

CMS OASIS Q&A Addendum Subsequent to CMS 12/2009 Official Update

May 2010

Note: Although the following are official responses issued by CMS to NAHC, Fazzi, and OASIS Certificate and Competency Board, these Q&As will not be integrated into the *OASIS Item-by-Item Tips and Frequently Asked Questions* (M-081) publication with other Q&As currently found there until they are posted on the CMS web site at: <https://www.qtso.com/hhdownload.html>

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M0080

Question: Can an OT establish the plan of care and perform the SOC assessment when a Medicare Advantage plan is the payer?

Answer: OT does not establish eligibility for the Medicare Traditional Home Health benefit. Therefore, an OT may not perform the initial assessment or complete the SOC comprehensive assessment on Medicare traditional fee-for-service (PPS) patients. Other payers, such as Medicaid, Medicare Advantage plans, or private insurers, may have different coverage guidelines that would allow OT to establish eligibility for each respective home health benefit. It will be necessary to contact the payer to find out if the Occupational Therapy discipline establishes program eligibility for that payer, to determine if OT may perform the initial assessment visit and the SOC comprehensive assessment.

M0090

Question: Does “assessment completed date” refer to information required to complete OASIS data items or any information contained within the agency’s comprehensive assessment?

Answer: M0090, Date Assessment Completed, is referring to the date the entire assessment was completed. The OASIS is just one component of the comprehensive assessment.

Question: As long as the RFA 4, Recertification OASIS M0090 date is within the 5 day window, can you visit on day one and complete (M0090) any of the other days if you were still gathering data?

Answer: Per the Condition of Participation, 484.55, the agency must perform a comprehensive assessment of the Medicare patient every second calendar month beginning with the start of care. The time period for the RFA 4, Recertification, has been further clarified in a number of references, Category 3 CMS OASIS Q&As, OASIS Assessment Reference Sheet, to mean the last 5 days of every 60 days, i.e. days 56-60 of the current 60-day period. A clinician may start the comprehensive assessment on day 56 and complete it on any day on or before day 60. Only one clinician may complete a comprehensive assessment though, so if Nurse A begins it on day 56, Nurse A must be the clinician who completes it.

M0102

Question: How should agencies respond to Date of Physician-Ordered SOC (M0102) and the Date of Referral (M0104) when conducting a SOC OASIS for patients who have switched from Medicare fee-for-service to Medicare Advantage plans or other payers? In these cases, a discharge assessment is often completed to end the traditional Medicare episode, but the patient is not discharged from care. A SOC assessment is conducted because of new payer requirements, but services are continued under the existing plan of care. Therefore there is no actual new referral date or ordered SOC date.

Answer: You are presenting a situation in which there is no real need to obtain either a physician's ordered start of care date or a referral date, as you are not initiating care, just changing payers. In the specific situation where a new SOC comprehensive assessment is completed for the sole purpose of changing payers, M0102, Physician ordered SOC date would be NA. For M0104, Date of Referral, enter the day prior to the new Start of Care date. If you know the date the insurance is changing, then actual dates can be used.

Question: If a patient is hospitalized and the agency is not notified until several days after the patient returns home of the need to resume care, how should the agency respond to M0102 and M0104?

Answer: In the above situation, M0102, Physician ordered Start of Care (ROC) would be NA as the agency was not given a specific date to initiate services. M0104, Date of Referral, would reflect the date the agency received authorization to resume care of the patient. If the patient returned home from the inpatient setting on Monday, but did not receive notification/authorization from the physician directly or through the inpatient discharge planner until Wednesday, M0104 would be reported as Wednesday. The notification/authorization from the physician at the Resumption of Care is considered the referral and the agency must then visit the patient within 48 hours.

Question: If the physician provides a range of dates in which home care should begin (for example, "begin care 3/1/2010 or 3/2/2010"), what date should be reported for M0102?

Answer: In order to be considered a physician-ordered SOC date the physician must give a specific date to initiate care, not a range of dates. If a single date to initiate services is not provided, the initial contact (via the initial assessment visit) must be conducted within 48 hours of the referral or within 48 hours of the patient's return home from the inpatient facility.

M0104

Question: How should agencies respond to Date of Physician-Ordered SOC (M0102) and the Date of Referral (M0104) when conducting a SOC OASIS for patients who have switched from Medicare fee-for-service to Medicare Advantage plans or other payers? In these cases, a discharge assessment is often completed to end the traditional Medicare episode, but the patient is not discharged from care. A SOC assessment is conducted because of new payer requirements, but services are continued under the existing plan of care. Therefore there is no actual new referral date or ordered SOC date.

Answer: You are presenting a situation in which there is no real need to obtain either a physician's ordered start of care date or a referral date, as you are not initiating care, just changing payers. In the specific situation where a new SOC comprehensive assessment is completed for the sole purpose of changing payers, M0102, Physician ordered SOC date would be NA. For M0104, Date of Referral, enter the day prior to the new Start of Care date. If you know the date the insurance is changing, then actual dates can be used.

Question: When completing M0104, Date of Referral, can we use the date of actual authorization from the Medicare Advantage plan rather than the date of referral from the inpatient facility or the MD office?

Answer: M0104, Date of Referral, reports the date the agency received authorization from the physician to initiate or resume home care services. The authorization may come directly from the physician, or on the physician's behalf through the hospital or SNF discharge planner. It is not the date authorization was received from the patient's payer. To address your question specifically, the date the Medicare Advantage case manager authorized service is not considered a referral date.

M1010

Question: If a patient is hospitalized (or in a SNF) and is given his/her routine medications BUT some of those medications are for diagnoses that are not the reason for the hospitalization, are the diagnoses for which the routine meds are given considered as being "treated" during the stay. For example: the patient is admitted to the hospital for surgery. While in the hospital, he is given his routine medication for HTN, atrial fib, GERD, etc. Should those dx be listed at M1010?

Answer: When completing M1010, Inpatient Diagnoses, only include the diagnoses actively treated during the inpatient facility stay within the past 14 days, not all the diagnoses the patient may have. "Actively treated" should be defined as receiving something more than the regularly scheduled medications and treatments necessary to maintain or treat an existing condition. In the scenario you provided, Hypertension would not be included in M1010 if the patient only received their maintenance dose of antihypertensive.

M1040/M1050

Question: Due to state law and/or agency policies, some home health staff may not be allowed to transport meds (including vaccines)? Patient and/or the family members might need to pick the vaccine up for the agency to administer. How would the agency get credit for these outcome measures?

Answer: The process measures describing the best practice gives credit not only when the agency provides the immunization(s) (regardless of who transports the vaccine to the patient's home), but the agency also may get credit by facilitating the patient's receipt of the immunization through other health care providers. This facilitation will be represented in M1045 and M1055, and computation of these related process measures will rely on both M1040 and M1045 (for influenza) and M1050 and M1055 (for pneumonia).

M1045

Question: Our agency does not provide flu shots. They are readily available in the community – so most of our patients have received from another health care provider (Response #1). If a patient has declined/refused a flu shot in the community – is the correct answer #3 - Offered

and declined, (though not offered by our agency); or is it #7 – None of the above, with explanation since our agency was not the health care provider offering the flu shot?

Answer: When completing M1045, Response 3- Offered and declined is appropriate if the patient or their healthcare proxy refuses the vaccine. It is not required that your agency offered the vaccine, just that the patient was offered the vaccine and they refused.

Question: If our agency immunized a patient during a mass immunization provided at an ALF or other setting can we report it in M1045 even though the residents were not registered members of our HHA at the time of immunization.

Answer: If you gave a current home health agency patient a flu shot during a previous roster billing situation during this year's flu season, then Response "2- Received from your agency previously during this year's flu season" would be appropriate when completing M1045, Reason Influenza Vaccine not received. If an agency does not give the flu vaccine or PPV is the correct response to M1045 (7) none of the above (assuming the episode occurs during the Oct 1-March 31) and M1055 (5) none of the above?

Answer: When the home health agency does not provide the immunizations per M1040 and M1050, there is the opportunity to report "why" it wasn't provided in M1045 and M1055. If none of the listed reasons (such as provided in another setting, contraindicated, etc) describe why the vaccine was not provided, the only appropriate response would be "None of the above". This response would be appropriate if the agency has elected not to administer vaccines to their patients.

M1100

Question: Does the rule that the availability of a call bell equates to "around the clock care" apply only to the ALF setting, or if one is available in congregate housing would the availability of assistance in that situation also be reported as around the clock availability of assistance as well?

Answer: If, in a congregate housing situation, the patient has available in-person assistance in response to a call bell 24 hours a day, the correct answer would be "around the clock."

Question: Is there a designated block of time that would define "regular daytime" or "regular nighttime" for M1100? For example is "regular daytime" 12 hours or during daylight hours?

Answer: When completing M1100, clinical judgment must be used to determine which hours constitute "regular daytime" and "regular nighttime" for each patient based on their specific activities and routines. No hours are specifically designated as daytime or nighttime.

Question: How do you answer M1100, Patient Living Situation, when the patient lives with their family member and the family member is being paid to care for the patient, either by the patient or by a state funded program?

Answer: When answering M1100, Patient Living Situation, if a patient lives with their family, Row b., Patient lives with other person(s) in the home, would appropriately depict their living arrangement, even if the patient pays their family member to provide care or the family member is being paid through another source, e.g. another family member or state funded program.

M1240

Question: Do all the OASIS pain items refer to severe pain? If not, how are they are different?

Answer: The home care clinician assesses for and is concerned about any and all pain the patient experiences. All pain is documented in the clinical record and addressed in the plan of care. Remembering that the OASIS items are just a part of the comprehensive assessment for patients who require data collection helps to put all the OASIS items and their focused data collection into perspective. M1240, Pain Assessment, is assessing if the patient had a formal pain assessment during the allowed assessment time period utilizing a standardized pain assessment tool, as defined in Chapter 3 of the OASIS-C Guidance Manual. The response options then report either “No” that the standardized assessment was not conducted or “Yes” that the assessment was conducted and whether it indicated severe pain or not.

When answering M2250, Plan of Care Synopsis, Row e, the assessing clinician is reporting whether the physician ordered plan of care included interventions to monitor and mitigate pain, any pain, not just severe pain. “NA” is an option if the comprehensive assessment, not necessarily the formal assessment, revealed the patient had no pain. “Yes” or “No” can be selected for M2250 based solely on the presence or absence of interventions on the physician ordered plan of care to monitor and mitigate pain, regardless of whether or not the patient was assessed for pain. “NA”, however, may not be selected unless the patient was assessed to have no pain. Therefore, if orders are included on the POC that address both the assessment and plans for mitigation of pain, M2250 may be answered as “yes”, even though the comprehensive assessment did not reveal any pain.

When answering M2400, Intervention Synopsis, Row d, the same principles apply except for two major differences. First, you may not select “NA” unless the formal pain assessment utilizing a standardized tool as defined in M1240 was conducted at the time of or since the last OASIS assessment and it revealed no pain. Second, in order to answer “Yes” or “No”, the orders to monitor and mitigate the pain not only have to be present, but there must be evidence in the clinical record that they were implemented.

Question: Is the intention of M1240 – Pain Assessment to identify whether a clinically significant pain is present at the time the pain assessment is conducted regardless of the activity level at the time (i.e., using a numeric pain scale ask the patient to rate his pain this moment) or the presence of clinically significant pain on the day of assessment (i.e., using a numeric intensity pain scale, ask the patient to rate his pain on the average for the day of assessment)?

Answer: M1240 - Pain Assessment, reports if the patient had a formal pain assessment during the allowed assessment time period utilizing a standardized pain assessment tool, as defined in Chapter 3 of the OASIS-C Guidance Manual. The response options then report either “No” that the

standardized assessment was not conducted or “Yes” that the assessment was conducted and whether it indicated severe pain or not, at the time of the standardized assessment, per the assessment’s scale and the Ch. 3 Response-Specific Instructions. The response selected is not necessarily a reflection of an average or summary of the pain experienced on the day of assessment. The home care clinician assesses for and is concerned about any and all pain the patient experiences. All pain is documented in the clinical record and addressed in the plan of care. Remembering that the OASIS items are just a part of the comprehensive assessment for patients who require OASIS data collection helps to put all the M items and their focused data collection into perspective.

M1310/1312/1314

Question: How do we measure a pressure ulcer if the wound lies on a slant? Is it literally from head to toe no matter what? If that is true, our measurement may not include longest and widest parts of wound.

Answer: For the purposes of completing M1310/1312/1314, identify and report the longest head-to-toe measurement and the longest measurement perpendicular to the head-to-toe measurement. You may choose to include other measurements in your clinical documentation, for situations where the OASIS requirement does not meet your needs.

M1324

Question: What is the stage of an unstageable pressure ulcer that is a suspected deep tissue injury (SDTI) in evolution?

Answer: Until the SDTI evolves and opens, the Stage will be considered NA, as the wound bed cannot be visualized.

M1342

Question: I am confused by one of the CMS OASIS Q&As. The answer to Q105.3 states that an implanted venous device is considered a surgical wound until it has been epithelialized completed for 30 days at which time it becomes a scar. The next sentence of the answer says that the site is considered a surgical wound as long as the device is in place. Can you clarify this?

Answer: An implanted venous access device is considered a current surgical wound as long as it is implanted in the patient’s body.

When first implanted, the incision is the surgical wound. The assessing clinician will follow the 12/09 WOCN guidance to determine the healing status of the incision. Once it is fully epithelialized, the site due to the implanted device will remain a current surgical wound with a status of “Newly epithelialized” for as long as it is present in the patient’s body, unless it later develops complications. This guidance clarifies and supersedes

Question: In reference to M1342, Status of Most Problematic (Observable) Surgical Wound, for surgical incisions healing by primary intention is it true that the only correct responses

are “0-newly epithelialized” and “3-Not healing” as there are no open wound beds with granulation tissue?

Answer: Surgical incisions healing by primary intention do not granulate. Because of this the only response that could be appropriate for a surgical wound healing by primary intention would be 0-Newly epithelialized or 3-Not healing. “Newly epithelialized” should be chosen if the surgical incision has epidermal resurfacing across the entire wound surface, and no signs/symptoms of infection exist.

Question: How do I mark the healing status of a Q-port that has needle access always in place? Would it be “non-healing”?

Answer: The assessing clinician must determine the healing status of a wound following guidance in Chapter 3 of the OASIS-C User’s Manual and the latest version of the WOCN’s OASIS Guidance Document. Some sites, because they are being held open by a line or needle, cannot fully granulate and may remain “non-healing” while the line or needle is in place.

M1350

Question: How do I answer M1350 if a patient is admitted with CHF, has no edema at SOC, but we include a plan to monitor for edema and s/s of CHF during the episode of care. Edema is considered a skin lesion or open wound. At discharge, the patient once again does not have any edema. Item intent states: “Identifies the presence or absence of a skin lesion or open wound NOT ALREADY ADDRESSED IN PREVIOUS ITEMS that is receiving clinical assessment or intervention from the home health agency.” At discharge is there ever a time when you WOULD answer this question “YES”?

Answer: M1350 is reporting if the patient has a skin lesion or open wound that is receiving intervention by the home health agency (other than those previously described in the pressure ulcer, stasis ulcer and surgical wound items, excluding bowel ostomies).

If there are no wounds or lesions receiving intervention on the day of the Discharge Assessment, the correct response to M1350, Skin Lesion or Open Wounds, would be “No”. In the scenario you provided above, the M1350 response would be “No” because the patient did not have a lesion that required assessment. The clinician was monitoring for the potential development of edema (which is considered a lesion), but the patient never developed the lesion, therefore the patient did not HAVE a lesion that required intervention from the agency.

M1350 could be answered “Yes” at Discharge. It is possible, that a patient discharged from the agency received (on the day of the Discharge assessment), intervention(s) for a wound that was not described in a previous OASIS wound item, e.g. a patient is being discharged as they are no longer home bound and had burn wounds requiring home health intervention on the day of assessment.

M1500

Question: Please explain the response “not assessed” and give an example of when it might be used.

Answer: When completing M1500, Symptoms in Heart Failure Patients, the response “Not assessed” means the patient with a diagnosis of heart failure was not assessed for symptoms of heart failure at the time of or since the previous OASIS assessment. This would not be a best practice. As stated in the Item Intent, the best practices/assessments stated in the item are not necessarily required in the Conditions of Participation. An example of appropriate use of “Not assessed” would be a situation where the assessing clinician is completing a Transfer OASIS on a heart failure patient shortly after recertification, where CHF was not the focus of care, and there is no evidence in the clinical record that an assessment of lung sounds, weight gain, dyspnea, orthopnea or lower extremity edema was performed at the time or since the recertification. Another example: a patient with CHF is admitted to the hospital and discharged with a new diagnosis such as hip fracture. The ROC visit and next visit focused on interventions related to the hip fracture, and no documentation of the heart failure assessment. Patient is unable to remain in the home and is transferred to a SNF. No CHF assessment between ROC and Transfer would mean that M1500 at Transfer would be “2-Not assessed”.

Question: How do we answer M1500 and M1510 if our patient has a diagnosis of Heart Failure, but the clinician believes the patient’s dyspnea is related to pneumonia?

Answer: M1500, Symptoms in Heart Failure Patients, is intended to report whether or not a patient with a diagnosis of heart failure exhibited symptoms of heart failure at the time of or since the previous OASIS assessment. Dyspnea is a symptom of heart failure and while it may also be a symptom of another co-existing disease process, such as pneumonia, it would still be reported in M1500 and M1510, Heart Failure Follow-up, if the patient has a diagnosis of heart failure.

M1510

Question: A patient has CHF. The documentation indicated the agency staff has provided instruction on care and management including weighing daily, an extra dose of Lasix with a 2 pound weight gain in a day and informing the physician. As a result, the record indicates that the patient developed signs of failure with a weight gain, appropriately took the extra Lasix that was ordered and called the physician the same day to report his actions. The patient informed the nurse of the event when she visited the next day. The nurse assessed the patient and found the weight was back to normal, reinforced the patient’s actions and called the physician to see if there was any need to change the treatment plan. Given the event took place in the quality episode, can the agency take credit for their indirect actions and previous teaching and select response 1, 3 and 4?

Answer: M1510, Heart Failure Follow-up captures all of the actions taken by the home health care providers in response to heart failure symptoms that occurred at the time of, or since the last assessment. Assuming these actions took place within this time frame and that the patient had symptoms at the time of the assessment when the education took place, the correct answer would be 3 and 4. The agency staff had provided physician ordered parameters (Response 3) that the

patient utilized when symptomatic, and provided education (response 4) at the start care when the patient was admitted with symptoms. Response 1 would not be correct, as the patient contacted the physician, not the agency staff. It is also not known if there was a response same day from the physician, which must also happen to choose response “1”.

It is not clear through your scenario whether the patient was symptomatic at SOC. If the patient did not have symptoms of heart failure at the time the CHF education was provided at the Start of Care, Response 4 could not be selected. Education provided routinely at Start of Care related to a diagnosis of CHF is not representative of the intent of this item. The best practice captured here is whether or not education (as well as other specified interventions) was provided in response to symptoms of heart failure.

If by “reinforced the patient’s actions” you meant the clinician reinforced prior education in response to the new onset of symptoms, Response 4 would be appropriate.

Question: In M1510 where we are reporting the actions taken in response to heart failure symptoms, are we allowed to consider interventions that take place over the phone when answering this item or must we only consider the interventions that occur face to face during a home visit? Many agencies use telehealth and may not be making face-to-face visits but adequately intervening in cases of increased weight gain, etc.

Answer: Interventions provided via the telephone or other telehealth methods utilized to address heart failure symptoms could be reported on M1510, Heart Failure Follow-up.

M1730

Question: We are seeking clarification about the PHQ2 depression screening tool and whether it can be used in certain situations. Instructions for PHQ2 imply that screening entails interview of the patient. However, the “Specific Instructions” in the OASIS manual state: “depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or other.” Is it acceptable to use the PHQ2 to screen for depression by asking the questions of a caregiver if the patient is unable to respond to the two questions? Is it acceptable for the home health clinician to complete the PHQ2 based on observations if the patient is unable to respond to the two questions?

Answer: No, it is not acceptable to use the PHQ-2 to screen for depression by asking the questions of a caregiver, or to respond to the two questions based on clinician observations. The PHQ-2 tool is a standardized, validated screening tool in which the patient is the source of report. The PHQ-2 instructions clearly define how the tool should be administered. The clinician is to ask the patient a specific question related to two problems. The information may also be self-reported, precluding the need for the interview. When evaluating the patient, the clinician must first assess whether the PHQ-2 is the appropriate depression screening tool. If the PHQ-2 is appropriate (the patient appears to be cognitively and physically able to respond), then the instrument may be used. If, however, the clinician is then unable to elicit responses to either of the PHQ-2 questions from the patient during the assessment, the clinician can report in M1730 that the PHQ-2 was administered (Response 1), and select N/A - unable to respond.

If the PHQ-2 is not appropriate due to limitations such as cognitive status or communication deficits, the clinician may choose to administer a different standardized depression screening tool with instructions that may allow for information to be gathered by observation and caregiver interview as well as self-report. In this case, the clinician would select Response 2 or 3 for M1730, depending on the outcome of the assessment.

If the clinician chooses not to assess the patient (because there is no appropriate depression screening tool available or for any other reason), Response 0, “No” should be selected.

Note that patients who have been assessed as “unresponsive”, based on M1710, When Confused and/or M1720, When Anxious, will not be included in the process measure for depression screening.

M1800

Question: OASIS-C excluded shampooing of hair from bathing and grooming...Do you see this as being captured any other place?

Answer: Shampooing of the hair is excluded from both the Bathing and Grooming items in OASIS B-1 and OASIS-C. Shampooing may be included as one of the ADLs in M2100, Types and Sources of Assistance, as this question is concerned broadly with types of assistance, not just the ones specified in other OASIS items.

M1810/M1820

Question: OASIS guidance is clear that if a patient adapts/modifies their environment (e.g. where items are stored, location of bedroom etc.) that if that change is intended to be permanent then it becomes their usual storage area when answering ADL questions. Would the same guidance apply if the patient has changed the type of clothing they wear? If the type of clothing they wear has been changed due to their condition, is there a time frame at which point this “new” clothing becomes “permanent /usual”?

Answer: If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the “routine” clothing.

The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient’s new routine clothing.

Question: How do you answer M1830, Bathing, if the patient has no tub and only needs help washing hard to reach areas? Are they a “4” – independent in bathing outside of tub/shower or “5” – requires supervision/assist throughout the bath outside of tub/shower? Neither response seems to exactly apply.

Answer: If there is a barrier preventing the patient from bathing safely in a tub/shower and the patient needs intermittent assistance to wash their entire body safely at a sink, in a chair or on a commode, the appropriate score would be a 5, even though response option 5 refers to the patient using assistance or supervision of another person throughout the bath. In order to score a 4, the patient must be able to safely bathe without any human assistance at some site outside the tub/shower (e.g., at the sink, in a chair, on the commode).

M1840 & M1850

Question: Regarding M1840 Toilet Transferring– Response 1 (reminded, assisted, or supervised by another person) & M1850 Transferring– Response 1 (minimal human assistance or with assistive device), what exactly do the terms “assisted” & “minimal human assistance” mean? In the therapy world, minimal assistance means the caregiver must provide less than 25% of the effort required to assist the patient in completing the task safely. Is this what the clinician is suppose to look at or could minimal human assistance mean verbal cueing or stand by assist only?

Answer: The OASIS-C Guidance Manual, Chapter 1, Conventions explains “When an OASIS item refers to assistance, this means assistance from another person unless otherwise specified within the item. Assistance is not limited to physical contact, but includes both verbal cues and supervision.”

When completing M1840, Toilet Transferring, if the patient requires any degree of hands-on assistance and/or standby assistance and/or verbal cueing/reminders to get to/from the toilet and/or transfer on/off the toilet safely, select Response 1. An example of Response “1” could be a patient who requires verbal cues regarding safe use of walker while ambulating to the toilet.

When completing M1850, Transferring, minimal human assistance referenced in Response 1 would include a minimal degree of any combination of verbal cueing, environmental set-up and/or actual hands-on assistance. In order for the assistance to be considered minimal, it would mean the individual assisting the patient is contributing less than 25% of the total effort required to perform the transfer.

An example of Response “1” could be a patient that requires hands-on assistance during the change in position from supine to sitting at the edge of bed, where the effort contributed by the individual assisting is less than 25% of total effort required to change position.

M1845

Question: What if a patient has a new colostomy which she is completely dependent on someone to empty the appliance (Bag) as well as change the appliance but she can cleanse herself and care for her clothing with voiding. The patient usually changes the bag 1-2 x week –unless there are problems. Is this patient a “0”? Are we interpreting correctly, the only way we would ever score this patient a “3” is if she is changing the Appliance more often than she is voiding?

Answer: M1845, Toileting Hygiene, assesses the patient's ability on the day of the assessment to manage personal hygiene and clothing when toileting. If the patient has a colostomy, the hygiene would include cleaning (wiping) the perineal area after voiding and around the stoma when necessary. M1845 does not include the patient's ability to manage the ostomy bag, stoma wafers or other ostomy equipment.

On the day of the assessment, if the patient has the ability to safely manage their clothing and perform the personal hygiene as described above, the appropriate score would be a "0". How often the appliance (equipment) is changed does not factor into the scoring of this item.

M1850

Question: Is M1850 Transferring assessed for the patient who has slept for years in a recliner?

Answer: M1850, Transferring, must be assessed for all patients requiring OASIS data collection. The item includes assessment of the bed to chair/chair to bed transfers. If your patient no longer sleeps in a bed (e.g. sleeps in a recliner or on a couch), you will assess the patient's ability to move from the supine position on their usual sleeping surface to a sitting position and then transfer to another sitting surface, like a bedside commode, bench, or chair.

M1900

Question: M1900 asks about Prior ADL/IADL functioning. The item intent specifies identification of changes occurring in the patient's ability to perform ADLs/IADLs since the onset of the current illness, exacerbation, or injury that INITIATED THIS EPISODE OF CARE. Our question is: when answering M1900 at ROC (which could be in the same payment episode, but is the start of a different quality episode) should the answer be based on the patient's functional status immediately prior to this hospitalization, or based the patient's functional status prior to the start of care?

Answer: M1900, Prior Functioning ADL/IADL, reports the patient's usual ability prior to the onset of the illness, exacerbation or injury that initiated this episode of care. Episode of care is defined as a quality episode, meaning from SOC/ROC to Transfer/Discharge. When you are resuming care of a patient, as you described, and there has been no new onset of a illness, exacerbation of a chronic condition or injury, then you would report the patient's ability prior to the onset of the illness that caused the need for home care at SOC. A patient, however, is most often hospitalized due to a new illness, injury or exacerbation of an existing condition. If that was the case, then M1900 at ROC would report the patient's ability prior to the problem that caused the hospitalization.

M1910

Question: When conducting a web search, there are several options within the therapy community for conducting a TUG. If an agency adds the TUG to a multifactor falls assessment, can the agency decide on which instructions to be used for uniformity within the agency?

Answer: The CMS requirement is that a standardized validated assessment is used, which would

include use of the accompanying validated protocol for administration, including any validated protocol or scoring variations. In addition, please see the question below.

Question: If an agency uses the TUG among its multifactor falls risk assessment items and the TUG cannot be conducted because the patient is wheelchair bound and can transfer only, can that be considered a failed TUG and could the clinician correctly select the response that a multifactor falls risk assessment was conducted?

Answer: The CMS requirement is that a standardized validated assessment is used, which would include use of the accompanying validated protocol for administration, including any validated protocol or scoring variations. If the patient is not able to participate in tasks required to allow the completion and scoring of the assessment(s) that the agency chooses to utilize, “0 – No multi-factor fall risk assessment conducted” should be reported.

Question: Does this Risk Assessment Screening Tool in the Resources section of the OASIS C Guidance Manual meet the criteria of a standardized and validated tool?

“Home Care Fall Reduction Initiative risk Assessment Screening Tool (A multi-factor falls risk screening tool from the Missouri Alliance for Home Care, specifically designed for home care patients at Start of Care and Re-certification)”

Answer: The MAHC tool, at this time, has not undergone the process of validation. The MAHC tool can be used, in conjunction with a standardized, validated performance assessment; like the TUG (Timed Up and Go) or Functional Reach Assessment, to meet the requirements of the multifactorial standardized validated fall risk assessment.

Question: Does the falls risk assessment at the following MedQIC web site meet CMS criteria for “multi-factor” and “validated?”

<http://www.qualitynet.org/dcs/ContentServer?cid=1105558778382&pagename=Medqic/MQTools/ToolTemplate&c=MQTools>

Answer: The multi-factor falls risk assessment must include at least one standardized tool that 1) has been scientifically tested on a population of community dwelling elders and shown to be effective in identifying people at risk for falls; and 2) includes a standard response scale. It is the agency’s responsibility to determine if the tools they are considering for the OASIS-C M item best practice assessments meet the requirements as detailed in Chapter 3 of the OASIS-C Guidance Manual and the CMS OASIS OCCB Q&As.

Question: Which falls risk assessments meet the OASIS-C criteria for “multi-factor” and “validated?”

Answer: CMS does not endorse the use of any specific falls risk assessment tool. To meet the OASIS-C criteria for best practice assessment, the multi-factor falls risk assessment must consist of or include a standardized tool that 1) has been scientifically tested on a population of community dwelling elders and shown to be effective in identifying people at risk for falls; and 2) includes a

standard response scale. It is the agency's responsibility to determine if the tools they are considering for the OASIS-C M item best practice assessments meet the requirements as detailed in Chapter 3 of the OASIS-C Guidance Manual and the CMS OASIS OCCB Q&As. An agency may use a standardized falls risk tool from any organization able to effectively develop, test and validate the tool for use on a population of community dwelling elders.

Question: Some agencies are using the Missouri Alliance for Home Care (MAHC) fall risk assessment (10 points total/a score of 4 means fall risk) in combination with the TUG. If a patient scores a 4 or more on MAHC's Fall Risk which indicates a risk for falls and scores as a "no or low risk" on the TUG test – should the patient be considered at risk for falls?

Answer: Since the validated standardized test (the Timed Up and Go or "TUG") shows the patient is not at risk, they are considered to be not at risk. The OASIS-C Guidance Manual Chapter 3, M1910 Response Specific Instructions state you are to score based on the results of the standardized test. While the MAHC tool (Home Care Fall Reduction Risk Assessment Tool) is standardized, it is not validated at this time, so it would be impossible to know if the cutoff point included in the tool is a valid threshold for fall risk. If it were a matter of two validated, standardized tests being in conflict, an "at risk" score on either tool would indicate the presence of fall risk.

As a provider, even though the standardized test revealed no risk, you may want to look at what caused them to score "at risk" on the MAHC and intervene in those areas.

Question: If an agency adds the TUG to a multifactor fall risk assessment, can the agency decide on how to administer the tool by selecting any one of the many publicly available administration protocols?

Answer: The CMS requirement is that a standardized validated assessment is used, which would include use of the accompanying validated protocol for administration, including any validated protocol or scoring variations.

Question: I'm looking for guidance related to answering M1910 in a patient who is nonambulatory, bedbound and/or cognitively impaired. Would it be appropriate to use a standardized, validated tool that measures cognition or another factor of falls risk, such as the Folstein Mini-Mental Status Exam or the Gloth Frail Elderly Functional Assessment questionnaire, instead of the Tinetti, Functional Reach or Timed Up and Go, which aren't appropriate in this population?

Answer: For an assessment tool to meet the criteria for a "yes" response on M1910, the assessment would need to have been validated as a tool that specifically measures risk for falls. If the patient is not able to participate in tasks required to allow the completion and scoring of the assessment(s) that the agency chooses to utilize, "0 – No multi-factor fall risk assessment conducted" should be reported. The agency should be aware there are a number of validated fall risk assessment tools, some which allow the use of assistance, assistive devices, and even provide risk assessment options for nonambulatory patients. A single tool may not meet the fall risk assessment needs of all patients in the agency.

Question: How do we handle M1910, Fall Risk Assessment, for the patient who is ambulatory at home on their own, but based on clinician judgment, appears to require assistance to ambulate in order to be SAFE? For example, we know the patient is at risk for falls and balance is precarious enough that the clinician needs to guard the patient during the assessment. Should the clinician ask the patient to complete the TUG regardless and use the fact that they require assist of another person to complete the test to claim “Yes” on M1910 - standard test completed and indicated risk for falls even if they completed in < 14 seconds, or should we report “No” to M1910, formal assessment not completed, and document that the patient could not safely participate in the assessment. We are afraid to answer No, because the patient is not safe or at best marginally safe to perform the test, concerned it will negatively impact our process measure outcomes for this item.

Answer: The CMS requirement is that a standardized validated assessment is used, which would include use of the accompanying validated protocol for administration, including any validated protocol or scoring variations. If the patient is not able to participate in tasks required to allow the completion and scoring of the assessment(s) that the agency chooses to utilize, “0 – No multi-factor fall risk assessment conducted” should be reported. The agency should be aware there are a number of validated fall risk assessment tools, some which allow the use of assistance, assistive devices, and even provide risk assessment options for non-ambulatory patients. A single tool may not meet the fall risk assessment needs of all patients in the agency.

Question: We are having some difficulty in verifying the need for a standardized fall risk assessment tool to answer question M1910. In the guidance section, it is stating there is NOT a mandate for the use of standardized tools. However, in the question and answer, Question 14 it is stating YES under Standardized Assessment Required. We are using a multi-factor risk assessment screening with six questions, consisting of the six areas noted in question M1910. Is this okay to do and then answer yes to this question?

Answer: When the guidance states standardized tools are not mandated, it means CMS does not mandate their use as a condition of participation. However, if you want to answer the OASIS Process Measure items “Yes” or “NA”, you must use a standardized tool for M1240, Pain Assessment, M1730, Depression Screening, and M1910, Fall Risk Assessment, as specified in the item.

A standardized tool is one that has been scientifically tested and validated as effective in identifying a specified condition or risk in population with characteristics similar to the patient being evaluated. A standardized tool includes a standard response scale, and must be appropriately administered based on established instructions. To meet the need of the pain assessment, the depression screen or the multifactor fall risk assessment referenced in the OASIS, an agency may use a standardized tool from any organization able to effectively develop, test, and validate the tool for use on a population similar to that of the patient(s) being assessed. Without the validation process, an agency may not simply create an assessment by combining clinical assessment factors, unless the OASIS item indicates that the assessment can be based on clinical judgment, such as M1300, Pressure Ulcer Risk.

For M1910, the agency can use a multi-factor, standardized, validated fall risk assessment tool, or alternatively, a standardized, validated performance assessment, like the TUG (Timed Up and Go) or Functional Reach Assessment, combined with at least one other factor, e.g. fall history, polypharmacy, impaired vision, incontinence, etc. to meet the requirements of the multifactor, standardized validated fall risk assessment. It is the agency's responsibility to determine if your tool includes these elements. If an agency has evidence (from published literature, the tool developer, or another authoritative source) that the tool they are using assesses multiple factors that contribute to the risk of falling, has been scientifically tested and validated on a population of community dwelling elders, has been shown to be effective in identifying people at risk for falls, and includes a standardized response scale, then the agency can consider the tool to meet the requirements for the OASIS-C best practice assessment.

M2002

Question: Per the guidance Manual, M2002 item intent , “ identifies if potential clinically significant problems... were addressed”. Per RSI—“Clinically significant medication issues are those that, in the care providers’s judgement, pose an actual or potential threat...”

Reconciliation is only one aspect of a significant problem. Per Question 34 from Oct 2009 Q and A, “the two way communication AND reconciliation (or plan to resolve the problem)”.

It is clear that the “care provider” has an obligation on behalf of the patient’s health and wellbeing to notify the physician of actual or potential problems. When that conversation occurs, whether it is with the covering physician on the weekend or the PCP, the care provider is transferring the responsibility to the physician to determine the seriousness of the actual or potential problem, whether or not an issue really exists, and therefore whether immediate or delayed actions (plan) are necessary to resolve the problem and protect the patient.

Q 16 from the Jan 2010 Q and A indicates that a weekend covering physician who directs the clinician to contact the PCP on Monday would not be considered as “formulating a plan to reconcile the specific medication issue”. Based on the information provided by the care provider, when a physician decides to defer action to another colleague at a later time, he/she is making the decision that the reported issue is of no immediate consequence and therefore of no perceived harm to the patient. If there is an problem of significance that requires quick attention there is no question that the care provider should exercise their judgment and continue to pursue the physician until the problem is resolved to protect the patient. However, “Reconciliation” is not the resolution for all types of potential issues as Q 34 from Oct 2009 seems to indicate. “Plan” in “plan to resolve...” is not defined in any of the guidance to date. When the physician responds to the clinician, he/she responds to the clinical judgment of the care provider, accepts responsibility for the consequence of his/her decision, even if it is to defer to his/her colleague. How does that action on the part of the physician not meet the criteria “acknowledgement of receipt of information” and a “plan” for further action? The RSI continues with “and/or” indicating” further advice or instructions” are not required for the Yes response.

Answer: In the Q&A you are referencing, it was determined that the on-call physician asked the home health clinician to call back after the weekend, because he/she was not familiar with the

patient. This Q&A did not infer that there was an assessment of the information by the physician of the potential problem. An example of when it would be appropriate to answer “Yes” to M2002 is where the on-call physician receives the information, responds after assessing the situation, determines that this is a low-risk situation, orders medications continue as ordered and agency staff to call the regular physician on Monday. This still represents best practice, as there was an actual report to, and then an assessment/plan by the physician.

Question: If a clinically significant medication issue is identified on a weekend, and the agency phones the physician on-call, who does respond but because he doesn't really know the patient directs the agency to contact the primary care physician on Monday, can the clinician select Response 1 Yes – Physician or physician-designee was contacted within one calendar day to resolve clinically significant medication issues?

Answer: When completing M2002, Medication Follow-up, if the physician or physician designee responds within one calendar day and there is a resolution to the clinically significant medication issue or a plan to resolve the issue, Response “1-Yes” should be selected. In your scenario, you describe a

situation where the physician was contacted and informed of the medication issue, but due to the contacted physician's unfamiliarity with the patient, you were directed to contact the primary care practitioner on Monday. Therefore no one reconciled, or formulated a plan to reconcile the specific medication issue identified within one calendar day, so “0-No” should be selected.

Question: I am aware that in order to mark response “1 - Yes”, the two-way communication AND plan for reconciliation must be completed by the end of the next calendar day after the problem was identified. Does that “next calendar day” have to be within the 5 days after the SOC?

That is if the nurse finds a problem with the patient's meds while completing the comprehensive assessment on day 5 after the SOC, and the physician is notified and the problems are reconciled but not until day 6 after the SOC, (although it is within the one calendar day), can “1 - Yes” be marked?

Answer: M2002, Medication Follow-up, is only collected at the SOC and ROC. The item must be answered within the timeframe allowed at the SOC/ROC to ensure compliance with the Condition of Participation regarding the completion of the comprehensive assessment. If a problem is identified, the communication and reconciliation (or plan to resolve the problem) must occur within one calendar day of identification and before the end of the allowed timeframe in order to answer “1 - Yes.” If a medication issue is identified on day 5 after the SOC, the physician is contacted within one calendar day and responds back with a plan for reconciliation on day 6 after the SOC, this 2-way communication could not be captured at the SOC, but M2002 could be marked “1 -Yes” at a ROC time point, reflecting that the identification and 2-way communication w/plan for reconciliation had occurred as required by the item.

M2004

Question: M2004 relates to clinically significant medication issues arising “since the previous OASIS assessment”. If no other OASIS assessments were done between the SOC/ROC and the transfer/discharge (when M2004 is being collected), should the response at transfer/discharge include the medication issues reported at the SOC/ROC OASIS, if no other clinically significant medication issues occurred after the SOC/ROC?

Answer: M2004, Medication Intervention, should report if there were any clinically significant medication issues identified at the time of or since the previous OASIS assessment and is collected only at Transfer and Discharge. If the last OASIS assessment completed was the SOC or ROC, and a clinically significant problem was identified at that SOC or ROC visit, the problem (and/or related physician communication) would be reported at both the SOC/ROC (on M2002), and again at Transfer or Discharge (on M2004), since the time frame under consideration for M2004 is since OR AT the previous OASIS assessment.

M2010/M2015

Question: For the assessing clinician to select a “Yes” response to M2010, must the high risk drug education be provided on the actual SOC/ROC visit or can it be provided/completed on another visit by the same clinician within the 5 days of SOC and 2 days of ROC?

Answer: To respond “1-Yes” for M2010 Patient/Caregiver High Risk Drug Education, the patient and/or caregiver must receive the specified education for all high-risk medications within the assessment timeframe. It is not required that it all occur on the actual SOC/ROC visit. The education can be provided by clinicians other than the clinician responsible for completing the assessment. Please see the M2010 response specific instructions in Chapter 3, which references how to handle the situations where other agency staff are providing the education.

Question: How would Patient/Caregiver Drug Education for M2010 and M2015 be impacted for patients living in assisted living where the medications are managed by facility staff?

Answer: When completing the OASIS process measures that address patient/caregiver education, M2010, Patient/Caregiver High Risk Drug Education and M2015, Patient/Caregiver Drug Education, for patient’s residing in an assisted living facility, it may be appropriate to educate the patient and/or the staff administering the medication on the topics included in each item. As with patients who live at home, the decision to direct the teaching to the patient, caregiver, or both should be made by the assessing clinician, based on the specific circumstances. For the purposes of selecting a response, the facility staff would be considered caregivers.

Question: It states in Chapter 3 for M2010 and M2015 “If agency staff other than the clinician responsible for completing the SOC/ROC OASIS provided education to the patient/caregiver on high-risk medications, ...this collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and ultimately must be completed by one clinician.” Could this education include an office nurse giving the education over the phone to the patient?

Answer: A clinician other than the assessing nurse or therapist may provide drug education in person or by phone to the patient and/or caregiver. If the assessing clinician has knowledge this has been done, he/she may take credit for the education by selecting “Yes” in M2010 – High Risk Drug Education, or M2015 – Drug Education, whichever applies.

Question: We are asking your response to the following question that we received about M2015. Scenario: An agency has a client on service for multiple certification periods. M2015 states: Patient/caregiver Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug interactions and side effects and how and when to report problems that may occur? The instructions state: Drug education interventions for M2015 should address ALL medications the patient is taking – prescribed and over the counter – by any route. Our questions are:

If the agency provided education intervention on all medications the first episode, but the patient had no new meds the second episode that required education and there was no need to re-teach on all medications would they have to answer no in this case?

Answer: The Condition of Participation, 484.55 requires a Drug Regimen Review (DRR) at every comprehensive assessment time point. When performing the DRR, at the Recertification, if the assessing clinician evaluated the patient’s retention of prior teaching and determined the patient possessed all the required knowledge related to all medications, then M2015 would be answered “Yes”. If the assessing clinician had not re-assessed the patient’s medication knowledge and found the patient to be fully knowledgeable, or not provided drug education related to all medications at the time of or since the previous OASIS assessment, the M2015 response would be “No” at Transfer/Discharge.

Question: If the agency taught on only one or two medications in the second episode because of a re-teaching need, could they answer yes since they did not teach on all medications?

Answer: Yes. If the assessing clinician evaluated the patient’s retention of prior teaching and determined the patient possessed some of the required knowledge related to their medications, but needed reinforcement instruction for other meds, M2015 would be answered “Yes” if the needed education was provided.

Question: If the client does receive a new medication during the second episode and receives teaching on that one medication, could the agency answer yes even though they did not teach on all medications?

Answer: M2015 could only be answered “Yes” if teaching was provided on all medications or as described above, evaluation of knowledge revealed no need for teaching on established medications and needed education was provided on the new medication.

M2020

Question: How would we score M2020 Management of Oral Medications when a client needs reminders to take a medication on an as needed basis such as pain medication or extra dose of Lasix if weight increases by 5 lbs?

Answer: In M2020, Management of Oral Medications, you are reporting the level of assistance the patient needs on the day of the assessment to be safe when managing ALL oral medications; therefore you report the level of assistance for the most dependent medication. If the medication is ordered prn, and on the day of assessment the patient needed a reminder for this prn, then the patient would be a “2”. If on the day of assessment, the patient did not need any prn medications, therefore no reminders, then assess the patient’s ability on all of the medications taken on the day of assessment.

Question: The patient is on multiple medications which span 3 times a day. Yesterday, the doctor started her on a varying dose of Prednisone. The patient admits to being confused about the directions and right dosage. The clinician observes that the med box the patient set up is filled correctly with all usual medications, but not correctly with the prescribed Prednisone administration. The clinician also notes that the medication for last evening remained in the pill planner. Upon questioning, the patient admits to being tired and forgetting to take her evening medication. The nurse discusses the use of an alarm clock to remind her to take her evening medication and fixes the Prednisone dosage for the rest of the week. Considering this patient needed help with setting up one medication (Response 1) and a reminder for another (Response 2) in the last 24 hrs, what is the correct scoring with rationale for this situation?

Answer: The patient you described would be scored a “3-Unable to take medication unless administered by another person because on the day of the assessment, the patient did not possess the ability to take the Prednisone at the correct time and dose and demonstrated that through her report and actions. The pill planner had not enabled her to take the medications as ordered and a reminder could not have enabled the patient to take a medication when she didn’t have any idea what time and dose she needed to take the medications.

Rationale: First, note you are to report your patient’s ability on the day of the assessment (24 hours prior to the visit, and the time while in the home) and if ability varied, you report what was true regarding the medication that required the most assistance during that timeframe. This would mean you would not report ability after skilled intervention, as this is not a reflection of what was true in the most dependent medication during the day of assessment.

Many factors impact a patient’s ability to take all medications safely and reliably at the correct dose and time on the day of assessment, including physical and mental/emotional/cognitive status, activities permitted, and environment. Another imperative component is the required knowledge of the drug’s dose and administration schedule. A patient who does not possess this knowledge, does not have the ability to take the correct dose at the correct time as they lack the required education, unless other compensatory mechanisms have been placed in the home and assessed to be successful. A patient who does not have the requisite knowledge and no existing compensatory mechanisms would be scored a “3” until after they received the required education and demonstrated to the

clinician that they were able to take ALL medications at the correct dose and time or until the clinician has introduced an assistive device, such as a pill planner, and the patient has demonstrated success at taking meds as ordered, at all times.

Question: Please further explain and provide examples for M2020 Response 3.

Answer: Response 3, unable to take medication unless administered by another person, describes a patient who does not have the physical or cognitive ability on the day of assessment to take all their medications at the correct dose every time it is ordered to be administered, and it has not been established (and therefore the clinician cannot assume) that set up, diary, or reminders have already been successful. The clinician would need to return to assess if the interventions, such as reminders or a med planner were adequate assistance for the patient to take all medications safely, so therefore, Response 3 would be appropriate until this is known.

Some examples of Response 3, (but not a finite list) include:

- A patient who decided not to take her new medications, because the varying doses worried her, and she was unsure of the instructions. There had not been a mediset up, nor reminders tried. The clinician would select Response 3 because it is unclear until reassessment if the interventions will be successful.
- A patient who, upon assessment, was not able to take prescribed medications at the correct time and doses even though reminded.
- A patient who, on the day of assessment, was prescribed oral medications, but was unable to safely swallow.

M2030

Question: If we give a physician ordered one-time influenza vaccination and the patient does not have any injectable medications otherwise, is the answer to M2030 NA or #3?

Answer: If there is an order for the patient to receive the influenza vaccine SQ in the home, it would be included when responding to M2030, Management of Injectable Medications, even if it was a one-time injection. Anytime the physician has ordered the RN to administer an injection, the patient's ability would be reported as a "3-Unable to take injectable medication unless administered by another person." as you must report the patient's ability to inject the medication for which the most assistance is needed and an order for the RN to administer the injection is viewed as a medical restriction, preventing the patient from self administering.

M2100

Question: I am requesting clarification regarding M2100 (d) and (e) on the OASIS. If the patient does not have a medical procedure/ treatment or equipment ordered, what is the correct response? Not Applicable is not a choice, and I do not believe any portion of this item can be left blank. The only other option is "no assistance needed in this area". Is this correct?

Answer: Yes. When completing M2100, Types and Sources of Assistance, Row c. Medication administration, Row d, Medical procedures/treatments and Row e, Management of Equipment, in cases where the patient takes no medications, does not have a medical procedure or treatment, or medical equipment, the appropriate response would be "No assistance needed in this area."

Question: If one individual is identified as the “caregiver” for one of the categories (a. through g) under “Types of Assistance” must that same person be considered to be the “caregiver” for all categories of assistance, or should responses for a. through g. be based on patient access to multiple caregivers, each meeting different needs?

Answer: M2100, Types and Sources of Assistance, is not limited to a single caregiver. M2100 identifies the availability and ability of the caregiver or multiple caregivers to provide assistance needed by the patient in the various categories of assistance included. Chapter 3, M-2, Response Specific Instructions state when more than one response in a row applies regarding the caregiver(s), then choose the response that represents the greatest need.

Question: What should the response be if there is only one caregiver (For example, a patient may live with a spouse who is physically disabled) and that caregiver is able to assist the patient with activities b. through g., but is incapable of providing a. ADL Assistance. Should the response to a. ADL Assistance be “Assistance Needed but no Caregiver available” since it is clear that this person is incapable of assisting with ADLs? Or, should the response to a. ADL Assistance be: “Caregiver not likely to provide assistance?” The CMS Manual, Chapter 3 implies that the answer should be “Caregiver not likely...” based on the guidance on page M-2: “Caregiver(s) not likely to provide’ indicates that the caregiver(s) has indicated an unwillingness to provide assistance, OR THAT THE CAREGIVER(S) IS/ARE PHYSICALLY AND/OR COGNITIVELY UNABLE to provide needed care.” However, agencies have reported being advised during training to respond “Assistance needed but no Caregiver available.”

Answer: When a patient has a caregiver, the response “Assistance needed, but no caregiver available” is not appropriate. This response applies only when the patient has no caregiver at all.

If there is a caregiver but they are unwilling or unable to provide needed assistance for some areas included in M2100, the appropriate response for that category of assistance would be “Caregiver not likely to provide.” In your example, with the information provided, the response “Caregiver(s) not likely to provide assistance” would be correct.

Question: When completing M2100 for a patient with a Foley catheter, what areas, under type of assistance, should be considered?

Answer: The types of assistance that a foley catheter patient might need may be captured in multiple rows in M2100, Types and Sources of Assistance, as described below:

- a- ADL assistance as part of toileting hygiene? - Examples: cleansing around the catheter/peri care
- d- Medical procedure? Examples: insertion/removal of catheter, e.g. self cath or intermittent catheterization
- e- Management of equipment? - Examples: emptying the bag, changing the bag Note that if a patient needs assistance with multiple tasks included in one of the broad categories of assistance, the response selected should be based on the area requiring the most need.

Question: Do the responses for M2100, Types and sources of assistance, reflect the patient’s needs on the day of assessment or another time period, like the recent past?

Answer: When completing M2100, Types and Sources of Assistance, at the SOC/ROC, the assessing clinician will determine, to the best of his/her ability through observation and interview, what is known on the day of assessment regarding the availability and ability of caregivers to provide help in the various categories of assistance for the upcoming episode of care. For example, if Monday is the day of assessment and the patient reports her son pays her bills and brings in groceries every Friday. Even though the assistance will not be provided until Friday, the assistance is reported, as it is the anticipated availability and ability of caregiver assistance. At Discharge, the assessing clinician is reporting what is known on the day of assessment regarding the availability and ability of caregivers to provide assistance to the patient at the time of the discharge.

Question: When answering M2100 b, our clinicians often answer “1” - Caregivers currently provide assistance, based on the patient’s “greatest need” for assistance with housekeeping and/or shopping.

Please confirm if “0” is the correct response for M2100 b in situations where the patient is independent with eating, planning/ prep meals and phone use – as documented in OASIS Assessments M1780 (Feeding/Eating) = “0” (independent) and M1880 (Plan/Prep Meals) = “0” (independent) and M1890 (Phone use) = “0” (independent).

We are having a problem with agency computer system not allowing us to enter “1” response to M2100 when M1780, M1880 and M1890 are all assessed as “0”. This seems contradictory to clinical guidance.

Answer: For M2100b, IADL assistance, if more than one response applies, you are to report the response that reflects the patient’s “greatest need”. In your example, the patient needs help with housekeeping and/or shopping, and with these needs met by the caregivers, the response should be “1” “Caregivers currently provide assistance”.

Software vendors can add edits or flags in the comprehensive assessments to aide clinicians in their consistency of data collection. An edit in the instance you described may be an appropriate warning, directing the clinician to confirm the response selected, but should still allow the clinician to still choose Response “1” when appropriate. You are encouraged to contact your software vendor in cases where provided edits are questionable.

Question : Which category of assistance would taking care of a wound VAC fall under...Row (d) Medical Procedures or would it be considered Row (e) Management of Equipment?

Answer: The application/changing/removal of the wound dressing, including the foam and drape used with a wound VAC would constitute a “Medical procedure” as other dressing changes do. This would be considered and reported under Row d, Medical procedures. The emptying of the VAC canister or the disconnection/reconnection to the VAC for short times to allow certain activities would be considered management of the equipment and would be included under Row e, Management of equipment. M2250 - Depression

M2110

Question: Will the answer to M2110 always correlate to the M2100 Types and Sources of Assistance response? For example, if a patient needs assistance with ADLs and IADLs but the caregiver is unable/unwilling to assist with bathing and medications, would the scoring be based on the items that the patient needs the most assistance with but the caregiver is unable/unwilling to provide or would it be based on what assistance the caregiver provides regardless of patient need?

Answer: M2100, Types and Sources of Assistance, reports the source of assistance in a number of broad categories of activities (including ADLs, IADLs, Medication administration, Equipment Management, etc.) M2110, Frequency of Assistance, only addresses ADLs and IADLs, and provides more specific information related to the frequency with which assistance is provided for these broad tasks. You are correct that in M2100 you report the response that represents the most need and the availability and ability of the caregiver to meet that need. In M2110, simply report the frequency that the patient receives assistance with any ADLs/IADLs. Because of the different approaches with these items, a logical “tie” between the two may not always be apparent.

M2250

Question: M2250 - If the patient has a diagnosis of depression, but no symptoms per the standardized tool, can the clinician choose “NA”?

Answer: No. NA is only appropriate if the patient has NO diagnosis of depression AND the clinician completed an assessment that indicated the patient has no symptoms of depression (or does not meet criteria for further evaluation or treatment if a standardized depression screening tool was used).

M2250

Question: Many of the areas related to M2250 - Plan of Care Synopsis follow evidence-based practice. Use of fall prevention interventions, instruction in proper foot care for diabetic patients, pressure ulcer prevention education, and ongoing pain assessment/monitoring are all good clinical practices that routinely implement without specific physician’s orders. Are we now required to obtain physician’s orders for these general care practices?

Answer: It is understood that some of the best practices captured in M2250 includes care that might be routinely provided to a patient without a specific order. For instance, you may be admitting a patient for wound care, and in the process of your assessment, encounter a fall risk, like clutter on the floor. You might resolve the issue through intervention or education, all without obtaining a physician’s order.

However, if your agency wants to “get credit” for conducting this fall prevention intervention (by marking “yes” on M2250 (c)), you must have an order for fall prevention interventions.

Question: For M2250 - Plan of Care Synopsis.

Item Intent states that this identifies if the physician-ordered home health plan of care incorporates specific best practices. The “physician ordered plan of care” means that the patient

condition has been discussed and there is agreement as to the plan of care between the home health agency staff and the physician.

Response - Specific Instructions states that the question can be answered “Yes” prior to the receipt of signed ordered if the clinical record reflects evidence of communication with the physician to include specified best practice interventions in the plan of care.

In order to report on M2250 that physician orders exist, does that initial verbal/faxed communication need to include details of the specified best practice interventions (e.g. fall prevention interventions, pain monitoring, specific clinical parameters requiring physician notification, etc.)?

Could it be determined that all these specific best practice orders were present if the communication with the physician were more general (like the patient’s clinical findings are discussed with the physician and there is an agreement as to the general POC between the admitting clinician and the physician. Then the formal detailed POC is sent to the physician for signature, outlining the specific parameters and interventions)?

Answer: The OASIS-C process measures are not changing the expectations and requirements for communicating with the physician to obtain verbal orders prior to providing services.

The Medicare Benefit Policy Manual, defines clearly how orders can be obtained verbally if complete orders were not provided in the referral. Chapter 7, Section 30.2.5 states:

“Services which are provided from the beginning of the 60-day episode certification period based on a request for anticipated payment and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is an oral order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.”

All orders would be under the same instruction from CMS, including those which are reported in M2250 and M2400.

Question: Regarding the physician-ordered plan of care, when documenting that orders were obtained in the Plan of Care Synopsis, is it acceptable to incorporate the general wording of the current process measures into the plan of care or are orders expected to be more specifically documented? (e.g. SN to monitor and mitigate pain, instruct on fall prevention measures, etc.)

Answer: When completing M2250, Plan of Care Synopsis, it is not required that you include the exact words used in the M2250 item, just that interventions representing the specified best practice be included in the physician-ordered plan of care. In some cases, if all you included were the exact words, it would not meet the requirements. For example, if the order read “Monitor and mitigate pain”, the phrase “mitigate pain” would not be a specific intervention that could be followed in an effort to relieve pain. It would be expected that an order for a specific intervention be included, e.g. Tylenol 500 mg q6h, teach guided imagery techniques to relieve pain, etc. However, in other cases, using the exact words from the M item would suffice, e.g. “Monitor lower extremities for lesions and teach patient/caregiver proper diabetic foot care.”

Question: When referring to the plan of care in M2250, are you just referring to the original Plan of Care (e.g. 485) or are you referring to Interim Physician orders that are sent during the episode as well?

Answer: The physician plan of care includes all additional orders as an extension of the original Plan of Care.

Question: Please clarify the timeframe allowed for completing M2250 at the ROC. Chapter 3, Response-Specific Instructions reference “the 2-day ROC window”. Is that within 2 days of the ROC date, M0032, as our OASIS data specs allow or within 2 days of the patient’s discharge from the inpatient facility?

Answer: When completing M2250 at the ROC, orders for the specified best practices must be obtained within 2 calendar days of the patient’s discharge from the inpatient facility, or within 2 calendar days of knowledge of the patient’s return home in order to answer “Yes”.

Question: Does the inclusion of existing ordered antidepressant medications on the medication profile equate to a “Yes” response to Depression Interventions on M2250 and/or M2400?

Answer: M2250, Plan of Care Synopsis and M2400, Intervention Synopsis, report whether the physician ordered plan of care includes depression interventions. The presence of an existing antidepressant medication in the medication profile/plan of care is considered a depression intervention.

M2250a

Question: I am confused about when I will pick NA for M2250a.

Answer: When completing M2250a - Patient-Specific parameters, at the Start of care or Resumption of the Care, the clinician will Answer:

- “Yes” if the plan of care includes specific parameters ordered by the physician for this specific patient or after reviewing the agency’s standardized parameters with the physician, s/he agrees they would meet the needs of this specific patient.
- “No” if there are no patient specific parameters on the plan of care and the agency will not use standardized physician notification parameters for this patient.
- “NA” if the agency uses their own agency standardized guidelines, which the physician has NOT agreed to include in the plan of care for this particular patient.

M2250g; M2400f

Question: For M2250g - Plan of Care Synopsis and 2400f – Intervention Synopsis, Is a protective skin barrier considered a moist wound treatment for a pressure ulcer? Can you provide specific examples of moist wound healing treatments for pressure ulcers?

Answer: Moist wound healing treatment is basically any primary dressing that hydrates or delivers moisture to a wound thus promoting an optimal wound environment and includes films, alginates,

hydrocolloids, hydrogels, collagen, negative pressure wound therapy, unna boots, medicated creams/ ointments. CMS cannot provide you with specific products.

Question: For M2250g – Plan of Care Synopsis and M2400 – Intervention Synopsis, may I answer “Yes” if either the physician ordered plan of care has orders for pressure ulcer treatments based on the principles of moist wound healing, OR if I requested these orders from the physician, but s/he refused to agree to them or have not been established yet?

Answer: M2250, Plan of Care Synopsis, Row g. may be answered “Yes” if, by the end of the allowed assessment time period (5 days after SOC date/2 days after inpatient facility d/c for ROC) the physician-ordered plan of care includes orders for pressure ulcer treatment based on the principles of moist wound healing. The assessing clinician may also answer “Yes” in cases where the moist wound healing treatment was requested of the physician, by the end of the allowed assessment time period. It would not be required that the response from the physician be obtained in order to qualify as a “Yes”. If the physician response is “No, moist wound healing is not appropriate for this patient” NA would be the correct response.

The parallel item in M2400 does not offer any option that an order for treatment using principles of moist wound healing was requested from the MD. So at M2400 if the MD does not order treatment based on principles of moist wound healing, “no” must be reported on line f unless the patient meets the criteria listed to mark NA.

Question : Is it the clinician’s clinical decision or the physician’s that will determine the patient has no pressure ulcers with need for moist wound healing at M2250 and M2400?

Answer: A physician ordered plan of care means that the patient condition has been discussed and there is agreement as to the plan of care between the home health agency staff and the physician. The clinician would discuss the patient’s pressure ulcers with the physician and not make the decision regarding appropriate treatment alone. While clinicians caring for patient with pressure ulcers may be cognizant of wound care guidelines for pressure ulcer management and understand that certain pressure ulcers are not appropriate for moist wound healing, each patient status is to be discussed with the physician who ultimately makes all treatment plan decisions. When it is determined by the clinician/physician team or solely by the physician that moist wound healing is not appropriate for the patient, the response “NA” would be chosen, and the clinician would then document the rationale behind not utilizing the moist wound healing techniques.

M2310

Question: If a patient goes to the hospital emergency department for a suspected DVT and scans/tests rule out DVT, is the correct response for M2310 #18 (Deep Vein Thrombosis, pulmonary embolus) or #19 (Other than above reasons)?

Answer: M2310, Reason for Emergent Care, reports the reason the patient sought emergent care. In the situation you described, the patient sought care for a suspected DVT, even though the result of the evaluation was negative for a DVT, it was the reason they sought care and Response 18, Deep Vein Thrombosis, would be appropriate.

Question: OASIS-C reflects changed wording for the Emergent Care Reason Response 2 - Injury Cause by Fall. OASIS B-1 previously indicated Injury Caused by Fall or Accident at Home in answer 3 (M0840). When reviewing the response-specific instructions in Chapter 3 for M2310 an example is given indicating a fall at home. Is the intent of M2310 Response 2 for all falls or falls at home?

Answer: M2310, Response 2 “Injury caused by fall” is no longer restricted to a fall at home. It should be selected when the patient sought care in the emergency room for an injury caused by any fall, anywhere, e.g. while at home, at the physician’s office, church, etc. The home health agency should educate the patient and caregiver on fall prevention measures applicable to any location where the patient may be. The home health agency is responsible for preparing the patient for safety and function after discharge.

Question: A clinician assesses the patient at SOC and calls the physician with a report and to discuss the POC. The clinician asks if the physician would like a report of abnormal vital signs during the episode and recites the parameters found in the agency’s standardized guidelines. The physician says “Yes” and the order with the parameters are printed on the POC for his signature. Is this considered “patient specific parameters” resulting in a YES response for row a?

Answer: If the physician agrees that the agency’s standardized parameters would meet the needs of this specific patient, they would become patient specific parameters.

M2400

Question: Does the inclusion of existing ordered antidepressant medications on the medication profile equate to a “Yes” response to Depression Interventions on M2250 and/or M2400?

Answer: M2250, Plan of Care Synopsis and M2400, Intervention Synopsis, report whether the physician ordered plan of care includes depression interventions. The presence of an existing antidepressant medication in the medication profile/plan of care is considered a depression intervention.

Question: We are trying to understand the criteria for NA for M2400. Is the formal assessment considered only when it appears as a data element on the previous assessment? The SOC or ROC is not always the previous assessment. Can a formal assessment be considered any time the agency chooses to conduct one as long as it occurs at the time of or since the previous assessment? Here are some scenarios.

The patient has a SOC and recertification assessment. The formal assessments using tools meeting the criteria of standardized and validated for pain and falls risk were conducted at SOC. At discharge, looking back the previous OASIS assessment is recertification. Is NA an eligible choice for M2400b and d since M1240 and M1900 are not OASIS data elements collected at recertification?

Answer: No. See below.

Question: Is NA an eligible choice for M2400b and d if the clinician chooses to conduct and documents the results of the formal assessments at the time of recertification?

Answer: Yes. See below.

Question: The patient has a SOC and recertification assessment. The agency practice is to conduct a formal pain assessment with each visit. The formal pain assessment conducted the visit prior to the discharge visit indicates pain at a level of 2 on a scale of 1-10. The day of discharge, the patient rates his pain as 0. Is NA the appropriate response?

Answer: The formal assessment on the day of discharge revealed no pain, so NA is appropriate. In order to select “NA”, a formal assessment such as those specified in M1240, M1300, M1730, and M1910 must have indicated the intervention(s) was not applicable to the patient. Even though not required, you may elect to perform the best practice formal assessments at anytime from the time of the last OASIS assessment until the time of the Transfer/Discharge. Doing so, would give you have the opportunity to select “NA” when appropriate, in cases where the patient, at previous OASIS assessment did not receive the specified formal assessments.

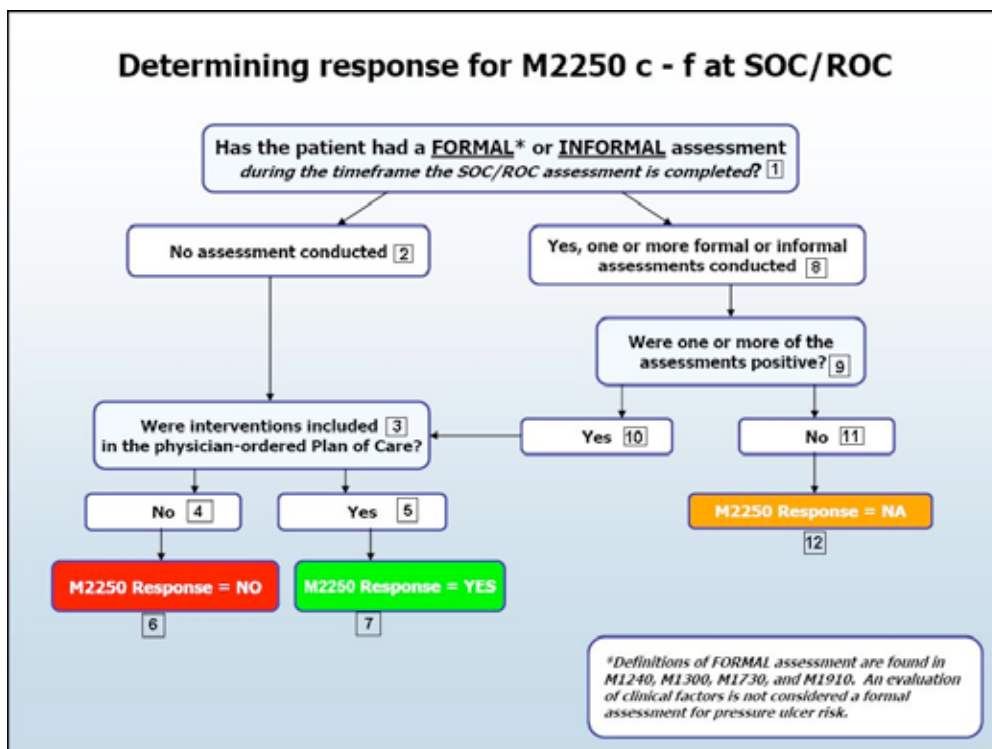
Question: The “NA” column of M2400 refers to use of a “formal” assessment tool”. Does formal mean standardized? Is the clinician allowed to respond “yes” (interventions on the POC and implemented) if a formal/standardized tool was not used in the assessment of b through e?

Answer: Chapter 3 Item Intent states “The formal assessment that is referred to in the last column for rows b-e refers to the assessment defined in OASIS items for M1240 – Formal Pain Assessment, M1300 – Pressure Ulcer Assessment, M1730 – Depression Screening, and M1910 – Fall Risk Assessment.” For M1240, M1730, and M1910 this means a standardized assessment. For M1300 – Pressure Ulcer Assessment, the use of a standardized assessment tool is optional.

You may say “Yes” to M2400 b - e, if the specified clinical interventions were included in the physician ordered plan of care and implemented at the time of or since the previous assessment whether or not a formal assessment was performed. However, the Response Specific Instructions state that for Rows b-e, in order to select “NA-Not applicable”, a formal assessment must have been performed as defined in the relevant OASIS items.

Question: Please clarify the use of the “NA” response option in M2250 rows c-f, and M2400 rows b-e, specifically when the previous/most recent assessment was a Recert assessment, where items related to pain, pressure ulcers, depression and fall risk assessment are not collected. The Chapter 3 guidance states this: ‘For rows b-e, a formal assessment (as defined in the relevant OASIS item M1240, M1300, M1730, and M1910) must have been performed to select “Not Applicable.” My question is then if the recert assessment did not contain these fields, am I correct to assume that the answers for each row would be “No”, and not “NA”.

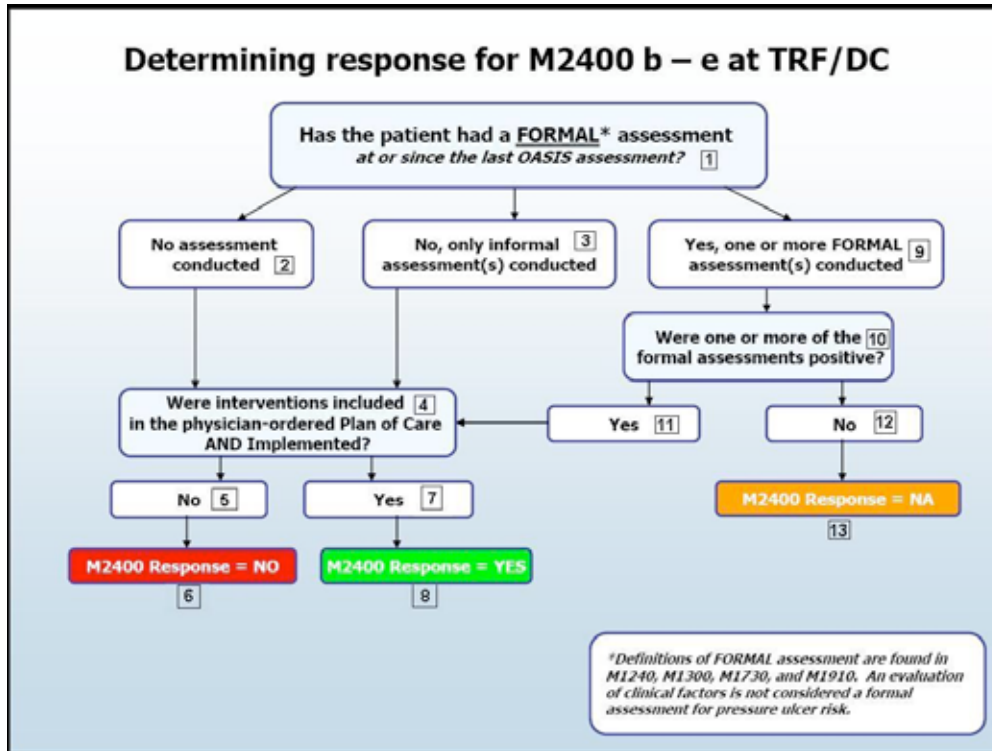
Answer: When collecting OASIS data at transfer or discharge where the most recent assessment was a recertification, M2400 rows b-e do not necessarily need to be reported at “No” because the formal assessments for pain, pressure ulcers, depression and fall risk are not collected on the Recert assessment. The clinician may have conducted a formal assessment either at the recert time point, or since that time, indicating that the patient was not at risk for falls (or did not have pain, etc.), in which case “NA” might be the appropriate response, depending on all other available information. The following two flowcharts guide M2250 and M2400 decision making:



Definitions of FORMAL assessment are found in M1240, M1300, M1730, and M1910. An evaluation of clinical factors is not considered a formal assessment for pressure ulcer risk.

If no formal or informal assessment was conducted, determine whether interventions were included in the physician-ordered Plan of Care.

Step	Action
1	Determine whether a formal or informal assessment was completed during the timeframe the SOC/ROC assessment was completed.
2	If no formal or informal assessment was conducted, determine whether
3	interventions were included in the physician-ordered Plan of Care.
4	If no interventions were included in the physician-ordered Plan of Care, the
5	M2250 response is NO.
6	If interventions were included in the physician-ordered Plan of Care, the
7	M2250 response is YES.
8	If a formal or informal assessment was conducted, determine whether one
9	or more of the assessments were positive.
10	If one or more of the assessments were positive, determine whether interventions were included in the physician-ordered Plan of Care. If no interventions were included in the physician-ordered Plan of Care, the M2250 response is NO. If interventions were included in the physician-ordered Plan of Care, the M2250 response is YES.
11	If one or more of the assessments were not positive, the M2250 response is
12	NA.



Definitions of FORMAL assessment are found in M1240, M1300, M1730, and M1910. An evaluation of clinical factors is not considered a formal assessment for pressure ulcer risk.

Step	Action
1	Determine whether a formal assessment was completed at or since the last OASIS assessment was completed. If no formal or informal assessment was conducted,
2	If no assessment was conducted, or only informal assessments were
3	conducted, determine whether interventions were included in the physician ordered
4	Plan of Care and whether those interventions were implemented.
5	If no interventions were included in the physician-ordered Plan of Care and
6	implemented, the M2400 response is NO.
7	If interventions were included in the physician-ordered Plan of Care and
8	implemented, the M2400 response is YES.
9	If one or more formal assessment(s) was conducted, determine whether
	one or more of the formal assessments were positive.
10	If one or more of the formal assessment(s) was positive, determine whether
11	interventions were included in the physician-ordered Plan of Care and implemented.
	If no interventions were included and implemented, the M2400 response is NO.
	If interventions were included and implemented, the M2400 response is YES.
12	If one or more of the formal assessments were not positive, the M2400
13	response is NA.

M2420

Question: For M2420, if the patient is discharged home and the family has arranged for a paid caregiver that is not through a private duty agency, is this a “formal assistive service” or “without formal assistive service”?

Answer: The “formal assistive services” referenced in Response options 1 and 2 refer to those services provided through organizations or by paid helpers. Examples:

Personal care services provided by a home health agency, paid assistance provided by an individual, meals provided by Meals on Wheels.

Informal services are provided by friends, family, neighbors, or other individuals in the community for which no financial compensation is provided. Examples: Assistance with ADLs provided by a family member, transportation provided by a friend, meals provided by church members (i.e., meals not provided by the church organization itself, but by individual volunteers).