is able to take the correct medication in the correct dosage at the correct time as a result of this set up, then you would consider her independent and response 0 would apply. If your patient relies on a list of medications created by another person to set up her pill planner, response 1 would be more appropriate. If the patient follows a list that she made herself, she is independent and response 0 would apply.

Q163. M0780. 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 if the list is created for the patient by another person. The statement for response 1c ("someone" 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, then response 1 is the appropriate choice.

Q164. M0780. 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 M0780?

A164. M0780 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. M0780. For a patient who is independent (response level 0) with all medications except one, which he/she is unable to take without being administered by someone else, would the last statement in the item-by-item instructions ("If patient's ability to manage medications varies from medication to medication, consider the total number of medications and total daily doses in determining what is true most of the time") require that M0780 be marked as 0?

A165. Following the instructions quoted above, the clinician must determine the total number of daily doses involved to determine what is true most of the time. For example, a patient who had two medications, one of which was taken once daily and one of which was taken 4-6 times a day (e.g., Parkinson's medications), and was independent with taking both medications the first time in the morning, but needed reminders to take the remaining 3-5 doses of the second medication, Response 1 would be appropriate.
[Q&A added 06/05]

Q166. M0780. When scoring M0780, Management of Oral Medications, should medication management tasks related to filling and reordering/obtaining the medications be considered?

A166. No. Tasks related to filling, reordering and obtaining medications are considered part of the instrumental activity of daily living – shopping task, and they are evaluated during the scoring of M0760.
[Q&A added 06/05]

Q167. M0780. When scoring M0780 – Management of Oral Medications, should assessment include only prescription medications? Or should over-the-counter oral medications be included as well?

A167. Scoring of M0780 should include all oral medications, prescribed and non-prescribed, that the patient is currently taking and are included on the plan of care.
[Q&A added 06/05]

Q168. M0800. Sometimes the physician orders indicate that the nurse must administer the injectable medication. How does this affect the response to M0800?

A168. Response 2 should not *automatically* be selected for an injectable medication that the physician has ordered the nurse to administer. M0800 requires an assessment of the patient's ability to prepare and take all prescribed injectable medications. You must consider the patient's ability to draw up the correct dose using accurate aseptic technique, to inject in an appropriate site using correct technique, and to dispose of the syringe properly. You must also consider why the physician has ordered a nurse to administer the medication. Is it because of the specific medication, the site or technique necessary for injection, or the patient's cognitive status, etc.? If the patient were physically and cognitively able to administer the injectable medication, to follow appropriate technique, and to observe the appropriate procedures for handling the medication, the response 0 would be an appropriate response. Be sure to make additional notes in the clinical record to document your assessment findings.

Q169. M0810. I am unsure how to respond to M0810 (or M0820) if my patient has an epidural infusion of pain medication? A subcutaneous infusion?

A169. In M0250, it was established that patients receiving epidural infusions or subcutaneous infusions were receiving IV/infusion therapy. Therefore, M0810 and M0820 should be answered. For M0810, the patient'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. NA would not be an appropriate response to M0810 in this situation.

Q170. M0810. Does this item include delivery devices for inhaled medications, TENS units, or mechanical compression devices?

A170. M0810 (and M0820) consider management of equipment and supplies only for oxygen, IV/infusion therapy, enteral/parenteral nutrition, and ventilator therapy and do not include the delivery devices or equipment associated with other treatments such as the type listed. (Note that inhaled medications are addressed in M0790.)

Q171. M0820. My patient has a caregiver who does everything but manage the equipment. How should I answer M0820?

A171. This item addresses only the caregiver's ability to manage the specific types of equipment listed. Thus, your response should reflect only the caregiver's ability in this particular aspect of care. The item is very circumscribed (to a specific aspect of care and to specific equipment), so your response should be confined to only these components of care delivery. The other care provided by the caregiver can be recorded in the clinical record in other areas.

Q172. M0830. When I called to schedule my visit, I learned that my patient was seen in the ER and was then admitted to the hospital. How should I answer M0830?

A172. Emergent care includes all unscheduled visits to medical services as noted in the response options, including a hospital emergency room. You should mark M0830 with response 1 - Hospital emergency room. In this situation, since the patient was admitted to the hospital following the emergency room visit, you would also complete the items for Transfer to the inpatient facility (RFA 6 or 7 to M0100).

Q173. M0830. 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.

Q174. M0830. The patient had a planned visit for cataract surgery at the outpatient surgical center. Is this emergent care?

A174. Emergent care is defined as an "unscheduled visit to any (emergent) medical services." The situation you described was a planned visit and thus is not considered emergent care.

Q175. M0830. If a patient receives portable x-ray in their home/place of residence after a fall, is this considered emergent care for responding to M0830? And if so, what response is selected?

A175. Yes, this would be considered emergent care and should be reported as such on M0830. The response selected should be based on the physician's office, hospital, or clinic that provided the service. If the service was not provided by any of those entities, but as a contracted service, then M0830 should be scored based on who ordered the x-ray.
[Q&A added 06/05]

Q176. M0830. If the patient receives a home visit from a nurse practitioner from the doctor's office in response to a fall, or increased pain, or other problematic symptoms, would this be considered emergent care?

A176. Yes, the (non-home care) nurse's home visit would be considered emergent care and would be reported based on the entity (hospital, doctor's office, outpatient clinic) that sent the nurse.
[Q&A added 06/05]

Q177. M0830. Should all unscheduled MD visits be considered emergent care for purposes of responding to M0830? Or only those which the clinician judges to represent an MD visit being utilized in lieu of an emergency room visit? For instance, if the clinician calls the physician with patient reports of marked calf pain, tenderness, and acute SOB and the physician wants the patient to come into his office, would that be considered emergent care?
If the clinician calls the physician to report that the patient's knee range of motion is not progressing as rapidly as expected and the doctor tells the patient to move up their appointment by a few days and come in today; would that be considered emergent care?

A177. In M0830 Emergent Care, we are trying to determine if the patient received emergent medical care for an illness or injury since the last time an assessment was completed. "Emergent/unscheduled (within 24 hours) care is the definition that we are using and following. CMS has not changed the definition of M0830. It remains the same as the current manual.
The clinician needs to use the information for any necessary care planning changes; for example, was there a change or addition in medications or treatments? The item does not justify "why" the patient sought emergent care, only that emergent care occurred (or not). The "24 hour" timeframe is a guideline to see if the need for the physician visit was emergent or not. If a patient is listed on an adverse event report, then the agency needs to investigate the event to determine whether or not the care for this patient was problematic.
[Q&A added 06/05]

Q178. M0830. Please clarify how to respond for the patient who dies in the ER (before being formally admitted to the inpatient facility) and for the patient who is pronounced "dead on arrival" at the ER.

A178. The patient who dies in the emergency room is NOT considered to have died while under the care of the agency and therefore is NOT considered a death at home.

(This patient would have a transfer assessment completed, which would require that M0830 be completed.) This is true even though the patient was never formally admitted to the inpatient facility, because the facility was actively providing care at the time of the patient's death. In contrast, the patient who is pronounced "dead on arrival" by the ER physician on arrival at the ER is considered to have passed away while under the care of the agency and would be considered to have died at home. (This patient would have a "death at home" assessment completed, which does not require M0830.)
[Q&A added 06/05]

Q179. M0830. 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 M0830, (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 8 of the Implementation Manual clarify that responses to M0830 – Emergent Care, include the entire period since the last time OASIS data were collected, including current events. Any access of emergent care, regardless of how brief the encounter, should be reported on M0830 if it occurred since the last time OASIS data were collected.
[Q&A added 06/05]

Q180. M00830. 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. M0830, 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 M0830 regarding emergent care be based on the last time any OASIS assessment was completed, or should it be based on the last assessment where M0830 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 (M0830) 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 M0830 is 0-no emergent care services were provided.
[Q&A added 06/05]

Q181. M0830. Is M0830 limited to the service sites specifically listed in the OASIS responses? What if a patient was a direct admit to the hospital unit, without passing through the emergency room?

A181. M0830 identifies whether the patient received an unscheduled visit to any of the following services; hospital emergency room, doctor's office/house call, or outpatient department or emergency clinic. A direct admit to a hospital unit would not be reported as emergent care on M0830. This situation would, however, be considered a transfer to

an inpatient facility, as long as the admission lasted 24 hours or longer for reasons other than diagnostic testing, and would be considered an "emergent" reason for hospital admission in responding to M0890.
[Q&A added 06/05]

Q182. M0855. For M0855 are 'Rehabilitation Facility' and 'Nursing Home' both considered skilled nursing facilities?

A182. For M0855, response 2, 'rehabilitation facility' is a certified, distinct rehabilitation unit of a nursing home OR a freestanding rehabilitation hospital. For response 3, 'nursing home' includes either a skilled nursing facility or an intermediate care facility.

Q183. M0855. 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 M0855?

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 M0855. 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.
[Q&A added 06/05]

Q184. M0870. 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. M0880. How would outpatient therapy services be categorized?

A185. Response option 3 - assistance or services provided by other community resources is an appropriate response in this situation.

Q186. M0880. What if my patient is being discharged from a payer source in order to begin care under a new payer source?

A186. The OASIS items do not request a reason for discharge, only whether the patient is continuing to receive services if he/she remains in the community. In this situation, the appropriate response for M0870 would be 1 - Patient remained in the community, and the correct response for M0880 would be 3 - Yes, assistance or services provided by other community resources.

Q187. M0890. What if M0830 was already answered "yes?" How should I answer this item?

A187. You should respond to M0890 appropriately for the situation. M0830 might have been answered "yes" for a separate instance of emergent care, not necessarily relating to this hospitalization. If the patient was hospitalized after having been seen in the emergency room, then M0830 would be answered "yes," and M0890 would most likely be answered with response 1 - Hospitalization for emergent (unscheduled) care.

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, which is not necessarily associated with a home visit. M0903 must be the date of an actual home visit. See the *OASIS User's Manual,* Chapter 4, for additional information on "unexpected discharges."

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 added 06/05]

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. M0903 (date of last home visit) would be 11/30, and M0906 (death date) would be 12/01.