

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

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

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

A1. The most current version of the OASIS data set will always be available on the OASIS website  
[http://www.cms.hhs.gov/HomeHealthQualityInits/12\\_HHQIOASISDataSet.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage). When revisions are necessary in the future, we will post them on the website well in advance of their effective dates. [Q&A EDITED 08/07]

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

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

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

A3. While we encourage HHAs to integrate the OASIS data items into their own assessment instrument in the sequence presented on the OASIS data set for efficiency in data entry, we are not precluding them from doing so in a sequence other than that presented on the OASIS data set. Agencies collecting data in hard copy or electronic form must incorporate the OASIS data items EXACTLY as they are written into their own assessment instrument. Agencies must carefully consider any skip instructions contained within the questions in the assessment categories and may modify the skip language of the skip pattern as long as the resulting data collection complies with the original and intended skip logic. When agencies encode the OASIS data they have collected, data MUST be transmitted in the sequence presented on the OASIS data set. The software that CMS has developed for this function (HAVEN) prompts the user to enter data in a format that will correctly sequence the item responses and ultimately be acceptable for transmission. HAVEN includes certain editing functions that flag the user when there is missing information or a question as to the accuracy or validity of the response. Agencies may choose to use software other than HAVEN to report their data so as long as the data are ultimately presented to the State agency in the required CMS data submission format found on the CMS Website at [http://www.cms.hhs.gov/oasis/04\\_dataspecifications.asp](http://www.cms.hhs.gov/oasis/04_dataspecifications.asp). This file that contains the OASIS data items in the same order as contained on the OASIS data set. [Q&A EDITED 08/07]

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

A4. We are not aware of any standardized quality assurance tool that exists to verify that clinical staff members are using OASIS correctly. A variety of audit approaches might be used by an agency to validate the appropriate responses to OASIS items. For example, case conferences can routinely incorporate OASIS items as part of the discussion. Multi-discipline cases with visits by two disciplines on adjacent days can contribute to discussion of specific items. (Note that only one assessment is reported as the 'OASIS assessment.')

Supervisory (or peer) evaluation visits can include OASIS data collection by two clinicians, followed by comparison of responses and discussion of any differences. Other approaches to data quality monitoring are included in the *OASIS User's Manual*, Chapter 12 available at [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp). [Q&A EDITED 08/07]

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

A5. We have posted the OASIS data set in both .PDF format, i.e., read only format, and Word format on the OASIS Data Sets page at [http://www.cms.hhs.gov/HomeHealthQualityInits/12\\_HHQIOASISDataSet.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage). [Q&A EDITED 08/07]

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

A6. The most current version of OASIS will be found on the CMS OASIS website. HHAs are required to incorporate the OASIS data items exactly as written into the agency's comprehensive assessment. For agencies using software that does not accommodate bolding or underlining for emphasis of words in the same manner as the current OASIS data set, capitalizing those words is acceptable. We also recommend including the M0xxx numbers when integrating to alert clinicians that the M0xxx labeled items MUST be assessed and completed. Ultimately this will minimize delays in encoding due to uncompleted OASIS data items. Please refer to Appendix C of the *OASIS User's Manual* (available at [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp)) for examples of a comprehensive assessment (sample clinical records) showing an integration of the OASIS data items with other agency assessment items for each time point. The OASIS data sets are available in Appendix B in the *OASIS User's Manual* or on the OASIS Data Sets page at [http://www.cms.hhs.gov/HomeHealthQualityInits/12\\_HHQIOASISDataSet.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage). [Q&A EDITED 08/07]

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

A7. The sample assessment forms (incorporating OASIS items) found on the OASIS Data Sets page [http://www.cms.hhs.gov/HomeHealthQualityInits/12\\_HHQIOASISDataSet.asp#TopOfPage](http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage) most closely resemble nursing assessments. CMS does not have sample rehab

assessment examples, though such assessments have been developed by commercial vendors. If an agency chooses to develop its own rehab-specific assessment forms, the principles for documenting OASIS items into an agency's clinical documentation are outlined in Chapters 4 and 7 of the *OASIS User's Manual* available at [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp). [Q&A EDITED 08/07]

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

A8. The a) definer (related to an inpatient stay) is specific to SOC (or resumption of care after an inpatient stay), and Follow-up assessment time points. It is not appropriate for the Discharge and therefore is omitted from that time point version. The data set instructs “\*At discharge, omit references to inpatient facility stay.” [Q&A EDITED 08/07]

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

A9. The Comprehensive Assessment Final Rules, published January 25, 1999, state that the OASIS data items are to be incorporated into the HHA's own assessments, not only for the start of care, but for all the time points at which an update of the comprehensive assessment is required. Because all such documentation is part of the patient's clinical record, it follows that the OASIS items are also part of the clinical record. Verifying the accuracy of the transmitted OASIS data (part of the condition of participation [CoP] on Reporting OASIS information) requires that the OASIS data be retained as part of the clinical documentation. To access the CoP, go to <http://www.cms.hhs.gov/center/hha.asp>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. [Q&A EDITED 08/07]

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

A10. As noted in CFR §484.55 (the condition of participation [CoP] regarding comprehensive assessment), "each patient must receive a patient-specific comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes." The preamble to this rule also notes that the OASIS data set is not intended to constitute a complete comprehensive assessment. Each agency must determine, according to their policies and patient population needs, the additional assessment items to be included in its comprehensive assessment forms. Clinical notes are to be completed as required by 42 CFR 484.48 and the home care agency's clinical policies and procedures. To access the CoP, go to

<http://www.cms.hhs.gov/center/hha.asp>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. [Q&A EDITED 08/07]

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

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

A12. In the ADL/IADL data items (M0640 through M0800), the patient's ability 14 days prior to the start (or resumption) of care is addressed. In these items, 'prior' indicates the patient's status on the 14th day before the start (or resumption) of care. Adhere strictly to this 14-day time point. If the patient was in a hospital at that time, describe the patient's ability on that day. Several other OASIS items (e.g., M0170, M0200, etc.) address events that may have occurred within the last 14 days. In responding to those items, the entire 14-day period should be considered. For example, was the patient discharged from an inpatient facility during the span of 14 days? [Q&A EDITED 08/07]

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

A13. The answer to this question depends on whether your agency uses separate assessment forms for Transfer to an Inpatient Facility and for Discharge (not to an inpatient facility). If it has separate forms, these three data items should be included in the assessment for Transfer to Inpatient Facility and not included in the Discharge assessment. On the Transfer to an Inpatient Facility, these items are included in the list of assessment items to be completed. Under Discharge from Agency - Not to an Inpatient Facility, these items are correctly not included. If your agency uses only one form that includes both Transfer and Discharge, however, these items should be included, with notation directing the assessing clinician to only collect these and Transfer (RFA 6 or 7) and not at Discharge (RFA 9). [Q&A EDITED 08/07]

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

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

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

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

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

A17. Since home care visits can occur at any time of the day, and to standardize the time frame for assessment data, the “day of the assessment” refers to the 24-hour period directly preceding the assessment visit, plus the time the clinician is in the home conducting the assessment. This standard definition ensures that fluctuations in patient status that may occur at particular times during the day can be considered in determining the patient’s ability and status, regardless of the time of day of the visit. [Q&A added 06/05; Previously CMS OCCB 8/04 Q&A #1] [Q&A EDITED 08/07]

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

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

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

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

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

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

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

**Q4. What do the “M000” numbers stand for?**

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

#### **Q4.1. M0010 & M0072**

- 1. As of May 23, 2007, should M0010 Agency Medicare Provider Number report the six-digit Medicare Provider Number, as in the past, or the agency's NPI number?**
- 2. And should M0072 Primary Referring Physician ID report the six-digit UPIN, as in the past, or the ten-digit NPI number for the referring physician?**

A4.1: M0010 will not report the new agency NPI number, but will continue to report the Agency Medicare Provider Number (now called Centers for Medicare and Medicaid Services Certification Number or "CCN"). M0010 is a six-digit field and would not accommodate the ten-digit NPI number. The agency NPI number will not be collected anywhere in the OASIS data set, although, after set up, it can be imbedded in the header and body of the transmission file.

Beginning May 23, 2007, home health agencies may begin entering the physician's NPI number in M0072 Primary Referring Physician ID. To accomplish this, agencies will need to collect NPI numbers from referring physicians to be entered into OASIS item M0072 for any assessment completed on or after May 23, 2007. Agencies should also be working with their software vendors to determine if any changes are required to accommodate this. The OASIS Data Specifications Version 1.50 and HAVEN 7.1 currently provide 10 spaces for this OASIS item. This space is sufficient to accommodate the Physician's NPI number.

If by May 23, 2007, the agency is unable to comply with the instruction to enter the physician's NPI number in M0072, they should continue to enter the UPIN number and at least initially assessments will not be rejected. Mandatory collection of the physician's NPI number on the OASIS data set is not required under the HIPAA National Privacy Rule (NPI) Rule, but CMS may require NPI collection on the OASIS in the future. Since it is not currently required, there will not be an integrity check. The file will not be rejected if M0072 is filled with the UPIN number.

Since the agency must collect and use this number to comply with the NPI Rule, it is recommended that as they attain compliance with collection and use of the physician's NPI number for required functions; they simultaneously use it to report the Primary Referring Physician ID in M0072. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #8]

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

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

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

A6. The start of care date (M0030) is the date of the first reimbursable service and is maintained as the start of care date until the patient is discharged.. It should correspond to the start of care date used for other documentation, including billing or physician orders. [Q&A EDITED 08/07]

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

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

**Q7.1. M0030. Related to M0030, the 06/06 revisions to Chapter 8 of the OASIS Implementation Manual, have redefined the SOC date to be the day of the first skilled visit. The revisions substituted "skilled" for "reimbursable". Does this mean that once need and eligibility is established, aide visits provided before the first skilled visit are not included in the episode of care? For instance, if PT and HHA are ordered, and a registered nurse does a non-billable initial assessment visit to establish needs and eligibility for a therapy only patient, can't the home health aide make a "reimbursable" visit prior to the day the therapist makes the first "skilled" visit for a Medicare patient? And wouldn't the aide's visit establish the SOC?**

A7.1: CMS Q&A, Category 2, Question 36 clarifies that the "start of care" is defined as the first billable visit. The change in language found on page 8.18 of the 06/06 revision to Chapter 8 of the OASIS Implementation Manual, where the word "reimbursable" was replaced with "skilled" was unintentional and providers are instructed to continue to define the Start of Care as the date the first covered or reimbursable service is provided.

It is possible that the visit that establishes the SOC is not skilled, as in the scenario presented in the question above where the aide's visit is both reimbursable and establishes the start of care for the episode. The Conditions of Participation 484.55, Comprehensive Assessment of Patients Interpretive Guidelines states "For all practical purposes, the start of care date is the first billable home visit. For payers other than Medicare, the first billable visit might be a visit made by a home health aide." More recent instruction in the Medicare Benefits Manual (Chapter 7, Sequence of Qualifying Services) does state that now, even for Medicare, the first billable visit might be a visit made by a home health aide, once the need and eligibility has been established. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #7]

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

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

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

A9. Yes.

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

Q10. The patient's Medicare number should be entered, whether or not Medicare is the pay source for the episode. Keep in mind that Medicare is often a secondary payer, even when another payer will be billed first. In order to bill Medicare as a Secondary Payer, the patient must be identified as a Medicare patient from the start of care. If the agency does not expect to bill Medicare for services provided by the agency during the episode, then Medicare would not be included as a pay source on M0150, even though the patient's Medicare number is reported in M0063. [Q&A EDITED 08/07]

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

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

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

**Q12.1. M0010 & M0072**

- 3. As of May 23, 2007, should M0010 Agency Medicare Provider Number report the six-digit Medicare Provider Number, as in the past, or the agency's NPI number?**
- 4. And should M0072 Primary Referring Physician ID report the six-digit UPIN, as in the past, or the ten-digit NPI number for the referring physician?**

A12.1: M0010 will not report the new agency NPI number, but will continue to report the Agency Medicare Provider Number (now called Centers for Medicare and Medicaid Services Certification Number or "CCN"). M0010 is a six-digit field and would not accommodate the ten-digit NPI number. The agency NPI number will not be collected anywhere in the OASIS data set, although, after set up, it can be imbedded in the header and body of the transmission file.

Beginning May 23, 2007, home health agencies may begin entering the physician's NPI number in M0072 Primary Referring Physician ID. To accomplish this, agencies will need to collect NPI numbers from referring physicians to be entered into OASIS item M0072 for any assessment completed on or after May 23, 2007. Agencies should also be working with their software vendors to determine if any changes are required to accommodate this. The OASIS Data Specifications Version 1.50 and HAVEN 7.1 currently provide 10 spaces for this OASIS item. This space is sufficient to accommodate the Physician's NPI number.

If by May 23, 2007, the agency is unable to comply with the instruction to enter the physician's NPI number in M0072, they should continue to enter the UPIN number and at least initially assessments will not be rejected. Mandatory collection of the physician's NPI number on the OASIS data set is not required under the HIPAA National Privacy Rule (NPI) Rule, but CMS may require NPI collection on the OASIS in the future. Since it is not currently required, there will not be an integrity check. The file will not be rejected if M0072 is filled with the UPIN number.

Since the agency must collect and use this number to comply with the NPI Rule, it is recommended that as they attain compliance with collection and use of the physician's NPI number for required functions; they simultaneously use it to report the Primary Referring Physician ID in M0072. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #8]

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

A13. In item M0080 - Discipline of Person Completing Assessment, you will find the initials of clinicians (RN, PT, SLP/ST, OT) who can initiate a qualifying Medicare home health service and/or are able to complete the assessment. Social workers are not able to initiate a qualifying Medicare home health benefit or complete the comprehensive assessment, but may support other qualifying services. In the Medicare Conditions of Participation (CoP), CFR 484.34, conducting a comprehensive assessment of the patient is not considered a service that a social worker could provide. To access the CoP, go to <http://www.cms.hhs.gov/center/hha.asp>, click on "Conditions of Participation: Home Health Agencies" in the "Participation" category. [Q&A EDITED 08/07]

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

A14. Generally, you would enter the last day that assessment information was obtained on the patient in his/her home, if all clinical data items were completed. However, if the clinician needs to follow-up, off site, with the patient's family or physician in order to complete an OASIS or non-OASIS portion of the comprehensive assessment, M0090 should reflect the date that last bit of information is collected. [Q&A EDITED 08/07]

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

A15. That message is intended to be a reminder that you should complete a transfer assessment within 48 hours of learning of it. The regulation states that the assessment must be completed within 48 hours of learning of a transfer to an inpatient facility, so in this case, the assessment has been completed in compliance. The warning does not prevent the assessment from being transmitted. If you find that this warning occurs consistently, you may want to examine whether your staff are appropriately tracking the status of patients under their care. [Q&A EDITED 08/07]

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

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

In the situation where the clinician needs to follow up, off site, with the patient's family or physician in order to complete a specific clinical data item that the patient is unable to answer, M0090 should reflect that date. [Q&A EDITED 08/07]

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

A17. The HHA has the overall responsibility for providing services, assigning ICD-9-CM codes, and billing. CMS expects that each agency will develop their own policies and procedures and implement them throughout the agency in a manner that allows for correction or clarification of records to meet professional standards. It is appropriate for the clinician to enter the medical diagnosis on the comprehensive assessment. The HHA can assign a qualified coder to determine the correct numeric code based upon the written diagnosis provided by the assessing clinician. The date at M0090 (Date Assessment Completed) should reflect the actual date the assessment is completed by the qualified clinician. If agency policy allows the assessment to be performed over more than one visit, the date of the last visit (when the assessment is finished is the appropriate date to record. The M0090 date should not necessarily be delayed until coding staff verify the numeric codes. [Q&A added 06/05] [Q&A EDITED 08/07]

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

A18. While a thorough review by a clinical supervisor may improve assessment completeness and data accuracy, the process for such review is an internal agency decision and is not required. The assessment completion date (to be recorded in M0090) should be the last date that data necessary to complete the assessment is collected. [Q&A EDITED 08/07]

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

- a. Can the agency perform the RFA 09 and RFA 01 on the same visit?
- b. If so, what is the discharge date for the RFA 09 at M0090?
- c. If so, what is the admission date for RFA 01 at M0090?

**d. Will recording of the same date for both of these assessment result in errors when transmitted to the state agency?**

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

**Q19.1. M0090. The RN conducted the SOC assessment on Monday. The RN waited to complete the assessment until she could confer with agency therapists after they had completed their therapy evaluations. This communication occurred on Tuesday and included a discussion of the plan of care and the therapists' input on the correct response for M0825. If the RN selects a response for M0825 based on the input from the therapists, does this violate the requirement that the assessment is to be completed by only one clinician? And what is the correct response for M0090, Date Assessment Completed?**

A19.1: Tuesday would be the correct date for M0090. Tuesday was the date the assessing clinician gathered all the information needed to complete the assessment including M0825. In this case, the assessing clinician appeared to need to confer with internal agency staff to confirm the plan of care and the number of visits planned. M0825 is an item which is intended to be the agency's prediction of the number of therapy visits expected to be delivered in the upcoming episode, therefore, an agency practice may include discussion and collaboration among the interdisciplinary team to determine the M0825 response and this would not violate the requirement that the assessment be completed by one clinician. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #2]

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

A20. Transfer means transfer to an inpatient facility, i.e., the patient is leaving the home care setting and being transferred to a hospital, rehabilitation facility, nursing home or inpatient hospice for 24 hours or more for reasons other than diagnostic testing. Note that the text of the item indicates that it means transfer to an inpatient facility. [Q&A EDITED 08/07]

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

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

by regulation (but collected for payment) in this case, the agency may choose whether or not the data is transmitted to the State system.

If OASIS data is required for payment by a non-Medicare/non-Medicaid payer (M0150 response does not include Response(s) 1,2,3, or 4), the resulting OASIS data, which may just include the OASIS items required for the PPS Case Mix Model, may be provided to the payer, but should not be submitted to the State system. Regardless of pay source, no discharge assessment is required, as the patient receives only one visit. Agency clinical documentation should note that no further visits occurred. No subsequent discharge assessment data should be collected or submitted. If initial SOC data is submitted and then no discharge data is submitted, you should be aware that the patient's name will appear on the data management system (DMS) agency roster report for six months, after which time the patient name is dropped from the DMS report. If the patient were admitted again to the agency and a subsequent SOC assessment submitted, the agency would receive a warning that the new assessment was out of sequence. This would not prevent the agency from transmitting that assessment, however. [Q&A EDITED 08/07]

**Q22. M0100. Which reason for assessment (RFA) should be used when a patient is transferred to another agency?**

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

**Q23. M0100. A patient receiving skilled nursing care from an HHA under Medicare is periodically placed in a local hospital under a private pay arrangement for family respite. The hospital describes this bed as a purely private arrangement to house a person with no skilled services. This hospital has acute care, swing bed, and nursing care unit. The unit where the patient stays is not Medicare certified. Should the agency do a transfer and resumption of care OASIS? How should the agency respond to M0100 and M0855?**

A23. Yes, if the patient was admitted to an inpatient facility, the best response to M0100-Reason for Assessment (RFA) is Transfer to an Inpatient Facility. Depending on the agency policy, the choice may be RFA 6 transfer to an inpatient facility – patient not discharged or RFA 7 transfer to an inpatient facility – patient discharged. The agency will need to contact the inpatient facility to verify the type of care that the patient is receiving at the inpatient facility and determine the appropriate response to M0855. If the patient is using a hospital bed, response 1 applies; if the patient is using a nursing home bed, response 3 applies. If the patient is using a swing-bed it is necessary to determine whether the patient was occupying a designated hospital bed, response 1 applies; or a nursing home bed, response 3 applies. The hospital utilization department should be able to advise the agency of the type of bed and services the patient utilized. [Q&A added 06/05]

**Q23.1. M0100. I understand that when calculating the days you have to complete the comprehensive assessment, the SOC is Day "0". At the other OASIS data collection time points, when you are calculating the number of days you have to complete an assessment, is the time point date, Day "0", e.g. for RFA 9, Discharge from Agency, the assessment must be completed within 2 calendar days of M0906, Disch/trans/death date. Is M0906 Day "0"?**

A23.1: Yes, when calculating the days you have to complete the comprehensive assessment, the SOC date is day “0”. For the other time points the date of reference (e.g., transfer date, discharge date, death date) is day “0”. Note that for the purposes of calculating a 60 day episode, the SOC day is day “1”. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #3]

**Q23.2. M0100. A patient is admitted to the hospital for knee replacement surgery. During the pre-surgical workup, a test result caused the surgery to be canceled. The patient only received diagnostic testing while in the hospital but the stay was longer than 24 hours. Does this situation meet the criteria for RFA 6 or 7, Transfer to Inpatient Facility?**

A 23.2: No, under the circumstances described, the patient did not meet the OASIS transfer criteria of admission to an inpatient facility for reasons other than diagnostic testing, if the patient, indeed, did not have any other treatment other than diagnostic testing during their hospitalization. If the patient received treatment for the abnormal test result, then the situation, as described, would meet the criteria for RFA 6 or 7, Transfer to Inpatient Facility. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #4]

**Q23.3. M0100. What do we do if the agency is not aware that the patient has been hospitalized and then discharged home, and the person completing the ROC visit (i.e., the first visit following the inpatient stay) is an aide, a therapist assistant, or an LPN?**

A23.3: When the agency does not have knowledge that a patient has experienced a qualifying inpatient transfer and discharge home, and they become aware of this during a visit by an agency staff member who is not qualified to conduct an assessment, then the agency must send a qualified clinician (RN, PT, OT, or SLP) to conduct a visit and complete both the transfer (RFA 6) and the ROC (RFA 3). Both assessments should be completed within 2 calendar days of the agency’s knowledge of the inpatient admission. The ROC date (M0032) will be the date of the first visit following an inpatient stay, conducted by any person providing a service under your home health plan of care, which, in your example would be the aide, therapist assistant, or LPN.

The home health agency should carefully monitor all patients and their use of emergent care and hospital services. The home health agency may reassess patient teaching protocols to improve in this area, so that the patient advises the agency before seeking additional services. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #5]

**Q23.4. M0100. The CoPs require that the comprehensive assessment be updated within 48 hours of the patient’s return home from the hospital. The OASIS Assessment Reference Sheet states that the Resumption of Care assessment be completed within 2 calendar days of the ROC date (M0032), which is defined as the first visit following an inpatient stay. Does this mean that the ROC assessment (RFA 3) must be at least started within 48 hours of the patient’s return home, but can take an additional 2 days after the ROC visit to complete?**

A23.4: No. When the agency has knowledge of a hospital discharge, then a visit to conduct the ROC assessment should be scheduled and completed within 48 hours of the patient’s return home. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #6]

**Q23.5. M0100. I accidentally completed the RFA 4 – Recertification assessment early (on day 54) for my Medicare patient. I did not realize this until I was into the next certification period. Should I do a new assessment or can the early assessment be used to establish the new case mix assignment for the upcoming episode?**

A23.5: Whenever you discover that you have missed completing a recertification for a Medicare patient within the required time frame (days 56-60), you should not discharge that patient and readmit, or use an assessment that was completed prior to the required assessment window. As soon as you realize that you missed the recert window, make a visit and complete the recertification assessment. You are out of compliance and will receive a warning from Haven or Haven-like software. Efforts should be made to avoid such noncompliance by implementing processes to support compliance with required data collection time frames. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #7]

**Q23.6. M0100. For the purposes of determining if a hospital admission was for reasons “other than diagnostic tests” how is “diagnostic testing” defined? I understand plain x-rays, UGI, CT scans, etc. would be diagnostic tests. What about cardiac catheterization, an EGD, or colonoscopy? (A patient does receive some type of anesthesia for these). Does the fact that the patient gets any anesthesia make it surgical verses diagnostic?**

A23.6: Diagnostic testing refers to tests, scans and procedures utilized to yield a diagnosis. Cardiac catheterization is often used as a diagnostic test to determine the presence or status of coronary artery disease (CAD). However, a cardiac catheterization may also be used for treatment, once other testing has established a definitive CAD diagnosis. Each case must be considered individually by the clinician without making assumptions. The fact that the procedure requires anesthesia does not determine whether or not the procedure is purely diagnostic or not. Utilizing the definition of diagnostic testing, a clinician will be able to determine whether or not a certain procedure or test is a diagnostic test. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #9]

**Q23.7. M0100 & M0855. HHAs are providing services for psychiatric/mental health patients. The physician admits the patient to the hospital for "observation & medication review" to determine the need to adjust medications. These admissions can occur as often as every 2-4 weeks. The patient(s) are admitted to the hospital floor under inpatient services (not in ER or under “observation status”). The patient(s) are observed and may receive some lab work. They are typically discharged back to home care services within 3-7 days. Most patients DO NOT receive any treatment protocol (i.e. no medications were added/stopped or adjusted, no counseling services provided) while they were in the hospital. Is this considered a hospitalization? How do you answer M0100 & M0855?**

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

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

In your scenario, you are describing a patient that is admitted to the inpatient facility, and stays for 24 hours or longer for reasons other than diagnostic testing. An admission to an inpatient facility for observation is not an admission for diagnostic testing only. This is considered a hospitalization. The correct M0100 response would be either 6-Transfer to an Inpatient Facility, patient not discharged or 7-Transfer to an Inpatient Facility, patient discharged, depending on agency policy. M0855 would be answered with Response 1-Hospital as you state the patient was admitted to a hospital. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #10]

**Q23.8. M0100/M0830. Observation Status/Beds - A patient is held for several days in an observation bed (referred to as a “Patient Observation” or “PO” bed) in the emergency or other outpatient department of a hospital to determine if the patient will be admitted to the hospital or sent back home. While under observation, the hospital did not admit the patient as an inpatient, but billed as an outpatient under Medicare Part B. Is this Emergent Care? Should we complete a transfer, discharge the patient, or keep seeing the patient. Can we bill if we continue to provide services?**

A23.8: For purposes of OASIS (M0830) Emergent Care - the status of a patient who is a being held in an emergency department for outpatient observation services is response 1 - hospital emergency department (whether or not they are ever admitted to the inpatient facility). If they are held for observation in a hospital outpatient department, response 3 should be reported for M0830.

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

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

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

The CMS Manual System Publication, 100-04 Medicare Claims Processing: Transmittal 787 - the *January 2006 Update of the Hospital Outpatient Prospective Payment System Manual Instruction for Changes to Coding and Payment for Observation* provides guidance for the use of two new G-codes to be used for hospital outpatient departments

to use to report observation services and direct admission for observation care. Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. Observation services must also be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #11]

**Q23.9. M0100. An HHA has a patient who has returned home from a hospital stay and they have scheduled the nurse to go in to do the Resumption of Care visit within 48 hours. However, this patient receives both nursing and physical therapy and the PT cannot go in on the 2nd day (tomorrow) and would like to go in today. I have found the standard for an initial assessment visit must be done by a registered nurse unless they receive therapy only. Is this the same case for resumption? Is it inappropriate for the PT to go in the day before and resume PT services and the nurse then to go in the next day and do the ROC assessment update?**

A23.9: The requirement for the RN to complete an initial assessment visit prior to therapy visits in multidisciplinary cases is limited to the SOC time point. At subsequent time points, including the ROC, either discipline (the RN or PT in the given scenario) could complete the ROC assessment. While the assessment must be completed within 48 hours of the patient's return home from the inpatient facility, there is no requirement that other services be delayed until the assessment is completed. Therefore, assuming compliance with your agency-specific policies and other regulatory requirements, there is no specific restriction preventing the PT from resuming services prior to the RN's completion of the ROC assessment. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #12]

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

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

secondary payer is to consider that patient a Medicare patient from day 1, so that all Medicare-required documentation, data entry and data submission exist. Although the agency may "intend" that the private pay source will pay the entire cost of the patient's home care that usually cannot be verified at start of care and may not be determined until the care is completed. [Q&A EDITED 08/07]

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

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

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

**Q27. M0150. A patient with traditional Medicare is referred for skilled services, and upon evaluation, is determined to *not* be homebound, and therefore *not* eligible for the home health benefit. The patient agrees to pay privately for the skilled services. Should M0150 include reporting of response 1 – Medicare (traditional fee-for-service)?**

A27. The purpose of M0150 is to identify any and all payers to which any services provided during this home care episode are being billed. Although the patient described is a Medicare beneficiary, response 1 of M0150, Medicare (traditional fee-for-service), would not be marked, since the current situation described does not meet the home health benefit coverage criteria. In fact, since Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 temporarily suspended OASIS data collection for non-Medicare and non-Medicaid patients, if the services will not be billed to Medicare or Medicaid, then no OASIS collection would be required for this patient; although, if desired, the agency may voluntarily collect it as part of the still-required comprehensive assessment. If at some point during the care, a change in patient condition results in the patient becoming homebound, and otherwise meeting the home health benefit coverage criteria, then a new SOC assessment would be required, on which response 1 – Medicare (traditional fee-for-service) would be indicated as a payer for the care. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #2]

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

A28. There is a discussion of payer source change in Chapter 8, Section E, of the *OASIS User's Manual*. Different States, different payers, and different agencies have varying responses to these payer change situations, so we usually find it most effective to ask, "Does the new payer require a new SOC?" HHAs usually are able to work their way through what they need to do if they answer that question. If the new payer source requires a new SOC (Medicare is one that DOES require a new SOC), then it is recommended that the patient be discharged from the previous pay source and re-

assessed under the new pay source, i.e., a new SOC comprehensive assessment. The agency does not have to re-admit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails a new admission). If the payer source DOES NOT require a new SOC, then the schedule for updating the comprehensive assessment continues based on the original SOC date. The HHA simply indicates that the pay source has changed at M0150. OASIS data collection and submission would continue for a Medicare/Medicaid patient changed to another pay source without a discharge. Because the episode began with Medicare or Medicaid as a payer, the episode continues to be for a Medicare/Medicaid patient. Transmittal 61, posted January 16, 2004, includes a section on special billing situations and can be found in the *Medicare Claims Processing Manual*. Go to [http://www.cms.hhs.gov/manuals/104\\_claims/clm104c10.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c10.pdf); scroll to page 94 of the document to read "Section 80 - special Billing Situations Involving OASIS Assessments." Questions related to this document must be addressed to your RHHI. [Q&A EDITED 08/07]

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

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

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

A29.1: If the patient has both VA and Medicare and both are expected payers, then you need to mark Response 1, Medicare (traditional fee-for-service) and Response 7, Other government (e.g. CHAMPUS, VA, etc.). But if the patient does not have Medicare, or Medicare is not an expected payer for provided services, then Response 7, Other government (e.g. CHAMPUS, VA, etc.) would be the correct response. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #8]

**Q29.2. M0150. If a patient is receiving Meals-on-Wheels services, do you capture the payment for the service as a Response 10; Self Pay on M0150 Current Payment Sources for Home Care?**

A29.2: No, food is not considered within the scope of M0150. Most patients pay for their food, whether they purchase it directly, a caregiver purchases and delivers it, or a service such as Meals-on-Wheels is utilized. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #9]

**Q29.3. M0150. On M0150, since Response "10" – Self Pay should be marked for a patient who pays for their medications, should Response "1" Medicare (traditional fee-for-service) be marked for a patient whose medications are expected to be paid for in part by the Medicare drug benefit?**

A29.3: No, M0150 is limited to identifying payers to which any services provided during this home care episode, and included on the home health plan of care will be billed by your home care agency. We are retracting a Q&A released in 06/05 which extended the

scope of M0150 to include reporting of “self pay” as a pay source for non-services (i.e. DME or medications) that are paid in part or full to a DME vendor or drug store for equipment or medications essential or integral to the home care episode. M0150 does not include payment for equipment, medications or supplies, and is limited to only services provided and billed for by your Medicare certified agency. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #10]

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

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

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

A31. A skilled nursing facility (response 3) means a Medicare-certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit. Other nursing home (response 4) includes intermediate care facilities for persons with mental retardation (ICF/MR) and nursing facilities (NF). [Q&A EDITED 08/07]

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

A32. "During the past 14 days" refers to the two-week period immediately preceding the start of care/resumption of care (SOC/ROC) date or the first day of the new certification period at follow-up. The easiest way to determine this is to refer to a calendar. For example, if the SOC/ROC is Wednesday, August 20, look at a calendar to refer to the same day of the week two weeks ago, which in this case is August 6. For follow-up assessments, count fourteen days before the first day of the new certification period. [Q&A edited 06/05] [Q&A EDITED 08/07]

**Q32.1. M0175. When a patient is discharged from an inpatient facility in the last 5 days of the certification period, should M0175 on the Resumption of Care (ROC) assessment report inpatient facilities that the patient was discharged from during the 14 days immediately preceding the ROC date or the 14 days immediately preceding the first day of the new certification period?**

A32.1: When completing a Resumption of Care assessment which will also serve as a Recertification assessment, M0175 should reflect inpatient facility discharges that have occurred during the two-week period immediately preceding the first day of the new certification period. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #11]

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

A33. As noted in the skip instructions for item M0175, if the patient was not discharged from an inpatient facility within the past 14 days, (i.e., M0175 has a response of NA), M0180 and M0190 should be skipped. If the patient was discharged from an inpatient facility during the past 14 days, but the date is unknown, you should mark UK at M0180 and leave the date blank.

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

A34. M0190 requests the two most relevant diagnoses that were actively treated during the inpatient facility stay, not all diagnoses that the patient may have. Agencies should carefully consider whether additional information is needed and, if so, how only the most relevant information is listed in “a” and “b” of M0190. OASIS items must be reproduced in the agency clinical forms exactly as they are written. If the agency desires additional information, the most appropriate course of action may be to insert an additional clinical record item immediately following M0190. [Q&A EDITED 08/07]

**Q35. M0190. It takes days (sometimes even a week) to get the discharge form from the hospital. How can we complete this item in a timely manner?**

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

**Q36. M0190. Can anyone other than the assessing clinician enter the ICD codes?**

A36. Coding may be done in accordance with agency policies and procedures, as long as the assessing clinician determines the primary and secondary diagnoses and records the severity indices. The clinician should write-in the medical diagnosis requested in M0190, M0210, M0230/M0240, and M0245, if applicable. A coding specialist in the agency may enter the actual numeric ICD-9 codes once the assessment is completed. The HHA has the overall responsibility for providing services, assigning ICD-9-CM codes, and billing. It is expected that each agency will develop their own policies and procedures and implement them throughout the agency that allows for correction or clarification of records to meet professional standards. It is prudent to allow for a policy and procedure that would include completion or correction of a clinical record in the absence of the original clinician due to vacation, sick time, or termination from the agency. [Q&A EDITED 08/07]

**Q37. M0190/M0210. What is the difference between M0190 and M0210?**

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

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

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

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

A39. M0200 asks about a change in the patient's medical or treatment regimen, not about a "new or changed diagnosis." It is possible that the treatment regimen change occurred because of a new or changed diagnosis, but the item only asks about the medical or treatment regimen change occurring within the past 14 days. The change may have occurred because of an exacerbation or improvement of an existing diagnosis. [Q&A EDITED 08/07]

**Q40. M0200. If the patient had a physician appointment in the past 14 days, or has a referral for home care services, does that qualify as a medical/treatment regimen change?**

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

**Q41. M0200. If the treatment regimen change occurred on the same day as the visit, does this qualify as within the past 14 days?**

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

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

**Q42.1. M0200. I was told that an exacerbation of a disease can be considered a change in medical or treatment regimen for M0200, Medical or Treatment Regimen Change Within Past 14 Days. Is this true?**

A42.1: The exacerbation of a disease, in and of itself, would not be considered a change in medical or treatment regimen for M0200. The changes in medication, service, or treatment that might result from a new diagnosis or the exacerbation of a disease would warrant in a "Yes" response on M0200. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #12]

**Q42.2. M0200. If physical therapy (or any other discipline included under the home health plan of care) was ordered at Start of Care (SOC) and discontinued during the episode, does this qualify as a service change for M0200 at the Resumption of Care (ROC) or DC OASIS data collection time points? I understand that the referral and admission to home care does not qualify as a med/tx/service change for M0200.**

A42.2: Physical therapy (or any other discipline) ordered at SOC and then discontinued during the episode, qualifies as a service change for M0200 at the ROC or DC OASIS data collection time points. You are correct that referral and admission to home care does not “count” as a medical or treatment regimen change. This means that all home care services or treatments ordered at SOC/ROC would not “count” for M0200, but would thereafter, if there was a change.

While a treatment change occurring on the same day as the assessment visit usually qualifies as occurring within the past 14 days, the discontinuation of home care services at DC, do NOT count as a “Yes” for M0200 (If it did, all episodes would include a “Yes” on M0200 at DC.) [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #13]

**Q43. M0210. For the medical diagnosis in the changed medication section at OASIS item M0210, does this need to be the current diagnosis we are seeing the patient for, or a diagnosis that is specific for the medication?**

A43. Item M0210 identifies the diagnosis(es) causing a change to the patient's treatment regimen, health care services, or medication within the past 14 days. The ICD-9 code can be a new diagnosis or an exacerbation of an existing condition that is specific to the changed medical or treatment regimen. Also note that this item is not restricted to medications, but refers to any change in medical or treatment regimen. [Q&A EDITED 08/07]

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

A44. For Clarification of OASIS items M0230, M0240, and M0245 please refer to the *OASIS User's Manual*, Attachment D to Chapter 8, at:  
[http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp). [Q&A EDITED 08/07]

**Q44.1. M0230/M0240. During a supervisor's audit of a SOC assessment, the auditor finds a manifestation code listed as primary without the required etiology code reported. Can this be considered a technical coding “error”, and can the agency follow their correction policy allowing the agency's coding expert to correct the non-adherence to multiple coding requirements mandated by the ICD-9-CM coding guidelines, without conferring with the assessing clinician?**

A44.1: The determination of the primary and secondary diagnoses must be completed by the assessing clinician, in conjunction with the physician. If the assessing clinician identifies the diagnosis that is the focus of the care and reports it in M0230, and ICD-9-CM coding guidelines required that the selected diagnosis is subject to mandatory multiple coding, the addition of the etiology code and related sequencing is not a technical correction because a diagnosis is being added. If any diagnosis is being added, in this case for manifestation coding requirements, the assessing clinician must be contacted and agree.

If, based on the review of the comprehensive assessment and plan of care, the auditor questions the accuracy of the primary diagnosis selected by the assessing clinician, this is not considered a “technical” error and the coding specialist may not automatically make the correction without consulting with the assessing clinician.

If after discussion of the manifestation coding situation between the assessing clinician and the coding specialist, the assessing clinician agrees with the coding specialist or auditor and that the sequence of the diagnosis codes should be modified to more accurately reflect the diagnosis that is most related to the current POC using current ICD-9-CM coding guidelines, agency policy will determine how (e.g., by whom) this change is made. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #14]

**Q44.2. M0230/M0240. Is it true that you can never change M0230 or M0240 from the original POC (cert) until the next certification?**

A44.2: Guidance in Chapter 8 of the OASIS User's manual, pg. 8.42 and 8.145, states the primary diagnosis is the chief reason the agency is providing home care, the condition most related to the plan of care. Secondary diagnoses are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care." "In general, M0240 should include not only conditions actively addressed in the patient's plan of care but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself." M0230, Primary Diagnosis and M0240, Other Diagnoses are reported at Start of Care, Resumption of Care and Follow-up/Recertification. At each time point, after completing a comprehensive assessment of the patient and receiving input from the physician, the clinician will report the patient's current primary and secondary diagnoses. Diagnoses may change following an inpatient facility stay - the Resumption of Care and following a major change in the patient's health status - the Other Follow up. The chief reason an agency is caring for a patient may change. The focus of the care may change. At each required time point the clinician will assess and report what is true at the time of the assessment. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #13]

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

A45. M0250 refers to therapies the patient is receiving during the day of the assessment or which the patient is ordered to receive as a result of the assessment visit. For example, if the assessment reveals the existence of dehydration, and the clinician's communication results in an order for IV therapy, response 1 would be marked. [Q&A EDITED 08/07]

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

A46. Only one question must be answered to determine whether these examples "count" as IV or infusion therapy -- is the patient receiving such therapy at home? If the patient were receiving such therapy at home, then response 1 for M0250 would be appropriate. If the infusion therapy is administered in the physician's office or outpatient center or dialysis center, and no infusion or flush is occurring in the home, response 4 would be marked. [Q&A edited 06/05] [Q&A EDITED 08/07]

**Q47. M0250. Does an IM or SQ injection given over a 10-minute period “count” as an infusion?**

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

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

A48. If the patient’s refusal has resulted in the patient not receiving enteral nutrition on the day of the assessment, response 3 would not be appropriate at the time of the assessment. The refusal of the tube feedings would be noted in the clinical record. Flushing the feeding tube does not provide nutrition. [Q&A EDITED 08/07]

**Q49. M0250. If the caregiver provides the enteral nutrition independently, should response 3 be marked, or does the HHA need to provide the care?**

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

**Q50. M0250. Do therapies provided in the home have to be documented in the clinical record?**

A50. It seems clear that any of the therapies identified in M0250 (IV/infusion therapy, parenteral nutrition, enteral nutrition) would be acknowledged in the comprehensive assessment and be noted in the plan of care. Even if the family or caregiver manages the therapies completely independently, the clinician is likely to evaluate the patient’s nutritional or hydration status, signs of infection, etc. It is difficult to conceive of a situation where the answer to this question would be “no.”

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

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

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

A52. Yes, if the IV is being discontinued the day of the assessment visit, then those respective services can be marked as “present” at the assessment. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #3]

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

A53. If the patient will receive an IV infusion as a result of the SOC assessment (i.e., the predetermined parameters are met), then response 1 is appropriate. If the parameters are not met at the SOC assessment, then response 1 does NOT apply. [Q&A added 06/05] [Q&A EDITED 08/07]

**Q53.1. M0250. When a patient has a G-tube (NG-tube, J-tube, and PEG-tube) and it is only utilized for medication administration, do you mark Response 3, Enteral nutrition for M0250, Therapies?**

A53.1: No, M0250 Response 3 captures the administration of enteral nutrition. Medication administration alone is not considered nutrition. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #15]

**Q53.2. M0250. When a patient has a feeding tube and it is only utilized for the administration of water for hydration (continuous or intermittent), do you mark Response 3, Enteral nutrition for M0250, Therapies?**

A53.2: No, M0250 Response 3 captures the administration of enteral nutrition. Hydration alone is not considered nutrition. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #16]

**Q53.3. M0250. I understand that if the patient is receiving infusion therapy in the home and the family or caregiver manages it completely that we should report the infusion therapy on M0250. Is this also true when the patient is receiving infusion therapy in the home from another provider?**

A53.3: Only one question must be answered to determine whether the infusion “counts” as IV or infusion therapy – “Is the patient receiving such therapy at home?” regardless of who is managing it. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #17]

**Q53.4. M0250. A patient has a Hickman catheter and is receiving TPN over 12 hours. At the beginning of the infusion, the line is flushed with saline and at the end of the infusion, it is flushed with saline and Heparin. For M0250, do you mark both 1 and 2?**

A53.4: When the patient is receiving intermittent parenteral therapy at home and requires a pre- and post-infusion flush, it is not appropriate to mark Response 1, Intravenous or infusion therapy (excludes TPN), in addition to Response 2, Parenteral nutrition (TPN or lipids). The flushing of the line for intermittent parenteral therapy is considered a component of the parenteral therapy. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #18]

**Q53.5. M0250. If a patient's appetite is poor and he/she has a g-tube and the physician orders Ensure prn through the g-tube? Does this count as enteral nutrition for this item?”**

A53.5: If a PRN order exists and the patient meets the parameters for administration of the feeding based on the findings from the comprehensive assessment, or has met such parameters and/or received enteral nutrition at home in the past 24 hours, the assessing clinician would mark Response 3. The clinician could not mark response 3 automatically when a PRN order exists at SOC because it is unknown if the patient will ever receive the enteral nutrition. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #14]

**Q53.6. M0250. We have been admitting patients status post lumpectomy for breast cancer. After the surgery, they are discharged with an eclipse (bulb) that**

**has Marcaine or Lidocaine that infuses pain medication into the wound bed. After 48 hours the bulb can be removed. If the patient still has this bulb on at start of care, should Response 1 be marked for M0250?**

A53.6: When a patient is receiving an infusion at home, M0250 should be marked with Response 1-Intravenous or infusion therapy. If the patient you describe is receiving a local anesthetic via an infusion device while in the home, M0250 would be marked "1" at SOC. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #5]

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

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

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

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

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

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

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

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

**Q57.1. M0340. What if paid help lives with the patient Monday through Friday, would we still score, in this section, 1-lives alone? My understanding is that this section is not asking about what kind of help the patient receives.**

A57.1: You are describing paid help that lives with the patient intermittently, Monday through Friday. Intermittent (e.g., a few hours each day, one or two days a week, etc.) paid help is not classified as help the patient “lives with.” The correct response for M0340, in this case, would be 1-Lives alone.

M0340 is asking with whom the patient is living with at the time of the assessment, even if the arrangement is temporary. Subsequent items will capture information about the primary caregiver and the type and quantity of assistance s/he provides. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #15]

**Q57.2. M0340 & M0350. What are the correct responses for M0340 and M0350 in the situation where family members that live outside the home are staying around the clock with a patient (caregivers are taking turns with each other)? If the patient has 24 hour supervision from people outside the home, is the patient living alone?**

A57.2: Chapter 8, Page 8.51 of the OASIS Implementation Manual ([www.cms.hhs.gov/OASIS/05\\_UserManual.asp](http://www.cms.hhs.gov/OASIS/05_UserManual.asp)) instructs that M0340 should identify whomever the patient is living with at the time of the assessment, even if the arrangement is temporary. It does not simply ask if the patient has 24 hour companionship or supervision, but who the patient lives with.

In situations where multiple caregivers/family members stay with the patient for a number of hours each day, if each of the caregivers comes and goes to their own residences outside of the patient's home, then they do not live with the patient, even if the cumulative "coverage" equates to 24 hour supervision/companionship. The patient is living alone and M0340 should be reported as response 1 - Lives alone. These caregivers should be considered when reporting assisting persons for M0350 (unless they are home care agency staff), and response 1 - relatives, friends or neighbors living outside the home, should be reported. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #16]

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

A58. Rules for licensing Assisted Living Facilities (ALFs) vary from State to State, and the actual physical structural arrangements vary from one facility to another, so the answer must be selected that is most appropriate for the individual situation. Most patients in an ALF are receiving paid help, at least (#3 under M0350), although they may also be receiving help from others listed. Refer to the explanation for this item in the *OASIS User's Manual*, Chapter 8, available at [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp). [Q&A EDITED 08/07]

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

A59. M0350 is asking the clinician to identify assisting person(s) other than home care agency staff. Response 3, paid help, includes all individuals who are paid to provide assistance to the patient, whether paid by the patient, family or a specific program. Meals-on-Wheels is a community-based service that assists the homebound by delivering meals and would be included in responding to M0350. [Q&A added 06/05; Previously CMS OCCB 03/05 Q #3]

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

A60. Rules for licensing ALFs vary from State to State, and the actual physical structural arrangements vary from one facility to another, so the answer must be selected that is most appropriate for the individual situation. The clinician making the assessment will need to determine who the primary caregiver is, and mark the appropriate response under M0360 and continue through the remaining items pertaining to the assistance provided by the primary caregiver. Refer to the explanations for these items in the *OASIS User's Manual*, Chapter 8, available at [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp) [Q&A EDITED 08/07].

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

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

**Q62. [Q&A DELETED 08/07; Duplicative of Chapter 8, OASIS User's Manual]**

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

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

**Q64: M0390. Does information on vision documented in OASIS have to be backed up with documentation elsewhere in the patient's record?**

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

**Q64.1. M0390. If a patient has a physical deficit, such as a neck injury, limiting his range of motion, which affects his field of vision and ability to see obstacles in his path, how is M0390, Vision to be answered? Is the physical impairment to be considered? Visual acuity has not been affected.**

A64.1: When selecting the correct response for M0390, Vision, the clinician is assessing the patient's functional vision, not conducting a formal vision screen or distance vision exam to determine if the patient has 20/20 vision. Therefore physical deficits or impairments that limit the patient's ability to use their existing vision in a functional way would be considered. If a patient sustained an injury that limits neck movement, the patient may not be able to see obstacles in their path. A patient who has sustained a facial injury may have orbital swelling that makes it impossible for them to see and they must locate objects by hearing or touching them. Conversely, it is possible for a patient

to be blind in one eye (technically not “normal vision”), but still be appropriately scored a “0” on M0390 if with the patient’s existing vision, they are able to see adequately in most situations and can see medication labels or newsprint. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #6]

**Q65: M0400. Our agency would like clarification concerning M0400 - Hearing and Ability to Understand Spoken language in patient’s own language. If a patient speaks Spanish and there is an interpreter, it is difficult to ascertain the level of complexity of interpreted instructions. How are we to answer this?**

A65. You will need to ask the interpreter to help you determine at what level the patient is responding. Responses to 'No observable impairment' (0) and 'Unable to hear and understand familiar words or common expressions consistently, or patient nonresponsive' (4) should be relatively simple to determine. To determine the difference between levels 1, 2 or 3, you can interact with the interpreter to determine with what difficulty the patient is responding. Inasmuch as the assessment includes assistance from an interpreter, your clinical documentation of the visit should indicate the presence of an interpreter who assists with communication between clinician and patient.

**Q66. M0400. Is it correct that both auditory and receptive language functions are included in responding to this item? Therefore a deaf patient who processes spoken language effectively using lip reading strategies is scored at response level 4 (Unable to hear and understand) because the item measures the combination of BOTH hearing and comprehension?**

A66. Yes, M0400 does include assessment of both hearing AND understanding spoken language. A patient unable to hear (even with the use of hearing aids if the patient usually uses them) would be scored at response level 4. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #4]

**Q66.1. M0400. My patient’s primary language is German, but he does speak English well enough for us to generally communicate without the use of an interpreter. Often I need to repeat my request, or reword my statements, but he eventually adequately understands what I’m asking or saying. When scoring M0400 Hearing and Comprehension of Spoken Language, I marked response “2” based on my assessment, but I wonder if the patient’s hearing/comprehension would be better (i.e., a Response “0” or “1”) if he were being spoken to in German, his primary language. Do I have to assess the patient with an interpreter in order to score M0400 in the patient’s primary language, even if I feel communication is generally adequate to allow evaluation of the patient’s healthcare needs and provision of care outlined in the Plan of Care?**

A66.1: M0400 is an evaluation of the patient’s ability to hear and understand verbal (spoken) language in the patient’s primary language. If a patient is able to communicate in more than one language, then this item can be evaluated in any language in which the patient is fluent. If however, as you suggest, your patient’s ability to hear and understand is likely not as functional in a secondary language, you should make efforts necessary to access an interpreter to determine the patient’s ability to hear and comprehend in the patient’s primary language. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #19]

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

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

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

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

**Q69. M0420. How can you assess if pain is interfering with activity or movement in a nonverbal patient? A nonresponsive patient?**

A69. Nonverbal or nonresponsive patients experience pain, and careful observation establishes its presence and affect on activity or movement. The clinician should observe facial expression (frowning, gritting teeth), note changes in pulse rate, respiratory rate, perspiration, pallor, pupil size, or irritability, or signs that activity is being affected by pain (e.g., limping, guarding). [Q&A EDITED 08/07]

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

A70. For pain to interfere with activity, it does not have to totally prevent the activity. Examples of how pain can interfere with activity without preventing it include: if pain causes the activity to take longer to complete, results in the activity being performed less often than otherwise desired by the patient, or requires the patient to have additional assistance. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #5]

**Q71. M0420. If a patient uses a cane for ambulation in order to relieve low back pain, does the use of the cane equate to the presence of pain interfering with activity?**

A71. If use of the cane provides adequate pain relief that the patient can ambulate in a manner that does not significantly affect distance or performance of other tasks, then the cane should be considered a "non-pharmacological" approach to pain management and should not, in and of itself, be considered as an "interference" to the patient's activity. However, if the use of the cane does not fully alleviate the pain (or pain effects), and even with the use of the cane, the patient limits ambulation or requires additional assistance with gait activities, then activity would be considered as "affected" or "interfered with" by pain, and the frequency of such interference should be assessed when responding to M0420. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #6]

**Q72. M0420. Would a patient who restricts his/her activity (i.e., doesn't climb stairs, limits walking distances) in order to be pain-free thus be considered to have pain interfering with activity? And if so, would the clinician respond to**

**M0420 based on the frequency that the patient limits or restricts their activity in order to remain pain-free?**

A72. Yes, a patient who restricts his/her activity to be pain-free does indeed have pain interfering with activity. Since M0420 reports the frequency that pain interferes with activity (not the presence of pain itself), then M0420 should be scored to reflect the frequency that the patient's activities are affected or limited by pain, even if the patient is pain free at present due to the activity restriction. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #7]

**Q73. M0420. A patient takes narcotic pain medications continuously and is currently pain free. Medication side effects, including constipation, nausea, and drowsiness affect the patient's interest and ability to eat, walk, and socialize. Is pain interfering with the patient's activity?**

A73. M0420 identifies the frequency with which pain interferes with a patient's activities, taking into account any treatment prescribed. If a patient is pain-free as a result of the treatment, M0420 should be answered to reflect the frequency that the patient's activities are affected or limited by pain. In this scenario, the patient is described as being pain-free, but also is described as having medication side effects that interfere with activity. Medication side effects are not addressed in responding to M0420 and, given the information in the scenario; pain apparently is not interfering with the patient's activity. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #3]

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

A74. In this data item, we are assessing the presence of intractable pain as defined in Chapter 8 of the *OASIS User's Manual*. Intractable pain refers not only to cancer pain but also to pain of other etiologies that occurs at least daily, is not easily relieved, which may affect the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, or ability or desire to perform activity. This type of pain likely interferes with the patient's activities and needs to be considered when developing the plan of care. [Q&A EDITED 08/07]

**Q75. M0430. A patient takes narcotic pain medications continuously and is currently pain free. Medication side effects, including constipation, nausea, and drowsiness affect the patient's interest and ability to eat, walk, and socialize. Based on the information provided, would this patient be considered to have intractable pain?**

A75. Intractable pain refers to pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, or ability or desire to perform activity. The clinician making the assessment will determine if the patient's pain meets the components of the definition of intractable pain. If the pain is well controlled by round-the-clock pharmacologic interventions, then the pain may not occur daily, and therefore would not be considered intractable. The assessing clinician, with input from the patient, will determine if the pain is easily relieved and will identify the effects of the pain on the patient's activities and life.

Note that M0420 and M0430 are separate items and should be assessed and considered separately. There is not an "if response ... on M0420, then response ... on M0430" algorithm that is appropriate to follow in responding to these items. [Q&A added 06/05] [Q&A EDITED 08/07]

**Q76. [Q&A DELETED 08/07; Duplicative of Chapter 8, OASIS User's Manual]**

**Q77. [Q&A DELETED 08/07; Outdated. Terminology deleted from current version of Chapter 8]**

**Q77.1. M0430. My patient has post-op pain which initially was well managed with pain medications. For the past few weeks the patient has been refusing to take her pain medications as prescribed due to fear of addiction. This has caused her to have pain that occurs at least daily and impacts her ability to sleep, get around her home, and carry out her home exercise program. The patient is being discharged to outpatient services. On my discharge assessment, I marked that the patient did NOT have intractable pain, because she could have "easily" relieved her pain if she took her pain medications as prescribed. Is this an appropriate application of the current guidance?**

A77.1: The assessing clinician, with input from the patient, will determine if the pain is easily relieved. In your example, it appears that you believe the patient's pain *could* easily be relieved, but in reality it is not relieved due to a fear of addiction. M0430 should be a reflection of the patient's current pain and its current impact on the patient's life, given the current parameters (e.g., pain level and characteristics, pharmacological and non-pharmacological treatments used). If the patient is not currently using adequate pain medication or non-drug pain management measures, even if they have been prescribed, and are present in the home, M0430 should still be a reflection of the patient's current pain experience (is the pain easily relieved, does it occur at least daily, and does it affect one or more of the quality of life activities noted in the item.) [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #20]

**Q77.2. M0430. My patient reports he can not afford to buy his pain medications, and does have pain that occurs at least daily and interferes with quality of life issues. Can I say that the pain is not easily relieved because the patient does not have a means to relieve it?**

A77.2: Knowledge that the patient is not currently taking medications as prescribed due to financial concerns is certainly an important finding that should be documented in the drug regimen review portion of the comprehensive assessment and addressed in the plan of care. If the patient is not currently using adequate pain medication, for any reason, including inability to afford medications prescribed, M0430 should still be a reflection of the patient's current pain experience (is the pain easily relieved, does it occur at least daily, and does it affect one or more of the quality of life activities noted in the item.) [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #21]

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

A78. 'Lesion' is a broad term used to describe an area of pathologically altered tissue. Wounds, sores, ulcers, rashes, crusts, etc. are all considered lesions. So are bruises or

scars. In responding to the item, the only 'lesions' that should be disregarded are those that end in 'ostomy' (e.g., tracheostomy, gastrostomy, etc.) or peripheral IV sites (central line sites are considered to be surgical wounds). For additional types of skin lesions, please consult a physical assessment text.

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

A79. Many different types of skin lesions exist. These may be classified as primary lesions (arising from previously normal skin), such as vesicles, pustules, wheals, or as secondary lesions (resulting from changes in primary lesions), such as crusts, ulcers, or scars. Other classifications describe lesions as changes in color or texture (e.g., maceration, scale, lichenification), changes in shape of the skin surface (e.g., cyst, nodule, edema), breaks in skin surfaces (e.g., abrasion, excoriation, fissure, incision), or vascular lesions (e.g., petechiae, ecchymosis).

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

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

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

A81. The definition of the term "nonobservable" varies depending on the specific OASIS item being assessed. If you know from referral information, communication with the physician, etc. that a wound exists under a nonremoveable dressing, then the wound is considered to be present for M0440, and the item would be answered "Yes." [Q&A EDITED 08/07]

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

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

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

A83. M0440 should be answered, "yes," since a lesion is present. Additional documentation that describes the burn should be included in the clinical record, but burns are not addressed in the OASIS items. The appropriate ICD-9-CM code for the burn should be entered in M0230 Primary Diagnosis or M0240 as appropriate for accurate documentation. [Q&A EDITED 08/07]

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

A84. Yes, a scar meets the definition of an "area of pathologically altered tissue." [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #8]

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

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

**Q86. M0440. Are implanted infusion devices or venous access devices considered skin lesions at M0440?**

A86. Yes, the surgical sites where such devices were implanted would be considered lesions at M0440 and would be included in the total number of surgical wounds (M0484). It does not matter whether the device is accessed at a particular frequency or not. [Q&A EDITED 08/07]

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

A87. Remember that OASIS items are only PART of a comprehensive assessment and include only those items that have proven useful for outcome measurement and risk factor adjustment. During the early stages of the research on which OASIS items are based, the status of many such lesions were tested for their utility as outcome measures. Only the types of wounds that 'worked' for outcome measurement or risk factor adjustment have been carried forward in OASIS, though other types of wounds are extremely important to document in the clinical record. The presence of ANY wound or lesion (other than ostomies and peripheral IV sites) should be noted by a 'yes' response to M0440. [Q&A EDITED 08/07]

**Q87.1. M0440 – M0488. Do CMS OASIS instructions supersede a clinical wound nurse training program?**

A87.1: CMS references, not clinical training programs should be used to guide OASIS scoring decisions. While CMS utilizes the expert resources of organizations like the Wound Ostomy Continence Nurses Society and the National Pressure Ulcer Advisory Panel to help suggest assessment strategies to support scoring of the integumentary items, in some cases, the OASIS scoring instructions are unique to OASIS and may not always coincide or be supported by general clinical references or standards. While CMS provides specific instructions on how OASIS data should be classified and reported, OASIS scoring guidelines are not intended to direct or limit appropriate clinical care planning by the nurse or therapist. For instance, even though for OASIS data collection purposes a gastrostomy is excluded as a skin lesion or open wound, such data collection exclusion does not suggest that the clinician should not assess, document and include in the care plan findings and interventions related to the gastrostomy. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #22]

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

A88. No. Cataract surgery and gynecological surgical procedures by a vaginal approach are not included in M0440 or M0482. M0440 captures skin lesions or an open wound to the integumentary system. Only certain types of wounds are described by OASIS. We would expect that any discharge, swelling, pain, etc. from either procedure would be reported in the agency's clinical documentation. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #4]

**Q88.1. M0440/M0482. Is a peritoneal dialysis catheter considered a surgical wound? Isn't the opening in the abdominal wall a type of ostomy?**

A88.1: The site of a peritoneal dialysis catheter is considered a surgical wound. The opening in the abdominal wall is referred to as the exit site and is not an ostomy. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #22]

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

A89. The clinician will have to speak with the physician who must make the determination as to whether a specific lesion is a diabetic ulcer, a pressure ulcer, stasis ulcer, or other lesion. There are some very unique coding issues to consider for ulcers in diabetic patients (vs. ulcers in non-diabetic patients), and the physician should be aware of these in his/her contact with the patient. In responding to the OASIS items, an ulcer diagnosed by the physician as a diabetic ulcer would be considered a lesion (respond "yes" to M0440), but it would not be considered a pressure ulcer or a stasis ulcer.

**Q89.1. M0445. If a pressure ulcer or a burn is covered with a skin graft, does it become a surgical wound?**

A89.1: No, covering a pressure ulcer with a skin graft does not change it to a surgical wound. It remains a pressure ulcer. Applying a skin graft to a burn does not become a surgical wound. The burn remains a skin lesion, with details captured in the comprehensive assessment. In either case, a donor site, until healed, would be considered a surgical wound. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #23]

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

A90: Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel (NPUAP). If a pressure ulcer is stage 4 at Start of Care and is granulating at the follow-up visit, the pressure ulcer remains a stage 4 ulcer. Your clinical documentation (and possibly the M0464 Status of Most Problematic (Observable) Pressure Ulcer score on a subsequent assessment) will reflect the healing process. The NPUAP web site

<http://www.npuap.org/> has valuable information and teaching tools regarding pressure ulcers, documenting healing, treatment, etc. [Q&A EDITED 08/07]

**Q90.1. M0450, M0460. I have reviewed the new 2/07 NPUAP pressure ulcer staging document and it states that a pressure ulcer with slough or eschar can be staged if the necrotic tissue does not obscure the wound bed preventing visualization of tissue loss. There is a CMS OCCB Q&A dated 7/06 that states you cannot stage a pressure ulcer when any amount of eschar or slough is present, even when the bone is visible. Can I stage a pressure ulcer when eschar or slough is present as long as the wound bed is visible?**

A90.1: Yes, you can stage a pressure ulcer when some eschar or slough is present as long as the wound bed is visible and you can see the extent of tissue involved. In response to the latest National Pressure Ulcer Advisory Panel (NPUAP) guidance, we are retracting the CMS OCCB Q&A #24 dated 7/06 that states “any pressure ulcer with any amount of eschar or slough present, even an ulcer with bone visible, would be considered non-observable and therefore could not be staged.”

In the latest NPUAP staging document, the Stage III pressure ulcer definition states “Slough may be present but does not obscure the depth of tissue loss.” The Stage IV pressure ulcer definition states “Slough or eschar may be present on some parts of the wound bed.” An Unstageable pressure ulcer has “Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and therefore stage, cannot be determined.”

The new NPUAP staging document is also consistent with the latest (7/06) WOCN guidance on OASIS skin and wound status M0 items in which the Stage III pressure ulcer definition includes the statement that: “Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.” and that a Stage IV pressure ulcer includes: “Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule).” These definitions state that Stage III and IV pressure ulcers can have necrotic tissue present and therefore are NOT unstageable. The WOCN does go on to explain that a non-observable pressure ulcer is a “Wound unable to be visualized due to an orthopedic device, dressing, etc. A pressure ulcer cannot be accurately staged until the deepest viable tissue layer is visible; this means that wounds covered with eschar and /or slough cannot be staged, and should be documented as non-observable.” which again is supported by the NPUAP 2/07 document.

These new definitions are consistent with the Chapter 8 guidance for M0450, Current Number of Pressure Ulcers at Each Stage that states “A pressure ulcer cover by eschar or a nonremoveable cast or dressing cannot be staged...”, “The bed of the ulcer must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar), it cannot be staged until the necrotic tissue is removed.” and “Consult published guidelines of NPUAP ([www.npuap.org](http://www.npuap.org)) for additional clarification and/or resources for training.”

The 2/07 NPUAP’s Pressure Ulcer Staging document can be accessed at [www.npuap.org](http://www.npuap.org). The WOCN’s Guidance on OASIS Skin and Wound Status M0 Items

document can be accessed at [www.wocn.org](http://www.wocn.org). [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #7]

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

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

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

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

**Q93. M0445-M0464. How should these items be answered if a Stage 3 or Stage 4 pressure ulcer is completely healed?**

A93. The healing of a pressure ulcer is never indicated by "reverse staging" of the ulcer. If this were the only ulcer the patient had, the appropriate responses would be M0440 = yes and M0445 = yes. M0450 would be answered by indicating the stage of the healed pressure ulcer at its worst, with M0460 answered accordingly. On OASIS item M0464, the "best possible" answer for a healed pressure ulcer would be "fully granulating." [Q&A EDITED 08/07]

**Q94. M0445-M0464. If a Stage 3 pressure ulcer is closed with a muscle flap, what is recorded? What if the muscle flap begins to break down due to pressure?**

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

**Q95. M0445-M0464. If a pressure ulcer is debrided, does it become a surgical wound as well as a pressure ulcer?**

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

**Q96. M0445-M0464. If a single pressure ulcer has partially granulated to the surface, leaving the ulcer open in more than one area, how many pressure ulcers are present?**

A96. Only one pressure ulcer is present. The healing status of the pressure ulcer (for M0464) can be described by applying the *OASIS Guidance Document*, developed with

CMS by the Wound, Ostomy, and Continence Nurses Society (WOCN), found at <http://www.wocn.org/>. Other objective parameters such as size, depth, drainage, etc. should also be documented in the clinical record. The National Pressure Ulcer Advisory Panel web site (<http://www.npuap.org/>) has valuable information and teaching tools regarding pressure ulcers, documenting healing, treatment, etc.

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

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

Stage 1 pressure ulcers heal to normal appearing skin and are not at increased risk for future ulcer development. Stage 2 ulcers generally heal to nearly normal appearing skin, but may result in scar tissue formation. Healed stage 2 pressure ulcers only minimally increase the future risk of pressure ulcers at that location.

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

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

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

(M0445) Does this patient have a Pressure Ulcer?

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

[Q&A added 06/05] [Q&A EDITED 08/07]

**Q98. M0445-M0464. Can a previously observable Stage 4 pressure ulcer that is now covered with slough or eschar be categorized as Stage 4?**

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

[Q&A added 06/05] [Q&A EDITED 08/07]

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

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

**Q99.1. M0464. According to the WOCN Guidance on OASIS Skin and Wound Status M0 Items, a “non-healing” status applies to a pressure ulcer with greater than or equal to 25% avascular tissue and Early/Partial Granulation status applies to a pressure ulcer with minimal avascular tissue (i.e., less than 25% of the wound bed is covered with avascular tissue). Does this guidance supersede the Chapter 8 M0464 guidance that states “If part of the ulcer is covered by necrotic tissue then it is not healing (Response 3)?” What if only 5% of the wound bed is covered with eschar?**

A99.1: Follow the WOCN guidance. If only 5% of the wound bed is covered with eschar, according to the WOCN guidance, the status would be Early/Partial Granulation, as long as the other criteria are met. To meet the criteria for “Non-healing”, the portion of the wound bed coverage must be equal to or greater than 25% avascular tissue. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #25]

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

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

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

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

**Q102. M0482-M0488. Is a gastrostomy that is being allowed to close on its own considered a surgical wound?**

A102. A gastrostomy that is being allowed to close would be excluded from consideration as a wound or lesion (M0440), meaning that it could not be considered as a surgical wound. However, the "take-down" of an ostomy done as a surgical procedure

would result in both a wound/lesion ("yes" to M0440) and a surgical wound ("yes" to M0482).

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

A103. For M0440 you would answer YES for a lesion. At M0482, response 1-Yes is appropriate. The port-a-cath or mediport site is considered a surgical wound even if healed over. The presence of a wound or lesion should be documented regardless of whether the home care agency is providing services related to the wound or lesion. [Q&A EDITED 08/07]

**Q104. M0482. Are implanted infusion devices or venous access devices considered surgical wounds? Are these included in the "count" of surgical wounds? Does it matter whether or not the device is accessed routinely?**

A104. Yes, the surgical sites where such devices were implanted would be considered surgical wounds and included in the total number of surgical wounds at M0484. It does not matter whether the device is accessed at a particular frequency or not.

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

A105. No. Debridement is a treatment to a wound, and the traumatic wound does not become a surgical wound. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #9]

**Q105.1. M0482. If a patient has a venous access device that no longer provides venous access, (e.g. no bruit, no thrill, unable to be utilized for dialysis), is it considered a venous access device that would be "counted" as a surgical wound for M0482, Surgical Wound and the subsequent surgical wound questions?**

A105.1: Yes, as long as the venous access device is in place, it is considered to be a surgical wound whether or not it is functional or currently being accessed. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #26]

**Q105.2. M0482. Does the presence of sutures equate to a surgical wound? For example, IV access that is sutured in place, a pressure ulcer that is sutured closed or the sutured incision around a fresh ostomy.**

A105.2: No, the presence of sutures does not automatically equate to a surgical wound. In the examples given, if the IV was peripheral, it would be excluded from M0440 and M0482, and a pressure ulcer does not become a surgical wound by being sutured closed, and the ostomy would be excluded from M0440 and M0482. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #27]

**Q105.3. M0482. Since an implanted venous access device is considered a surgical wound for M0482, when it is initially implanted, is the surgical incision through which it was implanted a second surgical wound (separate from the venous access device?).**

A105.3: No. The surgical incision is considered a surgical wound until it is healed, becoming a scar. The site of the venous access device is initially considered a surgical wound, as long as it is in place. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #28]

**Q105.4. M0482. If an abscess is incised and drained, does it become a surgical wound?**

A105.4: No, an abscess that has been incised and drained is an abscess, not a surgical wound. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #29]

**Q105.5. M0482. I understand that a simple I&D of an abscess is not a surgical wound. Does it make a difference if a drain is inserted after the I&D? Is it a surgical wound if the abscess is removed?**

A105.5: For purposes of scoring the OASIS integumentary items, a typical incision and drainage procedure does not result in a surgical wound. The procedure would be reported as a surgical wound if a drain was placed following the procedure.

Also, if the abscess was surgically excised, the abscess no longer exists and the patient would have a surgical wound, until healed. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #17]

**Q105.6. M0482. A patient, who has a paracentesis, has a stab wound to access the abdominal fluid. Is this a surgical wound?**

A105.6: When a surgical procedure creates a wound in which a drain is placed (e.g., an incision or stab wound), the presence of the drain (or drain wound site until healed) should be reported as a surgical wound. If a needle was inserted to aspirate abdominal fluid and then removed (no drain left in place), it should not be reported as a surgical wound. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #18]

**Q105.7. M0482. Does a cardiac cath site qualify as a surgical wound for M0482?**

A105.7: If a cardiac catheterization was performed via a puncture with a needle into the femoral artery, the catheter insertion site is not reported as a surgical wound for M0482. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #19]

**Q105.8. M0482. Does a patient have a surgical wound if they have a traumatic laceration and it requires plastic surgery to repair the laceration?**

A105.8: Simply suturing a traumatic laceration does not create a surgical wound. A traumatic wound that required surgery to repair the injury would be considered a surgical wound (e.g., repair of a torn tendon, repair of a ruptured abdominal organ, or repair of other internal damage), and the correct response to M0482 for this type of wound would be "1-Yes." [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #20]

**Q105.9. M0482. Is a PICC placed by a physician under fluoroscopy and sutured in place considered a surgical wound? It would seem that placement by this procedure is similar to other central lines and would be considered a surgical wound.**

A105.9: Even though the physician utilized fluoroscopy to insert the peripherally inserted central catheter (PICC) and sutured it in place, it is not a surgical wound, as PICC lines are excluded as surgical wounds for OASIS data collection purposes. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #21]

**Q105.10. M0482. If a surgical wound is completely covered with steri-strips is it considered non observable?**

A105.10: Chapter 8 of the OASIS Implementation Manual states, "A [surgical] wound is not observable if it is covered by a dressing (or cast) which is not to be removed, per physician's orders." Although unusual, if the steri-strip placement did not allow sufficient visualization of the incision, and if the physician provided specific orders for the steri-strips to not be removed, then the wound would be considered not observable. However, a surgical wound with steri-strips should be considered observable in the absence of physician orders to not remove strips for assessment, or if usual placement allows sufficient visualization of the surgical incision to allow observation of clinical features necessary to determine the surgical wound's healing status (e.g., incisional approximation, degree of epithelialization, incisional necrosis (scab), and/or signs or symptoms of infection). [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #8]

**Q105.11. M0482. Is a heart cath site (femoral) considered a surgical wound? If not, what if a stent is placed?**

A105.11: If a cardiac catheterization was performed via a puncture with a needle into the femoral artery, the catheter insertion site is not reported as a surgical wound for M0482. The fact that a stent was placed does not have an impact. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #9]

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

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

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

A107. A wound no longer qualifies as a surgical wound when it is completely healed (thus becoming a scar). Utilizing skilled observation and assessment of the wound, follow the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document*) found at <http://www.wocn.org/> to determine when healing has occurred. CMS does not follow time intervals in determining when a wound has healed, since the healing status of the wound can only be determined by a skilled assessment and the time for healing varies widely between patients. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #10]

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

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

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

A109. Please refer to the definition of "nonobservable" used in the OASIS surgical wound items in the *OASIS User's Manual* – "nonobservable" is an appropriate response ONLY when a nonremoveable dressing is present. This is not the case with a mediport. As long as the mediport is present, whether it is being accessed or not, the patient is considered as having a current surgical wound. If needed, the manual can be downloaded from [http://www.cms.hhs.gov/HomeHealthQualityInits/14\\_HHQIOASISUserManual.asp](http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp). [Q&A EDITED 08/07]

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

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

**Q111. [Q&A DELETED 08/07; Outdated due to revision of WOCN guidance]**

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

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

**Q112.1. M0488. A venous access device is routinely accessed and upon assessment has a scab at the puncture site. Assuming there are no signs or symptoms of infection, is the wound status early/partial granulation or fully granulating?**

A112.1: To answer M0488, the healing status of a wound can only be determined by a skilled assessment (in person). Follow the Wound, Ostomy, and Continence Nurses' guidelines (*OASIS Guidance Document*) found at <http://www.wocn.org/> to determine the status. Based on the WOCN guidelines, a wound with  $\geq 25\%$  avascular tissue is considered "non-healing"; therefore a venous access puncture site which is covered by a scab (avascular tissue) would be classified as Response 3 - non-healing. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #30]

**Q112.2. M0488. Is it true that the status of a new surgical incision that is closed, with no signs or symptoms of infection present, well approximated, but with a small scab, should be evaluated at 3 - Not healing, even though the scab is normal part of incision healing? Since this potentially impacts reimbursement, we want to ensure we are doing it right.**

A112.2: In order to determine the healing status of a surgical wound, clinicians are directed to rely on the "WOCN Guidance on OASIS Skin and Wound Status M0 Items" document available at [www.wocn.org](http://www.wocn.org). This document provides guidance specific for determining the healing status for surgical wounds healing by primary intention, and separate guidance for wounds healing by secondary intention. A typical routine surgical incision as you describe would be considered healing by primary intention. Referencing the WOCN guidelines, it is noted that a wound that demonstrates incisional necrosis (of any amount for primary intention), is considered "Not Healing".

Note that if we were discussing a dehisced wound, we would be assessing a wound healing by secondary intention, and would follow different guidelines which take into consideration the amount of avascular tissue in determining the healing status (e.g.  $\geq 25\%$  = not healing).

For further clarification, review the CMS OCCB Q&A's (07/2006), Question #30 at [www.oasiscertificate.org](http://www.oasiscertificate.org) which confirms that a scab equates to avascular tissue, which the WOCN Document Glossary equates to necrotic tissue. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #10]

**Q112.3. M0488. We are having a discussion as to whether a mediport is a "Not healing" or "Early/partial granulation" wound in M0488 when the needle is present in the wound. And if the needle has just been removed within the last 24 hrs how would it be scored; or if the site has not been accessed for several months and there is no open area visible how is it to be scored? We are assuming that this is a wound that is healing by secondary intention.**

A112.3: The assessing clinician must determine the healing status of a wound following guidance in Chapter 8 of the OASIS 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, may not reach a "fully granulating" state while the line or needle is in place.

Once the needle is removed before a scab has formed, the wound bed may be clean but non-granulating. Based on the WOCN Guidance, the wound would be reported as Response 3 – Not healing for M0488. Or if the venous access device is routinely accessed and upon assessment has a scab at the puncture site, assuming there are no signs or symptoms of infection, a wound with greater than or equal to 25% avascular tissue is considered "non-healing". Therefore a venous access puncture site which is covered by a scab (avascular tissue) would also be classified on M0488 as Response 3 – not healing.

If the site has not been accessed for months, then guidance from CMS OASIS Q&As Category 4b Q106 assists in determining the healing status of an implanted vascular access device by suggesting that to answer M0488, the healing status of a wound can only be determined by a skilled assessment (in person). It is possible for such a wound to be considered "fully granulating" (the best level the wound could attain on this particular item) for long periods of time, but it is also possible for such wounds to be considered "early/partial granulation," or "not healing" if the site becomes infected. These sites would not be considered as "non-healing" unless the signs of not healing are apparent. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #11]

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

A113. M0490 asks when the patient is noticeably short of breath. In the response options, examples of shortness of breath with varying levels of exertion are presented. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest. If the patient does not have shortness of breath with moderate exertion, then either response 0 or response 1 is appropriate. If the patient is never short of breath on the day of assessment, then response 0 applies. If the patient only becomes short of breath when engaging in physically demanding transfer activities, then response 1 seems most appropriate.

In the case of the bedbound patient, the level of exertion that produces shortness of breath should also be assessed. The examples of exertion given for responses 2, 3, and 4 also provide assessment examples. Response 0 would apply if the patient were never short of breath on the day of assessment. Response 1 would be most appropriate if demanding bed-mobility activities produce dyspnea. [Q&A EDITED 08/07]

**Q113.1. M0490. What is the correct response for the patient who is only short of breath when supine and requires the use of oxygen only at night, due to this positional dyspnea? The patient is not short of breath when walking more than 20 feet or climbing stairs.**

A113.1: Since the patient's supplemental oxygen use is not continuous, M0490 should reflect the level of exertion that results in dyspnea without the use of the oxygen. The correct response would be "4 – At rest (during day or night)". It would be important to include further clinical documentation to explain the patient's specific condition. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #31]

**Q113.2. M0490. What is the correct response to M0490, Dyspnea, if a patient uses a CPAP or BiPAP machine during sleep as treatment for obstructive sleep apnea?**

A113.2: Sleep apnea being treated by CPAP is not the same as dyspnea at rest (response 4 for M0490). M0490 asks about dyspnea (shortness of breath), not sleep apnea (absence of breath during sleep).

The two problems are not the same. Dyspnea refers to shortness of breath, a subjective difficulty or distress in breathing, often associated with heart or lung disease. Dyspnea at rest would be known and described as experienced by the patient. Sleep apnea refers to the absence of breath. People with untreated sleep apnea stop breathing repeatedly during their sleep, though this may not always be known by the individual. If the apnea does not result in dyspnea (or noticeable shortness of breath), then it would not be reported on M0490. If, however, the sleep apnea awakens the patient and results in or is associated with an episode of dyspnea (or noticeable shortness of breath), then response 4 - At rest (during day or night) should be reported. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #12]

**Q113.3. M0490. Patient currently sleeps in the recliner or currently sleeps with 2 pillows to keep from being SOB. They are currently not SOB because they have already taken measures to abate it. Would you mark M0490, #4 At Rest or 0 Never SOB?**

A113.3: M0490 reports what is true at the time of the assessment (the 24 hours immediately preceding the visit and what is observed during the assessment). If the patient has not demonstrated or reported shortness of breath during that timeframe, the correct response would be "0-Never" even though the environment or patient activities were modified in order to avoid shortness of breath. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #13]

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

A114. Note that the Response-specific Instructions for M0500 direct you to exclude any respiratory treatments that are not specifically listed in the item. If the patient's only respiratory treatment is Bi-PAP without oxygen, the appropriate response is 4, "None of the above." If the patient uses any of the listed treatments, the appropriate response(s) should be noted. If the patient was receiving oxygen, including delivery in conjunction with the Bi-PAP treatment, then the oxygen use would be reported in Response 1. In either case, the use of Bi-PAP would be documented in the patient's clinical record. [Q&A EDITED 08/07]

**Q114.1. M0500. If patient is on a ventilator, do you mark O2 & ventilator or is the O2 inclusive with the ventilator in this question?**

A114.1: M0500 instructs the assessor to mark all that apply. As it is possible for a patient to be ventilated with entrained room air and thus be on a ventilator without oxygen therapy, it would be accurate to mark both Responses 1-Oxygen and 2-Ventilator when the patient is receiving oxygen through the ventilator. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #14]

**Q115. [Q&A DELETED 08/07; Duplicative of Chapter 8]**

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

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

**Q117. M0520. Is the patient incontinent if she only has stress incontinence when coughing?**

A117. Yes, the patient is incontinent if incontinence occurs under any situation(s).

**Q118. M0520. A new urologist has just started referring patients who have a urostomy or ureterostomy. What should I mark for M0520?**

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

**Q119. M0520. A patient is determined to be incontinent of urine at SOC. After implementing clinical interventions (e.g., Kegel exercises, biofeedback, and medication therapy) the episodes of incontinence stop. At the time of discharge, the patient has not experienced incontinence since the establishment of the incontinence program. At discharge, can the patient be considered continent of urine for scoring of M0520, to reflect improvement in status?**

A119. Assuming that there has been ongoing assessment of the patient's response to the incontinence program (implied in the question), this patient would be assessed as continent of urine. Therefore Response 0, no incontinence or catheter, is an appropriate response to M0520.

Timed-voiding was not specifically mentioned as an intervention utilized to defer incontinence. If, at discharge, the patient was dependent on a timed-voiding program to defer incontinence, the appropriate response to M0520 would be 1 (patient is incontinent), followed by response 0 to M0530 (timed-voiding defers incontinence). [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #5]

**Q119.1. M0520. How long would a patient need to be continent of urine in order to qualify as being continent?**

A119.1: Utilize clinical judgment and current clinical guidelines and assessment findings to determine if the cause of the incontinence has been resolved, resulting in a patient no longer being incontinent of urine. There are no specific time frames that apply to all patients in all situations. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #23]

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

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

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

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

**Q121.1. M0530. If a patient is utilizing timed-voiding to defer incontinence and they have an “accident” once-in-a-while, can you still mark M0530 “0 – Timed-voiding defers incontinence”?**

A121.1: If the patient utilizes timed-voiding but still has an “occasional” accident, determine when the accidents occur and mark either Response 1 “during the day and night” or 2 “during the night only”. CMS does not offer specific timeframes to define the term “occasionally”. Clinical judgment will be required to determine if the last urinary accident is in the relevant past or if the patient’s current use of timed-voiding is 100% effective and therefore should be marked as “timed-voiding defers incontinence”. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #32]

**Q122. M0540. How should you respond to this item if the patient is on a bowel-training program? How would that be documented in the clinical record?**

A122. A patient on a regular bowel evacuation program most typically is on that program as an intervention for fecal impaction. Such a patient may additionally have occurrences of bowel incontinence, but there is no assumed presence of bowel incontinence simply because a patient is on a regular bowel program. The patient's elimination status must be completely evaluated as part of the comprehensive assessment, and the OASIS items answered with the specific findings for the patient. The bowel program, including the overall approach, specific procedures, time intervals, etc., should be documented in the patient's clinical record.

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

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

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

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

depressive feelings in M0590. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #11]

**Q124.1. M0570 & M0580. What does unresponsive mean?**

A124.1: It means the patient is unconscious, or is unable to voluntarily respond. A patient who only demonstrates reflexive or otherwise involuntary responses may be considered unresponsive. A patient with language or cognitive deficits is not automatically considered “unresponsive”. A patient who is unable to verbally communicate may respond by blinking eyes or raising a finger. A patient with dementia may respond by turning toward a pleasant, familiar voice, or by turning away from bright lights, or by attempting to remove an uncomfortable clothing item or bandage. A patient who simply refuses to answer questions should not automatically be considered “unresponsive”. In these situations, the clinician should complete the comprehensive assessment and select the correct response based on observation and caregiver interview. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #33]

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

A125. No, there are behaviors other than those listed in M0610 that can be indications of alterations in a patient’s cognitive or neuro/emotional status resulting in behaviors of concern for the patient’s safety or social environment. Other behaviors such as wandering can interfere with the patient’s safety, and if so, the frequency of these should be considered in responding to the item.[Q&A EDITED 08/07]

**Q126. M0630. At discharge, does M0630 pertain to the services the patient has been receiving up to the point of discharge or services that will continue past discharge? The psych nurse is the only service being provided.**

A126. OASIS items refer to what is true at the time of the assessment (unless a specified time point is noted, such as 14 days ago). Therefore, for the situation described, if the psych nurse is the only service provided at the time of the discharge assessment, the correct response is “yes.” Note that if the psychiatric nurse discharges on Tuesday, but the Physical Therapist does the discharge comprehensive assessment on Wednesday, then M0630 (at discharge) would not reflect the presence of psychiatric nursing services. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #3]

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

**Q127. M0640-M0800. At OASIS items M0640-M0800, what does IADL mean and what's the difference between IADLs and ADLs?**

A127. ADL stands for 'activities of daily living' while IADL stands for 'instrumental activities of daily living'. ADLs refer to basic self-care activities (e.g., bathing, dressing, toileting, etc.), while IADLs include activities associated with independent living

necessary to support the ADLs (e.g., use of telephone, ability to do laundry, shopping, etc.). There is a more complete discussion of this topic in the *OASIS User's Manual*, Chapter 8, Item-by-Item tips, on the page preceding the tips for items M0640-M0800.

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

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

**Q128.1. M0640-M0800. I know it is imperative that the assessing clinician be accurate on answering what the patient's status was on the "14th day prior to". Can you explain to me the importance of that 14th day? What bearing this has on their outcomes/payment? If we mark "unknown", does it hurt the agency?**

A128.1: Prior status contributes to the Case Mix Report categories of "ADL Status Prior to SOC" and "IADL Status Prior to SOC" and is utilized in risk adjustment for some of the outcome measures. The "prior status" variables have proven to be particularly useful in risk adjustment for the OBQI reports, as they indicate the chronicity of a functional impairment (thus impacting the patient's expected ability to improve in a specific outcome of interest).

The 14th day prior to SOC/ROC serves as a proxy for the patient's prior functional status. While it may not represent the "true" prior functional status, it allows the data collection of thousands of assessors to be standardized. General OASIS conventions state that data collectors should minimize the use of "unknown" as a response option, and to limit its use to situations where no other response is possible or appropriate. Under the current reimbursement for Medicare home care services, the "14 days prior" responses do not affect payment. However, since the responses from the prior status items do currently contribute to risk adjustment, it is possible that they may have a reimbursement impact in the future, depending on the parameters used to determine payment under the home health benefit and other programs. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #24]

**Q129. M0640. Must I see the patient comb his/her hair or brush his/her teeth in order to respond to this item?**

A129. No, as assessment of the patient's coordination, manual dexterity, upper-extremity range of motion (hand to head, hand to mouth, etc.), and cognitive/emotional status will allow the clinician to evaluate the patient's ability to perform grooming activities.

**Q130. M0640. Is toileting hygiene part of this item?**

A130. The term "toileting hygiene" typically is used to refer to the activities of managing clothing before and after elimination and of wiping oneself after elimination. If these are the activities implied by this question, the response is "no, toileting hygiene is not part of

this item.” If the question refers to the patient’s ability to wash his/her hands, this activity is considered part of grooming.

**Q130.1. M0640 & M0670. Is hair washing/shampooing considered a grooming task, a bathing task, or neither?**

A130.1: The task of shampooing hair is not considered a grooming task for M0640. Hair care for M0640 includes combing, brushing, and/or styling the hair. Shampooing is also specifically excluded from the bathing tasks for M0670, therefore the specific task of shampooing the hair is not included in the scoring of either of these ADL items. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #34]

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

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

**Q132. M0650. What if the patient must dress in stages due to shortness of breath? What response must be marked?**

A132. If the patient is able to dress herself/himself independently, then this is the response that should be marked, even if the activities are done in steps. If the dressing activity occurs in stages because verbal cueing or reminders are necessary for the patient to be able to complete the task, then response 2 is appropriate. (Note that the shortness of breath would be addressed in M0490.)

**Q132.1. M0650, M0660. In the dressing items, how do you answer if a disabled person has everything in their home adapted for them; for instance, closet shelves & hanger racks have been lowered to be accessed from a wheelchair. Is the patient independent with dressing?**

A132.1: M0650 & M0660, Upper and Lower Body Dressing, Response 0 indicates a patient is able to safely access clothes and put them on and remove them (with or without dressing aids). Because in these specific OASIS items, the use of special equipment does not impact the score selection, at the assessment time point, if the patient is able to safely access clothes, and safely dress, then Response 0 would be appropriate even if the patient is using adaptive equipment and/or an adapted environment to promote independence. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #25]

**Q132.2. M0650, M0660, M0780. For M0650 & M0660, we know you count things like prostheses & TED hose as part of the clothing. But the interpretation is that they have to only be independent with the "majority" of the dressing items & then they are considered independent. Because of the importance of being able to put a prostheses on and for a diabetic being able to put shoes & socks on, clinicians want to mark a patient who can do all their dressing except those items NOT independent. However, does this fit the criteria of "majority"?**

**The same issue can exist for medication compliance.....if a patient can take the majority of their meds (Vitamins, stool softeners, etc.) but cannot remember their digoxin....does that make them independent with the majority even though we know how important the digoxin is?"**

A132.2: Your understanding of the majority rule is correct. If a patient's ability varies among the tasks included in a single OASIS item (like M0660 lower body dressing, or M0780 Oral Medications), select the response that represents the patient's status in a "majority" of the tasks. The concerns of clinicians focus on critical issues that need to be addressed in the plan of care. It may help to remember that the OASIS is a standardized data set designed to measure patient outcomes. In order to standardize the data collected, there must be objective rules that apply to the data collection (e.g. the percentage of medications a patient can independently take). Less objective criteria, like which medications are more important, or which lower body dressing items are more important than others, have limitations in consistency in which a similar situation would likely be interpreted differently between various data collectors from one agency to the next. While these rules may cause the assessing clinician to pick an item response that lacks the detail or specificity that may be observable when assessing a given patient, as long as the clinician is abiding by scoring guidelines, he/she is scoring the OASIS accurately and the agency's outcome data will be a standardized comparison between other agencies. In any situation where the clinician is concerned that the OASIS score does not present as detailed or accurate representation as is possible, the clinician is encouraged to provide explanatory documentation in the patient's clinical record, adding the necessary detail which is required for a comprehensive patient assessment. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #26]

**Q132.3. M0660. If the patient has a physician's order to wear elastic compression stockings and they are integral to their medical treatment, (e.g. patient at risk for DVT), but the patient is unable to apply them, what is the correct response for M0660?**

A132.3: M0660 identifies the patient's ability to obtain, put on, and remove their lower body clothing, including lower extremity supportive or protective devices. A prescribed treatment that is integral to the patient's prognosis and recovery from the episode of illness, such as elastic compression stockings, air casts, etc., should be considered when scoring M0660. The patient in this situation would be scored based on their ability to obtain, put on and remove the majority of their lower body dressing items, as the elastic compression stockings are a required, prescribed treatment. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #35]

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

A133. As noted in the Item-by-Item Tips found in Chapter 8 of the *OASIS User's Manual*, the patient who regularly bathes at the sink or lavatory must be assessed in relation to his/her ability to bathe in the tub or shower. What assistance would be needed for the patient to be able to wash their body in the tub or shower? For example, if it is determined that the patient would be able to safely wash their body in the shower or bathe in the tub with the presence of another person throughout the bath for safety or assistance, response #2 would be marked. [Q&A EDITED 08/07]

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

- a) The patient's tub or shower is nonfunctioning or is not safe for use.**
- b) The patient is on physician-ordered bed rest.**
- c) The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again.**
- d) The patient chooses not to navigate the stairs to the tub/shower.**

A134. a) The patient's environment can impact his/her ability to complete specific ADL tasks. If the patient's tub or shower is nonfunctioning or not safe, then the patient is currently unable to use the facilities. Response 4 or 5 would apply, depending on the patient's ability to participate in bathing activities outside the tub/shower.

b) The patient's medical restrictions mean that the patient is unable to bathe in the tub or shower at this time. Select response 4 (unable to bathe in shower or tub and is bathed in bed or bedside chair) or 5 (unable to effectively participate in bathing and is totally bathed by another person), whichever most closely describes the patient's ability at the time of the assessment.

c) If the patient's fear is a realistic barrier to her ability to get in/out of the shower safely, then her ability to bathe in the tub/shower may be affected. If due to fear, she refuses to enter the shower even with the assistance of another person, either response 4 or 5 would apply, depending on the patient's ability at the time of assessment. If she is able to bathe in the shower when another person is present to provide required supervision/assistance, then response 3 would describe her ability.

d) The patient's environment must be considered when responding to the OASIS items. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower. While this may appear to penalize the patient whose tub or shower is on another floor, it is within this same environment that improvement or decline in the specific ability will subsequently be measured. [Q&A EDITED 08/07]

**Q135. M0670. How should I respond to this item for a patient who is able to bathe in the shower with assistance, but chooses to sponge bathe independently at the sink?**

A135. The item addresses the patient's ability to bathe in the shower or tub, regardless of where or how the patient currently bathes. If assistance is needed to bathe in the shower or tub, then the level of assistance needed must be noted, and response 1, 2, or 3 should be selected.

**Q136. M0670. Should the clinician consider the patient's ability to perform bathing-related tasks, like gathering supplies, preparing the bath water, shampooing hair, or drying off after the bath in responding to this item?**

Q136. When responding to M0670, only the patient's ability to "wash the entire body" should be considered. Bathing-related tasks, such as those mentioned, should not be considered in scoring this item. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #12]

**Q137. M0670. If a patient can perform most of the bathing tasks (i.e. can wash most of his/her body) in the shower or tub, using only devices, but needs help to reach a hard to reach place, would the response be “1” because he/she is independent with devices with a “majority” of bathing tasks? Or is he/she a “2” because he/she requires the assist of another “for washing difficult to reach areas?”**

A137. The correct response for the patient described here would be Response 2 "able to bathe in the shower or tub with the assistance of another person: c) for washing difficult to reach areas," because that response describes that patient's ability at that time. [Q&A added 06/05; Previously CMS OCCB 8/04 Q&A #13] [Q&A EDITED 08/07]

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

A138. M0670 defines the bathing item to identify the patient's ability to wash the entire body. Guidance for this item also indicates that when medical restrictions prevent the patient from accessing the tub/shower, his/her bathing ability will be 'scored' at a lower level. Tasks related to transferring in and out of the tub or shower are evaluated and scored when responding to M0690 – Transferring, and they are not considered part of the bathing tasks for M0670. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #6]

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

A139. If the patient truly is unable to effectively participate in any part of the bathing tasks in the shower, response 5 is appropriate. If the patient is able to participate at all in the bathing tasks in the shower, then response 3 is appropriate. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #6]

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

A140. The tub transfer should not be considered when responding to M0670. However, the response for M0670 should differentiate patients who are able to bathe (or be bathed) in the tub or shower (i.e., responses 0, 1, 2, 3, or 5) from those who are unable to bathe in the tub or shower (e.g., response 4) regardless of the specific cause or barrier preventing the patient from bathing in the shower or tub. Responses 0,1,2,3, reflect patients who are able to get in/out of the tub/shower, assisted or unassisted by any safe means and once in the tub/shower are able to safely participate in washing their body, either independently or with assistance. Responses 4 reflects patients who

are unable to get in/out of the tub/shower, assisted or unassisted by any safe means and therefore participate in washing their body outside of the tub/shower, either independently or with assistance. Response 5 reflects patients who are unable to participate in the tasks required to wash their body, regardless of whether or not the patient is able to get in/out of the tub/shower (e.g. the dependent bather is bathed in the bed, chair, or after being rolled into the shower in a shower chair).

[[Q&A added 06/05; Previously CMS OCCB 3/05 Q&A Q #7] [Q&A EDITED 08/07]

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

A141. The tub or shower transfer should not be considered when responding to M0670, and if the transfer is the only bathing task for which a patient requires help to bathe safely in the tub/shower, then the patient should be scored a 0 or 1, depending on his/her need for devices to safely perform all the included bathing tasks independently. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #8]

**Q141.1. M0670. Based on my SOC comprehensive assessment, I determine that my patient requires assistance to wash his back and feet safely in the tub. At the time of the assessment, I believe the patient *could* wash his back and feet safely *if* he had adaptive devices, like a long-handled sponge. Should the initial score be “1” able to bathe in the tub/shower with equipment or “2” requires the assistance of another person to wash difficult to reach areas?**

A141.1: Since at the time of the assessment the patient requires intermittent assist of another person to wash difficult to reach areas, then response “2” should be selected. If the clinician determined that the patient could become more independent (i.e., require less assistance) with the use of adaptive equipment, then such equipment could be obtained or recommended as part of the home health plan of care. If at discharge the patient is able to wash his entire body using the equipment provided, then response “1” should be reported. If the patient is financially unable or otherwise refuses to obtain the recommended equipment, then the clinician would not have the opportunity to instruct or evaluate the patient’s ability to determine if the equipment improves independence. If the patient does not get the equipment, or if even with the equipment the patient continues to require intermittent assistance, then response “2” would apply. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #36]

**Q141.2. M0670. I understand that recent clarification reveals that the transfer in/out of the tub/shower should not be included in the scoring of M0670. Previous guidance stated that in order for the patient to be able to bathe in the tub/shower they had to be able to get there (e.g., if a patient is restricted from stair climbing and their only tub/shower is upstairs, then they are unable to bathe in the tub/shower) Is this still true or is M0670 now limited to just the patient’s ability to wash their entire body once in the tub/shower? It seems strange that walking up the stairs *would* impact the bathing item score, but getting into the tub/shower *wouldn’t*.**

A141.2: Guidance for this item has evolved over time and additional clarification has been provided, allowing objective measurement of improvement in a specific portion of the bathing process; the patient’s ability to wash their entire body. If a patient can get to

the tub/shower and in/out of the tub/shower (by any safe means), then their ability to wash their entire body while in the tub/shower should be assessed, and the score reported as “0” if they need no human assistance or equipment, “1” if they need no human assistance but require equipment, “2” if they require intermittent assistance, “3” if they require constant supervision/assistance, “4” if they are unable to use the shower or tub and is bathed in bed or bedside chair, or “5” if they are unable to participate at all in washing their body. If medical restrictions prohibit the patient from activities which would be required for the patient to get to/from the tub/shower (e.g., restricted stair climbing), in/out of the tub/shower (e.g., some joint precautions), or from bathing or showering in the tub or shower (e.g., some cast or incision precautions), then the patient should be considered “unable to bath in the tub or shower” and would be scored a “4” or “5”, depending on their ability to participate in washing their body at any location outside of the tub/shower. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #37]

**Q141.3. M0670. For M0670 even the normal person requires a long-handled sponge or brush to wash their back. However, the July 27 CMS OCCB Q & A's # 36 indicates that if a patient can do everything except wash their back & requires a long-handled sponge or brush they would be marked a "1". Is this correct?**

A141.3: Assistive devices promote greater independence for the user by enabling them to perform tasks they were previously unable to, or had great difficulty safely performing. The intention of the use of the term “devices” in the response 1 for M0670 is to differentiate a patient who is capable of washing his entire body in the tub/shower independently (response 0), from that patient who is capable of washing his entire body in the tub/shower only with the use of (a) device(s). This differentiation allows a level of sensitivity to change to allow outcome measurement to capture when a patient improves from requiring one or more assistive devices for bathing, to a level of independent function without devices. Individuals with typical functional ability (e.g. functional range of motion, strength, balance, etc.) do not “require” special devices to wash their body. An individual may choose to use a device (e.g., a long-handled brush or sponge) to make the task of washing the back or feet easier. If the patient’s use of a device is optional (e.g., it is their preference, but not required to complete the task safely), then the score selected should represent the patient’s ability to bathe without the device. If the patient requires the use of the device in order to safely bathe, then the need for the device should be considered when selecting the appropriate score. CMS has not identified a specific list of equipment that defines “devices” for the scoring of M0670. The clinician should assess the patient’s ability to wash their entire body and use their judgment to determine if a device, assistance, or both is required for safe completion of the included bathing tasks. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #27]

**Q141.4. M0670. If a patient uses the tub/shower for storage, is this an environmental barrier? Is the patient marked a "4" in M0670?”**

A141.4: Upon discovering the patient is bathing at the sink, the clinician should evaluate the patient in attempts to determine why he/she is not bathing in the tub/shower. If it is the patient’s personal preference to bathe at the sink (e.g. “I don’t get that dirty.” “I like using the sink.”), but they are physically and cognitively able to bathe in the tub/shower; the clinician will pick the response option that best reflects the patient’s ability to bathe in the tub/shower. If the patient no longer bathes in the tub/shower due to personal preference and has since begun using the tub/shower as a storage area, the patient would be scored based on their ability to bathe in the tub/shower when it was empty. If

the patient has a physical or cognitive/emotional barrier that prevents them from bathing in the tub/shower and therefore has since starting using the tub/shower as a storage area, the clinician will score the patient as “4 –“Unable to use the shower or tub and is bathed in bed or bedside chair.”, unless they are a “5”, unable to participate in bathing and is totally bathed by another person. Note that the response of “4” (or “5”) is due to the patient’s inability to safely bathe in the tub/shower (even with help) due to the physical and/or cognitive barrier, not due to the alternative use of the tub for storage. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #28]

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

A142. M0680 does not differentiate between patients who have urinary catheters and those who do not. The item simply asks about the patient’s ability to get to and from the toilet or bedside commode. This ability can be assessed whether or not the patient uses the toilet for urinary elimination.

**Q143. M0680. If the patient can safely get to and from the toilet independently during the day, but uses a bedside commode independently at night, what is the appropriate response to this item?**

A143. If the patient chooses to use the commode at night (possibly for convenience reasons), but is able to get to the bathroom, then response 0 would be appropriate.

**Q144. M0680. If a patient is unable to get to the toilet or bedside commode and uses a bedpan for elimination, what response applies if the patient is able to safely and independently complete all tasks except removing and emptying the bedpan/urinal?**

A144. In M0680, the patient does not need to empty the bedpan or urinal to be considered independent. If the patient required assistance to use the bedpan/urinal (i.e., get on or off the bedpan or position the urinal), Response 4 would be the best response. If the patient could position the urinal or get on/off the bedpan independently, Response 3 would be appropriate. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #14]

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

A145. Tasks related to personal hygiene and management of clothing should not be considered when responding to M0680. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #15]

**Q146. M0680. If a patient is able to safely get to and from the toilet with assistance of another person, but they live alone and have no caregiver so they are using a bedside commode, what should be the response to M0680?**

A146. The OASIS item response should reflect the patient’s ability to safely perform a task, regardless of the presence or absence of a caregiver. If the patient is able to safely get to and from the toilet with assistance, then response 1 should be selected, as

this reflects their ability, regardless of the availability of a consistent caregiver in the home. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #9]

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

A147. M0680 does not include the transfer on and off the toilet (for response levels 0 and 1) or on/off the bedside commode (for response 2), as both these transfers are specifically addressed in responding to M0690 - Transferring. The transfer on and off the bedpan *is* considered for M0680 response level 3. If the patient requires assistance to get on/off the bedpan, then he/she would not be considered independent in using the bedpan and response 4 would be the best response. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #10]

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

A148. Yes, a patient who is able to safely get to and from the toilet should be scored at response levels 0 or 1, even if they require the use of a commode over the toilet. Note that the location of such a commode is not at the "bedside," and the commode is functioning much like a raised toilet seat. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #11]

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

A149. Response 3 is the option that most closely resembles the patient’s circumstance you describe. The patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast (“confined to the bed”) even though he cannot help with the transfer. Responses 4 and 5 do not apply for the patient who is not bedfast.

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

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

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

A151. You appear to be asking about a patient who is not bedfast. Remember that M0690 evaluates the patient’s ability to safely perform three types of transfers: bed to chair, on and off toilet or commode, and into and out of tub or shower. “Pushing up with both arms” could apply to two of these transfer types -- bed to chair and on/off toilet or commode. Taking extra time and pushing up with both arms can help ensure the

patient's stability and safety during the transfer process but does not mean that the patient is not independent. If standby human assistance were necessary to assure safety, then a different response level would apply to these types of transfers. Remember that transfer ability can vary across these three activities. The level of ability applicable to the majority of the activities should be recorded.

**Q151.1. M0690. When scoring M0690 – Transferring, response “1” indicates that that patient requires minimal human assistance or the use of an assistive device to safely transfer. What constitutes an “assistive device” for the purposes of differentiating “truly independent” transferring (response “0”) from “modified independent” transferring (response “1”, or transferring with equipment)?**

A151.1: CMS is in the process of defining assistive devices and will provide guidance when the issue is clarified. [Q&A ADDED 08/07. Previously CMS OCCB 08/04 Q&A #16]

**Q151.2. M0690. If a patient requires a little help from the caregiver to transfer (e.g., verbal cueing, stand by assist, contact guard), would the score for M0690 Transferring be “1” (requires “minimal human assistance”) or a “2” (“unable to transfer self”)? Both seem to apply.**

A151.2: If the patient is able to transfer self but requires standby assistance or verbal cueing to safely transfer, response “1” would apply. If the patient is unable to transfer self but is able to bear weight and pivot when assisted during the transfer process, then response “2” would apply. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #38]

**Q151.3. M0690. A quadriplegic is totally dependent, cannot even turn self in bed, however, he does get up to a gerichair by Hoyer lift. For M0690, is the patient considered bedfast?**

A151.3: A patient who can tolerate being out of bed is not “bedfast.” If a patient is able to be transferred to a chair using a Hoyer lift, response 3 is the option that most closely resembles the patient’s circumstance; the patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast (“confined to the bed”) even though he cannot help with the transfer. Responses 4 and 5 do not apply for the patient who is not bedfast. The frequency of the transfers does not change the response, only the patient’s ability to be transferred and tolerate being out of bed. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #29]

**Q151.4. M0690. How do you select a score for M0690 – Transferring, for the patient who is not really safe at response 1, but moving to response 2 seems a bit aggressive? Response 1 uses the word "or" NOT "and". If a patient requires both human assist AND an assistive device, does this move them to a 2, especially if they are not safe? It seems these patients can do more than bear weight and pivot--but it is the next best option. If they require human assist AND an assistive device, should we automatically move the patient to a "2", whether they are safe or not?**

Answer 151.4: If the patient is able to safely transfer with either minimal human assistance (but no device), or with the use of an assistive device (but no human assistance) then they should be reported as a “1-Transfers with minimal human

assistance or with use of an assistive device". If they are not safe in transferring with either of the above circumstances, (e.g., they transfer with only an assistive device but not safely, minimal assistance only is not adequate for safe transferring, or they require both minimal human assistance and an assistive device to transfer safely), then the patient would be scored a "2–Unable to transfer self but is able to bear weight and pivot during the transfer process"(assuming the patient could bear weight and pivot). Safety is integral to ability. If the patient is not safe when transferring with just minimal human assistance or with just an assistive device, they cannot be considered functioning at the level of response "1".

For the purposes of Response 1 – Minimal human assistance could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance, where the level of assistance required from someone else is equal to or less than 25% of the total effort to transfer and the patient is able to provide >75% of the total effort to complete the task. Examples of environmental set-up as it relates to transferring would be a patient who requires someone else to position the wheelchair by the bed and apply the wheelchair locks in order to safely transfer from the bed to the chair, or a patient who requires someone else to place the elevated commode seat over the toilet before the patient is able to safely transfer onto the commode. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #15]

**Q151.5. M0690. The patient is severely disabled with MS, is obese, cannot support her weight and the spouse is able to use a Hoyer lift to transfer her to a chair. Because of her size, she is not able to use a bedside commode. The bathroom entrance and layout does not allow for the Hoyer to pass through, so the patient is unable to be transferred to the bathroom toilet or into the shower. She can only do one of the three transfers via lift. She is not "confined to the bed" because she is able to be lifted to a chair. When in bed, she needs help turning and positioning. Is she a response 3 or a 5? Which principles apply and how would the transfer question be scored in this instance?**

A151.5: When selecting the correct response to a multi-task item like Transferring, you must first determine if your patient is bedfast or not. If the patient is bedfast, the response will be 4 or 5. If the patient is not bedfast and their ability varies between the three transfers, determine what is true in a majority of the more frequently performed transfers. Bedfast means that a patient is unable to tolerate being out of the bed. They are confined to the bed. You state that your patient is transferred out of bed via the Hoyer lift and sits in a chair, so she is not bedfast. Even though the patient is only able to perform one of the three transfers, due to environmental and physical barriers, Response 3 best describes this patient. In the most frequently performed transfer, she is unable to transfer self and is unable to bear weight or pivot when transferred by another person. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #16]

**Q152. M0700. What if my patient has physician-ordered activity restrictions due to a joint replacement? What they are able to do and what they are allowed to do may be different. How should I respond to this item?**

A152. The patient's medical restrictions must be considered in responding to the item, as the restrictions address what the patient is able to safely accomplish at the time of the assessment.

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

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

**Q154. M0700. If a patient uses a wheelchair for 75% of their mobility and walks for 25% of their mobility, then should they be scored based on their wheelchair status because that is their mode of mobility >50% of the time? Or should they be scored based on their ambulatory status, because they do not fit the definition of “chairfast?”**

A154. Item M0700 addresses the patient's ability to ambulate, so that is where the clinician's focus must be. Endurance is not included in this item. The clinician must determine the level of assistance is needed for the patient to ambulate and choose response 0, 1, or 2, whichever is the most appropriate. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #17]

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

A155. A patient who needs intermittent assistance (including any combination of hands-on assistance, supervision, and /or verbal cueing) to ambulate safely would be scored as a "1" on M0700. A patient who needs continuous assistance (including any combination of hands-on assistance, supervision, and/or verbal cueing) to ambulate safely would be scored as a "2" -- "able to walk only with the supervision or assistance of another person at all times." [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #7]

**Q155.1. M0700. My patient does not have a walking device but is clearly not safe walking alone. I evaluate him with a trial walker that I have brought with me to the assessment visit and while he still requires assistance and cueing, I believe he could eventually be safe using it with little to no human assistance. Currently his balance is so poor that ideally someone should be with him whenever he walks, even though he usually is just up stumbling around on his own. What score should I select for M0700?**

A155.1: It sounds as though your assessment findings cause you to believe the patient should have someone with them at all times when walking (Response “2”). When scoring M0700, clinicians should be careful not to assume that a patient, who is unsafe walking without a device, will suddenly (or ever) become able to safely walk *with* a device. Observation is the preferred method of data collection for the functional OASIS items, and the most accurate assessment will include observation of the patient using the device. Often safe use will require not only obtaining the device, but also appropriate selection of specific features, fitting of the device to the patient/environment and patient instruction in its use. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #39]

**Q155.2. M0700. For M0700, does able to walk “on even and uneven surfaces” mean inside the home or outside the home or both? If the patient is scored a 0, does this mean the patient is a safe community ambulator and therefore is not homebound?**

A155.2: “Even and uneven surfaces” refers to the typical variety of surfaces that the particular home care patient would routinely encounter in his environment. Based on the individual residence, this could include evaluating the patient’s ability to navigate carpeting or rugs, bare floors (wood, linoleum, tile, etc.), transitions from one type or level of flooring to another, stairs, sidewalks, and uneven surfaces (such as a graveled area, uneven ground, uneven sidewalk, grass, etc.).

To determine the best response, consider the activities permitted, the patient’s current environment and its impact on the patient’s normal routine activities. If, on the day of assessment, the patient’s ability to safely ambulate varies among the various surfaces he must encounter, determine if the patient needs some level of assistance at all times (Response 2), needs no human assistance or assistive device on any of the encountered surfaces (Response 0), or needs some human assistance and/or equipment at times but not constantly (Response 1).

Response 0, Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e. needs no human assistance or assistive device), is not intended to be used as a definitive indicator of homebound status. Some patients are homebound due to medical restrictions, behavioral/emotional impairments and other barriers, even though they may be independent in ambulation.

Refer to the Medicare Coverage Guidelines for further discussion of homebound criteria at <http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf>. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #30]

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

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

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

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

**Q157.1. M0710. For Feeding or Eating, what is the definition of meal set-up?**

A157.1: Meal set-up is included in Response 1 of M0710, Feeding or Eating. When reviewing Response 1, you will see that it is identifying patients who are able to feed self independently but need some special assistance to do so. With this in mind, meal set-up would include any special assistance that is required for the patient that others do not require in order to feed themselves once the food is placed in front of them. Examples of meal set-up activities that a patient may require assistance with include cutting the food into manageable pieces, buttering bread, or placing a straw in a cup. (Note: Chopping or

cutting of food is not considered meal set-up in homes where the culture dictates that the food be chopped or cut before being served, such as in some Asian cultures.) [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #40]

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

A158. M0720 identifies the patient's cognitive and physical ability to plan and prepare light meals or reheat delivered meals. While the nutritional appropriateness of the patient's food selections is not the focus of this item, any prescribed diet requirements (and related planning/preparation) should be considered when scoring M0720. Therefore a patient who is able to complete the mobility and cognitive tasks that would be required to heat a frozen dinner in the microwave or make a sandwich, but who is currently physically or cognitively *unable* plan and prepare a simple meal that complies with a medically prescribed diet should be scored as a "1- unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations," until adequate teaching/learning has occurred for the special diet, or until related physical or cognitive barriers are addressed. If the patient with any prescribed diet requirements is unable to plan and prepare a meal that complies with their prescribed diet AND also is unable to plan and prepare "generic" light meals (e.g. heating a frozen dinner in the microwave or making a sandwich), Response 2 – Unable to prepare any light meals or reheat any delivered meals" should be selected. This is a critical assessment strategy when considering the important relationship between this IADL and nutritional status. A poorly nourished patient with limited ability to prepare meals is at greater risk for further physical decline. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #8] [Q&A EDITED 08/07]

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

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

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

A160. For all the ADL/IADL OASIS items, the patient's ability to perform the tasks is the focus of the assessment. The frequency of leaving the home to shop or the amount of effort needed, two criteria often associated with homebound status, are not the assessment focus here. Refer to the Medicare Benefits Policy Manual available at <http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf> or contact your Regional

Home Health Intermediary (RHHI) for issues related to homebound status and other Medicare payment related issues. [Q&A EDITED 08/07]

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

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

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

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

**Q163. M0780. I have had several patients who use a list of medications to self-administer their meds. Would this be considered a drug diary or chart?**

A163. Yes, this is considered a drug diary or chart. The statement for response 1c ("someone" develops a drug diary or chart) pertains to someone other than the patient developing the aid. What you need to assess is whether the patient must use this list to take the medications at the correct times. If he/she does require the list and also requires someone else to create it, then response 1 is the appropriate choice. [Q&A EDITED 08/07]

**Q164. M0780. Some assisted living facilities require that facility staff administer medications to residents. If the patient appears able to take oral medications independently, how would the clinician answer M0780?**

A164. M0780 refers to the patient's ability to take the correct oral medication(s) and proper dosage(s) at the correct times. Your assessment of the patient's vision, strength and manual dexterity in the hands and fingers, as well as cognitive ability, will allow you to evaluate this ability, despite the facility's requirement. You would certainly want to document the requirement in the clinical record.

**Q165. M0780. For a patient who is independent (response level 0) with all medications except one, which he/she is unable to take without being administered by someone else, would the last statement in the item-by-item instructions ("If patient's ability to manage medications varies from medication to medication, consider the total number of medications and total daily doses in determining what is true most of the time") require that M0780 be marked as 0?**

A165. Following the instructions quoted above, the clinician must determine the total number of daily doses involved to determine what is true most of the time. For example, a patient who had two medications, one of which was taken once daily and one of which was taken 4-6 times a day (e.g., Parkinson's medications), and was independent with taking both medications the first time in the morning, but needed reminders to take the

remaining 3-5 doses of the second medication, Response 1 would be appropriate. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #18]

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

A166. No. Tasks related to filling, reordering and obtaining medications are considered part of the instrumental activity of daily living – shopping task, and they are evaluated during the scoring of M0760. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #19]

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

A167. Scoring of M0780 should include all oral medications, prescribed and non-prescribed, that the patient is currently taking and are included on the plan of care. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #20]

**Q167.1. M0780. A patient is typically independent in managing her own oral medications. At the time of assessment, the patient's daughter and grandchildren have moved in to help care for the patient, and the daughter has placed the meds out of reach for safety. This now requires someone to assist the patient to retrieve the medications. How should M0780 be answered?**

A167.1: M0780 assesses the patient's ability to prepare and take oral medications reliably and safely. Preparation includes ability to read the label (correct medication), open the container, select the pill/tablet or milliliters of liquid (correct dosage), and orally ingest at the prescribed time (take). In some cases, a patient lives in an environment where the facility or caregiver may impose a barrier that limits the patient's ability to access or prepare their medications, e.g. an Assisted Living Facility that keeps all medications in a medication room or a family that keeps the medications out of the reach of children for the child's safety - not the patient's. In these cases, the clinician will assess the patient's vision, strength and manual dexterity in the hands and fingers, as well as their cognitive status to determine the patient's ability to prepare and take their oral medications despite access barriers imposed by family or facility caregivers. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #17]

**Q167.2. M0780. The patient with schizophrenia is not compliant with his medication regimen when he must pour his oral medications from bottles. The nurse discovers that if the pharmacist prepares the medications in bubble packs, the patient is less paranoid, is able to open the pack and will safely and reliably take the majority of his medication doses at the correct time. Since the patient is able to manage the medications once they are in the home in a bubble pack is he considered independent (Response 0) in medication management or is the special packaging requirement considered a type of assistance and is response 1 the correct answer?**

A167.2: M0780 is asking if the patient has the ability to prepare and take oral medications reliably and safely - the correct dosage at the correct times. Preparation

includes the ability to read the label (or otherwise identify the medication correctly, e.g. illiterate patients may place a special mark or character on the label to distinguish between medications), open the container, select the pill/tablet or milliliters of liquid and orally ingest it at the correct times. Some patients may require medications to be dispensed in bottles with easy-open lids, while others may not. Arranging to have medications dispensed in bubble packs is an excellent strategy that may enable a patient to become independent in the management of their oral medications. Because a patient utilizes a special method or mechanism in order to take the correct medication, in the correct dose, at the correct time, does not necessarily make them dependent in the management of their oral medications. All patients are dependent on their pharmacist to dispense their medications in containers appropriate to their needs. Once in the home, if the patient requires someone else to prepare individual doses, or fill a pill box or planner, or create a diary or med list in order to take the correct med in the correct dose at the correct time, the patient would be scored a "1" indicating they require someone's else's assistance. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #18]

**Q167.3. M0780, M0790, M0800. If a patient was in the hospital 14 days prior to the OASIS data collection time point and hospital policy prevents the patient from managing their own medications, how do you respond to the patient's prior ability to manage their oral, injectable and inhalant/mist medications?**

A167.3: To answer the prior status items correctly, interview the patient/caregiver and determine what the patient's ability was on that particular day, despite the facility's policies or restrictions. The patient's cognitive, mental and physical condition on that particular day must be considered when determining the accurate response. Assessments of the patient's vision, strength and manual dexterity in the hands and fingers, as well as mental status will provide the necessary information to evaluate his/her ability. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #41]

**Q167.4. M0650, M0660, M0780. For M0650 & M0660, we know you count things like prostheses & TED hose as part of the clothing. But the interpretation is that they have to only be independent with the "majority" of the dressing items & then they are considered independent. Because of the importance of being able to put a prostheses on and for a diabetic being able to put shoes & socks on, clinicians want to mark a patient who can do all their dressing except those items NOT independent. However, does this fit the criteria of "majority"?**

**The same issue can exist for medication compliance.....if a patient can take the majority of their meds (Vitamins, stool softeners, etc.) but cannot remember their digoxin....does that make them independent with the majority even though we know how important the digoxin is?"**

A167.4: Your understanding of the majority rule is correct. If a patient's ability varies among the tasks included in a single OASIS item (like M0660 lower body dressing, or M0780 Oral Medications), select the response that represents the patient's status in a "majority" of the tasks. The concerns of clinicians focus on critical issues that need to be addressed in the plan of care. It may help to remember that the OASIS is a standardized data set designed to measure patient outcomes. In order to standardize the data collected, there must be objective rules that apply to the data collection (e.g. the percentage of medications a patient can independently take). Less objective criteria, like which medications are more important, or which lower body dressing items are more

important than others, have limitations in consistency in which a similar situation would likely be interpreted differently between various data collectors from one agency to the next. While these rules may cause the assessing clinician to pick an item response that lacks the detail or specificity that may be observable when assessing a given patient, as long as the clinician is abiding by scoring guidelines, he/she is scoring the OASIS accurately and the agency's outcome data will be a standardized comparison between other agencies. In any situation where the clinician is concerned that the OASIS score does not present as detailed or accurate representation as is possible, the clinician is encouraged to provide explanatory documentation in the patient's clinical record, adding the necessary detail which is required for a comprehensive patient assessment. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #26]

**Q168. M0800 [Q&A RECALLED 08/07]**

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

A169. Patients receiving epidural infusions or subcutaneous infusions are receiving IV/infusion therapy, therefore, M0810 and M0820 should be answered based on the patient/caregiver ability to manage associated equipment. For M0810, the patient's ability to set up, monitor and change equipment reliably and safely, including adding appropriate fluids or medication, cleaning/storing/disposing of equipment and supplies should be assessed. NA would not be an appropriate response to M0810 in this situation. [Q&A EDITED 08/07]

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

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

**Q170.1. M0810 & M0820. Is C-PAP *without* oxygen or a nebulizer included as equipment for M0810 and M0820?**

A170.1: No. If the patient's only equipment was C-PAP without oxygen or a nebulizer, the correct M0810 response would be NA – No equipment of this type used in care and M0820 would be skipped. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #42]

**Q170.2. M0810. Is dialysis thru a central line considered for this question?**

A170.2: Dialysis through a central line is included in M0810 as long as the dialysis occurs in the home. M0810 reports the patient's ability to manage the equipment used for the delivery of oxygen, IV/infusion therapy or enteral/parenteral nutrition. Dialysis is an infusion therapy.

If the patient were receiving such therapy outside the home, (e.g. at a dialysis center), then M0810 should be marked "NA – No equipment of this type used in care", assuming the patient care did not include use of any other included services at home (oxygen, enteral nutrition, etc.). [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #31]

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

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

**Q171.1. M0820. Is it true that nebulizers are not considered when answering M0810 & 820 unless they are given with oxygen? M0820 Response 3 states Caregiver is only able to complete small portions of task (e.g., administer nebulizer treatment). Are nebulizers considered in these OASIS items?**

A171.1: M0810 and M0820 are restricted to the management of oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment and supplies. A nebulizer utilizing oxygen in the treatment is considered for these items but a nebulizer without oxygen is not. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #32]

**Q171.2. M0825. Our agency is continuing with voluntary OASIS data collection for skilled private insurance patients. Some of our private insurance payers are using a reimbursement model similar to the Medicare PPS, which requires a response for M0825 of "0" or "1". Although the assessment strategies in Chapter 8 instruct us to mark "NA" for non-Medicare patients, would we be non-compliant to mark "0" or "1" for non-Medicare patients instead of "NA"?**

A171.2: No, the response to M0825 only affects the Medicare PPS when M0150 is marked "1 – Medicare (traditional fee for service), therefore marking "0" or "1" for non-Medicare patients is an acceptable agency practice. Some payment sources that are not Medicare-fee-for-service (i.e., other than Response 1 to M0150) will use this information in setting an episode payment rate. If your patient needs an HIPPS code for billing purposes a "Yes" or "NO" response to this item is required to generate the case mix weight rate code. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #43]

**Q171.3. M0825. If nursing and therapy are ordered, is there any requirement that the completion of the comprehensive assessment be delayed until the therapy evaluation(s) are completed in order to determine a response for M0825 Therapy Need, and the primary or secondary diagnoses?**

A171.3: The CoPs require the SOC comprehensive assessment be completed on or within 5 days after the SOC date. Evaluations by other disciplines (e.g., therapies) are required to occur in a timely manner consistent with patient needs and professional standards of practice. For multidisciplinary cases, there is no explicit requirement that the therapy evaluation(s) be conducted prior to completion of the SOC assessment by the RN, although agencies should realize that the additional information gained from the completion of the therapists' evaluations may contribute to a greater accuracy for therapy need for M0825 and may influence the selection of the primary diagnosis. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #44]

**Q171.4. M0825. If a RAP is cancelled and resubmitted because therapy visits do go over 10, must you correct the OASIS document where you answered "No" to M0825?**

A171.4: At times, providers may simply underestimate the number of therapy visits that will be required in the upcoming episode. If the adjustment to the patient's case mix is due solely to the correction of the therapy visits estimated at SOC and there is no clinical change in the patient's health status, no follow up assessment is required. However, there should be concurrent OASIS correction and clinical record documentation recording the difference between therapy originally estimated and therapy actually delivered. It is necessary to correct the original assessment at M0825 that will update the HHRG. Agencies can make this non-key field change to their records and retransmit the corrected assessment. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #33]

**Q171.5. M0825. A patient is recerted with knowledge that the patient will be admitted to a rehab facility in next few weeks. On the Recert OASIS, the RN answers M0825 "No". The patient receives less than 10 therapy visits before being transferred (RFA 6) to rehab. The patient is discharged home during the open episode and a Resumption of Care is performed. RN answers M0825 "Yes" and the patient does receive more than 10 therapy visits in the remainder of the episode. Should the Recert Oasis be unlocked and M0825 changed to "Yes"?**

A171.5: When the Resumption of Care (RFA 3) is completed, if M0825-Therapy Need is the only payment item that changes from the Recertification (RFA 4) assessment, then the agency may take necessary action to change the M0825 response on the Recertification assessments from "0 = No" to "1 = Yes" and cancel and resubmit the RAP with the corrected HHRG. Bear in mind that this will involve making a change in the clinical record (electronic or hard copy, as appropriate to the agency) as well as in the data submission files. The agency must follow the applicable laws, regulations, and agency policies when making a change to any clinical record, which is a legal document. When a change is made to a clinical record, the agency must carefully consider the reason for making that change and document the reason in the record. [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #34]

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

A172. Emergent care includes all unscheduled visits to medical services occurring within 24 hours of the patient's contact with the medical service, as noted in the response options, including a hospital emergency room. Since the patient was admitted to the hospital following the emergency room visit, (and assuming the patient stayed for 24 hours or more for reasons other than diagnostic testing) a Transfer to the inpatient facility (RFA 6 or 7 to M0100) would be required. You should mark M0830 with response 1 - Hospital emergency room. [Q&A EDITED 08/07]

**Q173. M0830. The patient was held in the ER suite for observation for 36 hours. Was this a hospital admission or emergent care?**

A173. If the patient were never admitted to the inpatient facility, this encounter would be considered emergent care. The time period that a patient can be 'held' without admission can vary from location to location, so the clinician will want to verify that the patient was never actually admitted to the hospital as an inpatient. [Q&A EDITED 08/07]

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

A174. Emergent care is defined as all unscheduled visits (to an emergency room, doctor's office or outpatient clinic) occurring within 24 hours of the patient contact to the medical service. The situation you described was a planned visit and thus is not considered emergent care. [Q&A EDITED 08/07]

**Q175. M0830 [Q&A RECALLED 08/07]**

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

A176. Yes, as long as the visit occurred within 24 hours of being scheduled, the (non-home care) nurse's home visit would be considered emergent care and would be reported based on the entity (hospital, doctor's office, outpatient clinic) that sent the nurse. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A #22] [Q&A EDITED 08/07]

**Q177. M0830. Should all unscheduled MD visits be considered emergent care for purposes of responding to M0830? Or only those which the clinician judges to represent an MD visit being utilized in lieu of an emergency room visit? For instance, if the clinician calls the physician with patient reports of marked calf pain, tenderness, and acute SOB and the physician wants the patient to come into his office, would that be considered emergent care?**

**If the clinician calls the physician to report that the patient's knee range of motion is not progressing as rapidly as expected and the doctor tells the patient to move up their appointment by a few days and come in today; would that be considered emergent care?**

A177. In M0830 Emergent Care, we are trying to determine if the patient received emergent medical care for an illness or injury since the last time an assessment was completed. "Emergent/unscheduled (within 24 hours) care is the definition that we are using and following. CMS has not changed the definition of M0830. It remains the same as the current manual.

The clinician needs to use the information for any necessary care planning changes; for example, was there a change or addition in medications or treatments? The item does not justify "why" the patient sought emergent care, only that emergent care occurred (or not). The "24 hour" timeframe is a guideline to see if the need for the physician visit was emergent or not. If a patient is listed on an adverse event report, then the agency needs to investigate the event to determine whether or not the care for this patient was problematic. [Q&A added 06/05; Previously CMS OCCB 08/04 Q&A 23]

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

A178. When a patient dies in the emergency room it is NOT considered a death at home. When a patient dies in the emergency room, a transfer assessment should be completed, and “Response 1 – Hospital emergency room” should be reported for M0830. This is true even though the patient was never formally admitted to the inpatient facility, because the facility was actively providing care at the time of the patient's death. The patient who is pronounced "dead on arrival" by the ER physician on arrival at the ER should be reported as a “death at home” and RFA 8 OASIS data collection would be required.. (The RFA Death at Home assessment items do not include collection of M0830.) [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #9 & 10] [Q&A EDITED 08/07]

**Q179. M0830. If a patient is admitted to an inpatient facility after initial access in the emergency room, can there be a situation in which that emergent care would NOT be reported on M0830, (i.e., patient is only briefly triaged in ER with immediate and direct admit to the hospital)?**

A179. The item-by-item response specific instructions in Chapter 8 of the Implementation Manual clarify that responses to M0830 – Emergent Care, include the entire period since the last time OASIS data were collected, including current events. Any access of emergent care, regardless of how brief the encounter, should be reported on M0830 if it occurred since the last time OASIS data were collected. [Q&A added 06/05; Previously CMS OCCB 10/04 Q&A #11]

**Q180. M00830. A patient whose Start of Care is January 9, has an emergent care visit on January 13 that does not result in hospitalization. The patient is subsequently recertified and discharged on March 17. M0830, which appears on the transfer and discharge assessments, specifies the response should be based on the “last time OASIS data was collected.” Should the response to M0830 regarding emergent care be based on the last time any OASIS assessment was completed, or should it be based on the last assessment where M0830 appears. In this scenario, the item is being asked at the time of discharge where the recertification OASIS was “the last time OASIS data was collected.” Since the emergent care visit occurred before the recertification, it would not have been identified at that time because it is not a required item.**

A180. The above scenario does not tell us when recertification assessment was completed. According to the Conditions of Participation for HHA, the recertification visit should have occurred during a five-day period prior to the end of the episode, which should be March 5-9. The OASIS item (M0830) Emergent Care asks for responses to include the entire period since the last time OASIS data were collected, including current events. Since the last time OASIS data were collected was at the recertification assessment, the emergent care visit occurred prior to that date. The correct response to M0830 is 0-no emergent care services were provided. [Q&A added 06/05]

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

A181. M0830 identifies whether the patient received an unscheduled visit to any of the following services; hospital emergency room, doctor's office/house call, or outpatient

department or emergency clinic. A direct admit to a hospital unit would not be reported as emergent care on M0830. This situation would, however, be considered a transfer to an inpatient facility, as long as the admission lasted 24 hours or longer for reasons other than diagnostic testing, and would be considered an "emergent" reason for hospital admission in responding to M0890. [Q&A added 06/05; Previously CMS OCCB 03/05 Q&A Q #13]

**Q181.1. M0830. We have a rather large physician's practice in our area where no appointments are scheduled in advanced. The patients needing to be seen simply are instructed to show up and are seen by the physician's on a first-come, first-served basis. Since all these appointments are "unscheduled", would all of these doctor's visits need to be reported as emergent care by the MD on M0830?**

A181.1: Since the determination of an MD emergent care visits is defined as a visit to/from the MD scheduled less than 24 hours in advance, then the patient's visits to the MD scheduled and provided as you describe would all meet the definition of being scheduled less than 24 hours in advance, and should be reported as emergent care Response 2 for M0830 – Emergent Care. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #45]

**Q181.2. M0830. My patient had a fall at home. The family called 911. The ambulance arrived and the patient was evaluated by the EMTs but not transported from the home. Is this considered emergent care for M0830, and if so what response should be marked?**

A181.2: M0830 reports the patient's use of emergent care by/from 3 distinct settings/providers, the hospital emergency department, the physician's office, and the outpatient clinic/urgicenter. Services from the ambulance staff are not included in the providers reported in M0830. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #46]

**Q181.3. M0830. An RN completes a SOC assessment and establishes the plan of care. After the admission visit, subsequent care is provided by the LPN and home health aide for a period of 2 weeks, during which time the patient is seen in the ER. The physician contacts the agency to discontinue home care without an opportunity to complete a discharge assessment visit. Based on current guidance, in this case of an unexpected discharge, the discharge comprehensive assessment would be based on the last visit by a qualified clinician (which was the SOC assessment by the RN.) Since it should reflect the patient's status on that SOC visit, should the emergent care use be captured, since it occurred after the SOC visit?**

A181.3: No, in the case of an unexpected discharge, the agency must go back to the last visit that was completed by a qualified clinician, and report the patient's health status at that actual visit, and would not capture events or changes in patient status/function (improvements or declines) that occurred after the last visit conducted by a qualified clinician. Agencies should recognize that the practice of allowing long periods of time where the patient's care is provided by those unable to conduct a comprehensive assessment may negatively impact the patient's care and outcomes, and in fact, in a situation as the one described, may be the reason that the patient required emergent care.

The home health agency should carefully monitor all patients and their use of emergent care and hospital services. The home health agency may reassess patient teaching protocols to improve in this area, so that the patient advises the agency before seeking additional services. [Q&A ADDED 08/07; Previously CMS OCCB 07/06 Q&A #47]

**Q181.4. M0840. I have a question about how to complete a Transfer OASIS when a client has a fall outside of the home. If they go to the doctor's office for care and falls there, should the answer to M0840 – Emergent Care Reason be #3 – Injury caused by fall or accident at home or #9 – Other than above reason (since the fall/accident did not occur in the home)?**

A181.4: M0840 Response 3 would be selected for an injury caused by a fall or accident at home. If a patient sought emergent care for an injury that occurred while away from home, the correct response to M0840 would be 9-Other than above reasons. [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #19]

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

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

**Q183. M0855. A patient receiving skilled nursing care from an HHA under Medicare is periodically placed in a local hospital under a private pay arrangement for family respite. The hospital describes this bed as a purely private arrangement to house a person with no skilled services. This hospital has acute care, swing bed, and nursing care units. The unit where the patient stays is not Medicare certified. Should the agency do a transfer and resumption of care OASIS? How should the agency respond to M0100 and M0855?**

A183. Yes, if the patient was admitted to an inpatient facility, the agency will need to contact the inpatient facility to verify the type of care that the patient is receiving at the inpatient facility and determine the appropriate response to M0855. If the patient is using a hospital bed, response 1 applies; if the patient is using a nursing home bed, response 3 applies. If the patient is using a swing-bed it is necessary to determine whether the patient was occupying a designated hospital bed(response 1 would apply) or a nursing home bed (response 3 would apply). The hospital utilization department should be able to advise the agency of the type of bed and services the patient utilized. [Q&A added 06/05]

**Q183.1. M0855. When a patient is transferred to a hospital ER and dies while in the ER, I understand a Transfer OASIS would be completed and not a Death at Home OASIS. At M0855, on a Transfer OASIS there are 4 options. There is no N/A option, as there would be on a Discharge OASIS. It does not seem appropriate to select Option 1 (hospital) since the patient was not admitted to the hospital, but we cannot transmit the OASIS without entering some type of response.**

A183.1: When a patient dies in the ER, the Transfer to an Inpatient Facility OASIS is completed. In this unique situation, clinicians are directed to mark Response "1-Hospital"

for M0855, even though the patient was not admitted to the inpatient facility (hospital). [Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #35]

**Q184. M0870. My patient was admitted to the hospital, and I completed the assessment information for Transfer to the Inpatient Facility. His family informed me that he will be going to a nursing home rather than returning home, so my agency will discharge him. How should I complete these items on the discharge assessment?**

A184. Once the transfer information was completed for this patient, no additional OASIS data would be required. Your agency will complete a discharge summary that reports what happened to the patient for the agency clinical record; however, no discharge OASIS assessment is required in this case. The principle that applies to this situation is that the patient has not been under the care of your agency since the inpatient facility admission. Because the agency has not had responsibility for the patient, no additional assessments or OASIS data are necessary.

**Q185. M0880. How would outpatient therapy services be categorized?**

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

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

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

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

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

**Q188. M0903. Do the dates in M0903 and M0090 always need to be the same? What situations might cause them to differ?**

A188. When a patient is discharged from the agency with goals met, the date of the assessment (M0090) and the date of the last home visit (M0903) are likely to be the same. Under three situations, however, these dates are likely to be different. These situations are: (1) transfer to an inpatient facility; (2) patient death at home; and (3) the situation of an “unexpected discharge.” In these situations, the M0090 date is the date the agency learns of the event and completes the required assessment, which is not necessarily associated with a home visit. M0903 must be the date of an actual home

visit. See the *OASIS User's Manual*, Chapter 4, for additional information on "unexpected discharges." [Q&A EDITED 08/07]

**Q189. M0903. What constitutes a "home visit" when responding to OASIS Item M0903? Medicaid programs pay for some home health services provided outside of the home. If these patients receive all their skilled care outside the home, must OASIS data be collected and transmitted? If some of the visits are provided outside of the home should a visit provided outside the home be considered the last visit for M0903, or should M0903 be the last visit at the patient's home?**

A189. The date of the last (most recent) home visit (for responding to M0903) is the last visit occurring under the plan of treatment. The HHA must conduct the comprehensive assessment and collect and transmit OASIS items for Medicaid patients receiving skilled care. [Q&A added 06/05]

**Q190. M0903/M0906. When a speech therapist is the last service in a patient's home, our agency has chosen to use an RN to complete the discharge assessment (with OASIS) as a non-billable visit. If the patient meets the speech therapist's goals on day 50 of the episode, but we cannot schedule an RN until day 51 of the episode, how do we respond to M0903 and M0906?**

A190. If the agency policy is to have an RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge assessment after the last visit by the SLP. This planned visit should be documented on the Plan of Care. The RN visit to conduct the discharge assessment is a non-billable visit. M0903 (Date of Last/Most Recent Home Visit) would be the date of the last visit by the agency; in this case it would be the date of the RN visit. The date for M0906 (Discharge/Transfer/Death Date) would be determined by agency policy. The date of the actual agency discharge date would be entered here. When the agency establishes its policy regarding the date of discharge, it should be noted that a date for M0906 (Discharge/Transfer/Death Date) that precedes the date in M0903 (Date of Last/Most Recent Home Visit) would result in a fatal error, preventing the assessment from being transmitted. [Q&A added 06/05]

**Q191. M0906. My patient died at home 12/01 after the last visit of 11/30. I did not learn of her death until 12/04. How do I complete M0903 and M0906? What about M0090?**

A191. You will complete an agency discharge for the reason of death at home (RFA 8 for M0100). M0090 would be 12/04 -- the date you learned of her death and completed the assessment. M0903 (date of last home visit) would be 11/30, and M0906 (death date) would be 12/01. [Q&A EDITED 08/07]

**Q191.1. M0906. How do you answer M0906 on a Transfer OASIS when a patient is transferred to an inpatient facility (hospital) during the evening of 1/24/07 but doesn't get admitted to the inpatient facility until 1/25/07?**

A191.1: Transfer is not defined as the date the patient was transported to the inpatient facility, or the date that the patient was transported and/or treated in the emergency department. Assuming the patient's inpatient admission lasted 24 or more hours, and included care/services other than diagnostic testing, the Transfer date would be the actual date the patient was admitted to the inpatient facility. If, as in your example, the

transportation occurred during the evening of 1/24/07, but the inpatient facility admission did not occur until 1/25/07, M0906 Transfer/Discharge/Death Date would be 1/25/07.  
[Q&A ADDED 08/07; Previously CMS OCCB 05/07 Q&A #36]