

# 2009 3<sup>rd</sup> Quarter OASIS Question and Answers from CMS

(this is the entire OASIS Q and A from CMS for 2009 3<sup>rd</sup> Quarter)

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#### **CATEGORY 4a – General OASIS questions**

**Question 1: Can I reference prior assessments for the purposes of OASIS-C data collection?**

**Answer 1:** For assessment items that reflect a patient's current status, like M1830, Bathing or M2020, Management of Oral Medications, clinicians should not reference previous assessments, but should select a response based on the patient's usual status on the day of assessment.

For items that are not limited to a patient's current status, the assessing clinician may be required to review the previous assessment, or other clinical documentation since the last OASIS assessment in order to determine the correct response, e.g., M1500, Symptoms in Heart Failure Patients, which reports if a patient with heart failure exhibited symptoms of heart failure at any point since the previous OASIS assessment; or M2400, Intervention Synopsis, which reports whether the patient's plan of care since the previous OASIS assessment included physician-ordered interventions to prevent pressure ulcers. This documentation review may be required to determine if specific events occurred, and/or what actions were taken (e.g., orders, interventions implemented). [\[Return to Table of Contents\]](#)

#### **CATEGORY 4b – Item Specific questions**

**M0102, Physician Ordered SOC date and M0104, Date of Referral**

**Question 2: When determining the physician-ordered SOC date (for M0102) or the date of referral (for M0104) should communication from the hospital/SNF DC planner be considered as representing physician referral?**

**Answer 2:** Yes, a referral received from a hospital or SNF discharge planner on behalf of the physician should be considered when determining the physician-ordered SOC date or the date of referral. [\[Return to Table of Contents\]](#)

**M0104, Date of Referral**

**Question 3: The home health agency received a referral on June 1<sup>st</sup>, and then on June 2<sup>nd</sup> received a faxed update with additional patient information that indicates a possible delay in the patient's hospital discharge date. What is the referral date for M0104?**

**Answer 3:** If start of care is delayed due to the patient's condition or physician request and no date was specified as the start of care date, then the date the agency received updated/revised referral information for home care services to begin would be considered the date of referral. In your scenario, June 2 is the correct response for M0104. [\[Return to Table of Contents\]](#)

**M1012, Inpatient Procedures**

**Question 4: Does the inpatient procedure have to occur in the past 14 days or just the inpatient stay? If the patient's stay was in the past 14 days, but the procedure was 3 weeks ago (because the LOS was that long), would that procedure be reported in M1012?**

**Answer 4:** Procedures related to inpatient stays with discharges occurring in the 14 days prior to home care admission are reported in M1012, if the procedures are relevant to the home health plan of care. A procedure may have occurred earlier than 14 days prior to home care admission. The 14 day time period applies to the timing of the inpatient discharge, not the date of the procedure. [\[Return to Table of Contents\]](#)

**M1018, Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days**

**Question 5: Does intractable pain listed as a response option in M1018 have the same definition as it did in OASIS-B1?**

**Answer 5:** Intractable pain occurs at least daily, it is not easily relieved, and affects the patient’s sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity. Intractable pain, as reported in response 3 of M1018, should refer to pain that is not relieved by ordinary medical, surgical, and nursing measures. The pain is often chronic and persistent and can be psychogenic in nature. [\[Return to Table of Contents\]](#)

**M1040, Influenza Vaccine**

**Question 6: When the influenza vaccine has been made available (from the CDC) does that establish the “current influenza season” or is it strictly October 1 through March 31?**

**For example, if we are discharging a patient in October, and we administered a flu vaccine to the patient in September, can M1040 be answered “Yes”?**

**Answer 6:** When the vaccine has been made available (from the CDC) it can be administered and reported in the OASIS influenza process measure items. The influenza season is established by CDC and recommendations may change from year to year.

The October 1 through March 31 time period specified in M1040 refers to the Influenza season, for purposes of identifying if the current outcome episode (SOC/ROC to Transfer/Discharge) is outside of the flu season, for purposes of selecting response NA. [\[Return to Table of Contents\]](#)

**Question 7: If the flu vaccine was given by the agency in late September (e.g. early due to the H1N1 flu preparation) would I report “1-Yes” when completing M1040, even though it was given outside of the flu season?**

**Answer 7:** Yes, assuming that part of the home health episode occurred within the October 1<sup>st</sup> – March 31<sup>st</sup> time frame. Each year, flu vaccine manufacturers only release the vaccine per CDC recommendations. If the flu vaccine has been made available and distributed for administration, it is considered to be within that year’s flu season. [\[Return to Table of Contents\]](#)

**Question 8: If the influenza vaccine is given in an episode occurring entirely outside of influenza season, what should be reported for M1040?**

**Answer 8:** Check “N/A-Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season.” [\[Return to Table of Contents\]](#)

**M1100, Patient Living Situation**

**Question 9: Does the Living Arrangement component of the item report usual status and the Availability of Assistance on the day of assessment?**

**Answer 9:**The *Living arrangement* component reports the patient’s usual status, which is considered the living arrangement prior to illness, injury, or exacerbation of condition for which the patient is receiving care in this episode, unless there exists a new living arrangement which is expected to be permanent. *Availability of assistance* refers to the expected availability and willingness of caregiver(s) for this upcoming outcome episode of care. [\[Return to Table of Contents\]](#)

**Question 10: My patient lives in an Assisted Living Facility with her spouse and it is the spouse who requires the facility's assistance, not my patient. The facility is not contracted to provide any level of assistance to my patient, only the husband. How do I report her living arrangement in M1100?**

**Answer 10:** Report the patient's living arrangement as "c. Patient lives in congregate situation (e.g., assisted living)" because she is living in the ALF. The availability of assistance selected should be determined using instructions from the OASIS Item guidance. [\[Return to Table of Contents\]](#)

**Question 11: To select a response for M1100, should an agency request to see the ALF contract to determine availability of assistance?**

**Answer 11:** For M1100, a response from row C should be selected for a patient living in an assisted living setting. This would be true regardless of the services provided to the patient. To determine the frequency of availability of assistance, the clinician may refer to the ALF service contract or may gather information from the patient or family. [\[Return to Table of Contents\]](#)

**M1240 Pain Assessment, M2250 Plan of Care Synopsis, and M2400 Intervention Synopsis**

**Question 12: If I complete my comprehensive assessment late (my M0090 date is 6 days post SOC) and I do a standardized pain assessment on that 6<sup>th</sup> day, would I report the pain assessment when completing M2250 (and when completing M2400 at Transfer/Discharge) because I did conduct the pain assessment?**

**Answer 12:** M2250 and M2400 don't directly report if the pain assessment was conducted. M2250 reports if the physician-ordered plan of care includes specific interventions (in this case, to monitor and mitigate pain) and should be marked "No" or "Yes", depending on the presence of the orders, whether or not a formal pain assessment for the related issue was conducted within the assessment time frame, or conducted at all.

M2400 reports if specific interventions (in this case, to monitor and mitigate pain) were BOTH included in the physician-ordered plan of care AND implemented. M2400 should also be marked "No" or "Yes" based on the presence of the orders and documentation of their implementation, whether or not a formal pain assessment for the related issue was conducted within the assessment time frame, or conducted at all. "NA - Formal assessment did not indicate pain since the last OASIS assessment" may not be selected in this case, since item guidance states that the formal assessment referred to for column d is M1240, Pain Assessment, and that since the pain assessment was conducted after completion of the comprehensive assessment (and outside the assessment time frame), M1240 should be reported as "0 – No standardized assessment conducted", and therefore "NA" could not be reported for row d on M2400. [\[Return to Table of Contents\]](#)

**M1240, M1300, M1730, M1910, Assessments for Process Measures**

**Question 13: For the Process Measure items related to patient assessments, I am not clear when a standardized tool is required and when the assessment can be completed based on clinical factors of the clinician’s choosing.**

**Answer 13:** Standardized assessments are required to meet the intentions of the M1240 Pain Assessment, the M1730 Depression Assessment, and the M1910 Multi-factor Fall Risk Assessment. Clinical factors may be used to conduct the M1300 Pressure Ulcer Assessment, or the agency may use a standardized Pressure Ulcer Risk Assessment tool. [\[Return to Table of Contents\]](#)

M item	Standardized Assessment Required
M1240 Pain	Yes
M1300 Pressure Ulcer	No; optional
M1730 Depression	Yes
M1910 Falls	Yes

**Question 14: For the process measure items requiring use of a standardized assessment, can an agency develop their own “standardized tool” based on agency policy or do they need to use a tool developed by a nationally recognized authority? Define “standardized”.**

**Answer 14:** A standardized tool is one that has been scientifically tested and validated as effective in identifying a specified condition or risk in population with characteristics similar to the patient being evaluated. A standardized tool includes a standard response scale, and must be appropriately administered based on established instructions. To meet the need of the pain assessment, the depression screen or the multi-factor fall risk assessment referenced in the OASIS, an agency may use a standardized tool from any organization able to effectively develop, test, and validate the tool for use on a population similar to that of the patient(s) being assessed. An agency may not create an assessment by combining clinical assessment factors, unless the OASIS item indicates that the assessment can be based on clinical judgment, such as M1300, Pressure Ulcer Risk. [\[Return to Table of Contents\]](#)

**Question 15: If I mark a process measure assessment item “Yes” (that the assessment was done), is that sufficient documentation or do I have to explain which tool I used and how I came to the decision regarding my patient’s level of risk?**

**Answer 15:** Whether the clinician uses a standardized assessment or a combination of clinical factors for assessment of fall risk, pain severity, depression, or pressure ulcer risk, it is expected that the clinical record would detail the clinical factors or tool that was used and the related findings and analysis to support the OASIS response selected. [\[Return to Table of Contents\]](#)

**Question 16: Only the Fall Risk Assessment process measure item (M1910) contains specific guidance in the Response-Specific Instructions stating “the fall risk assessment must have been completed by the clinician completing the SOC or ROC Comprehensive Assessment.” M1240, Pain Assessment, M1300 Pressure Ulcer Risk Assessment and M1730, Depression Screening do not include this directive.**

I am the assessing clinician and I began my SOC comprehensive assessment on Monday, I completed an informal pain assessment and due to patient fatigue, I did not complete my comprehensive assessment until day 2. The PT visited later in the day on SOC and performed a formal pain

**assessment prior to beginning therapy. Can I answer M1240 “Yes” because the therapist completed a formal pain assessment during the allowed assessment timeframe?**

**Answer 16:** No. The clinician responsible for completing the comprehensive assessment must perform the formal assessments and screenings included in M1240, M1300, M1730 and M1910 in order to answer “Yes”. [\[Return to Table of Contents\]](#)

#### **M1310, M1312, M1314, Pressure Ulcer Length, Width, and Depth**

**Question 17: A Stage III or IV pressure ulcer completely epithelializes (closes). Should M1310, M1312 & M1314 report length, width and depth each as 00.0 (as instructed in OASIS Item Guidance response specific instructions bullet 3), or should these items be skipped after complete epithelialization has been present more than 30 days (as instructed in the response specific instructions bullet 9)?**

**Answer 17:** Immediately after a Stage III or IV pressure ulcer achieves complete epithelialization (closes), assuming it is the pressure ulcer with the largest surface dimension), its length, width and depth would be each reported as 00.0 forever, unless the ulcer deteriorates, or is replaced by an advancement or muscle flap procedure. [\[Return to Table of Contents\]](#)

#### **M1320, Status of Most Problematic (Observable) Pressure Ulcer**

**Question 18: What is the healing status (M1320) of a suspected deep tissue injury when it has not evolved yet into an open pressure ulcer?**

**Answer 18:** Since the suspected DTI does not granulate, and would not be covered with new epithelial tissue, the status of “Not Healing” is the most appropriate response. [\[Return to Table of Contents\]](#)

**Question 19: What is the healing status (M1320) of a pressure ulcer that presents as an intact serum filled blister?**

**Answer 19:** An intact serum-filled blister resulting from pressure would be reported as a Stage II pressure ulcer. Since Stage II pressure ulcers do not granulate, and since the presence of the serum-filled blister demonstrates a defect in epidermis, the status of “Not Healing” is the most appropriate response. [\[Return to Table of Contents\]](#)

#### **M1334, Status of Most Problematic (Observable) Stasis Ulcer**

**Question 20: M1334, Status of Most Problematic (Observable) Stasis Ulcer has a new response option of “Newly epithelialized”. Should healed stasis ulcers now be reported on OASIS?**

**Answer 20:** Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a stasis ulcer (in M1330), or counted (in M1332), or described (in M1334). This guidance remains the same as under OASIS-B1 data collection rules. The response option “Newly epithelialized” in M1334 should not be selected for a healed stasis ulcer, as a completely epithelialized (healed) stasis ulcer is not reported on OASIS. [\[Return to Table of Contents\]](#)

#### **M1500, Symptoms in Heart Failure Patients**

**Question 21: My patient is bedfast and was diagnosed with HF during a physician house call conducted during the home health episode of care. The physician ordered appropriate heart failure clinical interventions which were implemented by the agency. Several days later, the patient was transferred to the inpatient facility for more aggressive treatment.**

**Chapter 3 Response Specific Instructions state “Select only response options 0, 1, or 2 if the patient has a diagnosis of heart failure in any one or all of: M1010: Inpatient Diagnoses, M1016: Diagnoses Causing Change in Treatment, or M1020/1022/1024: Primary/Secondary diagnoses for home care. Select “NA” if the patient does not have a diagnosis of heart failure.”**

**Since there was no other OASIS assessment performed since SOC that reported a diagnosis of heart failure, how do I answer M1500 and M1510 at the transfer?**

**Answer 21:** The process measure will be calculated based on your agency's patients that have a diagnosis of heart failure documented in their prior OASIS assessment. Since there is no diagnosis of heart failure in any of the following items - M1010: Inpatient Diagnoses, M1016: Diagnoses Causing Change in Treatment, or M1020/1022/1024: Primary/Secondary/Payment diagnoses for home care, you would mark M1500, NA and skip M1510, to avoid conducting a chart review and collecting data that will not be used. Had an RFA 5, Other Follow-up been completed and the heart failure diagnosis entered into M1020/1022/1024, then the response to M1500 could have been reported as 0, 1, or 2 at the transfer.

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#### **M1510, Heart Failure Follow-up**

**Question 22: What is meant by “physician-ordered patient-specific established parameter for treatment”? If my patient has a diuretic in her medication regimen and I ask her if she took it as ordered, did I implement a physician-ordered patient-specific established parameter for treatment?**

**Answer 22:** Establishment of “patient-specific established parameters for treatment” means the physician has provided an order that identifies specific parameters or guidelines for implementing treatment to the patient based on the patient's condition. An example would be an order for the patient to take an additional 2 mg. p.o. dose of a diuretic if the patient gains 3 CMS OCCB Q&As – October 2009 (www.oasiscertificate.org) Page 7 of 11 pounds in two days or if patient develops rales in bilateral bases, give 1 mg of the diuretic IV. Reminding the patient to take a diuretic that has been ordered q day with no allowance for dose adjustment based on the patient's changing condition, does not qualify as a physician-ordered patient-specific established parameter for treatment. [\[Return to Table of Contents\]](#)

#### **M1610, Urinary Incontinence or Urinary Catheter Presence**

**Question 23: How do I answer M1610 if a urinary catheter was inserted or discontinued during the comprehensive assessment?**

**Answer 23:** If it was inserted, Response 2-Patient requires a urinary catheter is appropriate. If it was discontinued, Response 0 or 1, depending on whether or not the patient is incontinent. [\[Return to Table of Contents\]](#)

#### **M1610 Urinary Incontinence or Urinary Catheter Presence & M1615, When does Urinary Incontinence Occur**

**Question 24: Do I mark response “2-During the night only” if my patient voluntarily urinates into a diaper at night only for convenience? She ambulates to the toilet during the day, but states she is tired at night and doesn't like getting up.**

**Answer 24:** M1610 reports the presence of urinary incontinence for any reason. Urinary incontinence is defined as involuntary leakage of urine. If the nightly urination is voluntary, meaning the patient has the cognitive and physical ability to urinate in a toilet, etc. but chooses to use a diaper, the patient would not be reported as incontinent in M1610, and M1615 would therefore be skipped. [\[Return to Table of Contents\]](#)

#### **M1615, When does Urinary Incontinence Occur**

**Question 25: How do I respond to this item if the stress incontinence only happens during the day? Do I mark two responses?**

**Answer 25:** M1615 is not a “mark all that apply” item. If your patient only experiences occasional stress incontinence, the correct response is “1-Occasional stress incontinence” regardless of the time of day it

occurs. If your patient is experiencing urinary incontinence on a regular basis, meaning almost every day, then “2, 3, or 4” would be reported. [\[Return to Table of Contents\]](#)

#### **M1710, When Confused and M1720, When Anxious**

**Question 26: May the clinician use clinical judgment to determine if the confusion or anxiety is relevant to this home health episode or should they report all confusion during the past 14 days, (e.g., my patient was anxious 14 days ago and was started on an antianxiety drug and has not experienced anxiety for the last 12 days)?**

**Answer 26:** When completing M1710, When Confused and M1720, When Anxious, the clinician should report any episodes of confusion or anxiety that meet the descriptors contained in the item that occurred during the last 14 days, without regard to the cause or potential relevance of the confusion/anxiety to this episode of care. [\[Return to Table of Contents\]](#)

#### **M1800 – M1900, ADLs/IADLs**

**Question 27: Are service animals considered a form of assistance?**

**Answer 27:** If required for a patient’s safe function, service animals should be considered an assistive device for purposes of selecting responses to the OASIS items. Service animals should not be considered as assistance; in other words, should not be equated to human assist (as in “someone must assist”...) [\[Return to Table of Contents\]](#)

#### **M1845, Toileting Hygiene**

**Question 28: Does toileting hygiene include a catheterized patient’s ability to cleanse around the urinary catheter?**

**Answer 28:** Yes, M1845 includes the patient’s ability to maintain hygiene related to catheter care. [\[Return to Table of Contents\]](#)

#### **M1850, Transferring**

**Question 29: For M1850 Transferring, how do I score the item when the patient does not have a chair in the bedroom and it is impossible to bring one into the bedroom?**

**Answer 29:** If there is no chair in the patient’s bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, the assessing clinician should report the patient’s ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and then sit on whatever surface is applicable to the patient’s environment and need, (e.g., a chair in another room, a bedside commode, the toilet, a bench, etc.) [\[Return to Table of Contents\]](#)

#### **M1910, Fall Risk Assessment**

**Question 30: Please define “multi-factor” fall risk assessment. If my assessment includes two factors, (such as falls history and a Timed Up and Go performance screen) is that a “multi-factor” assessment since it is assessing more than one factor?**

**Answer 30:** Yes, assessment of at least two factors correlated to fall risk can establish a multifactor fall risk assessment as referenced in M1910. The multi-factor assessment may be a single standardized assessment tool that addresses 2 or more factors, or may be a standardized screen (like the Timed Up and Go), coupled with evaluation of at least one more fall risk factor (e.g., incontinence, polypharmacy, etc.) [\[Return to Table of Contents\]](#)

**Question 31: Could responses from select OASIS items themselves, be considered a multi-factor fall risk assessment?**

**Answer 31:** A multi-factor risk assessment as referenced in M1910 must contain at least two factors identified to be predictive of fall risk, in the form of at least one standardized fall risk assessment. OASIS items that report data relevant to identifying fall risk, such as fall history (M1032), polypharmacy (M1032), impaired vision (M1200), incontinence (M1610), and/or ambulatory status (M1860) may be used to supplement the clinician’s multi-factor fall risk assessment, but as generally collected do not constitute a standardized multi-factor fall risk assessment. [\[Return to Table of Contents\]](#)

**M1510, M2002, M2004, M2250, Process Measure Items requiring physician and/or physician designee communication**

**Question 32:** Some process measure items refer to providing and/or receiving communication to/from the physician or physician-designee (M2002 & M2004), another refers to the physician or other primary care practitioner (M1510) while another (M2250) includes only the physician. Please define physician-designee and primary care practitioner. Do they include physician extenders, like physician assistants and nurse practitioners? When an item refers to “physician-ordered”, would that include DOs?

**Answer 32:** For process measure items reporting communication to/from the physician or physician-designee, (such as reporting heart failure symptoms for M1510, or communication to report/resolve medication issues for M2002) communication can be directly to/from the physician, or indirectly through physician’s office staff on behalf of the physician, in accordance with the legal scope of practice. For process measure items requiring physician orders, (e.g., M2250 Plan of Care Synopsis), the plan of care/orders must be “physician-ordered” including orders from MDs, Doctors of Osteopathic Medicine (DOs), and Doctors of Podiatric Medicine (DPMs) practicing within their legal scope of practice. M2250 includes only physicians as defined here. [\[Return to Table of Contents\]](#)

**M2000 Drug Regimen Review and M2002 Medication Follow-up**

**Question 33:** The assessing clinician identifies a problem with medications. The patient has not picked up a prescription because she was not sure she absolutely needed it. If the assessing clinician’s education results in the resolution of the situation prior to the completion of the comprehensive assessment, can the clinician indicate on M2000 that there is no clinically significant problem, eliminating the need to address it in M2002 Medication Follow-up?

**Answer 33:** If a medication related problem is identified and resolved by the agency staff by the time the assessment is completed, the problem does not need to be reported as an existing clinically significant problem. [\[Return to Table of Contents\]](#)

**M2002 Medication Follow-up and M2004 Medication Intervention**

**Question 34:** Must the physician acknowledgement of the agency’s communication, and resulting reconciliation occur in the specified time frame (within one calendar day), in order to select response “1” for M2002 or M2004?

**Answer 34:** Yes, in order to select response 1, the two-way communication AND reconciliation (or plan to resolve the problem) must be completed by the end of the next calendar day after the problem was identified. [\[Return to Table of Contents\]](#)

**M2040, Prior Medication Management**

**Question 35:** Does this item include over the counter (OTC) medications, or just prescribed meds as stated in the Item Intent?

**Answer 35:** This item includes all oral and injectable medications (prescribed and over the counter) the patient is currently taking and included on the plan of care. [\[Return to Table of Contents\]](#)

**Question 36: For M2040, Prior Medication Management, the OASIS Item Guidance instructs the item should identify changes in ability since the onset of the current illness, exacerbation or injury hat initiated this episode of care. Is the episode of care referenced in this item, a quality episode – SOC/ROC to Transfer/Discharge, or a payment episode?**

**For example, if I am resuming care of my patient, do I report his ability to manage his medications prior to the onset of the illness, exacerbation, or injury that precipitated the need for home care admission or his ability prior to the most recent admission to the inpatient facility?**

**Answer 36:** M2040 reports the patient’s ability to manage medications prior to this current illness, exacerbation or injury that initiated this episode of care. Episode refers to an outcome episode (beginning with the most recent SOC or ROC). For example, if a patient is resuming home care services after a recent inpatient admission, M2040 would report the patient’s ability to manage medications prior to the most recent illness, injury or exacerbation that that is resulting in this resumption of home care services. [\[Return to Table of Contents\]](#)

### **M2100, Types and Sources of Assistance**

**Question 37: For M2100, Types and Sources of Assistance, which category of assistance would donning Ted hose or a back brace be addressed under, Row (a) ADL assistance (dressing) or Row (d) Medical procedures/treatments?**

**Answer 37:** Although T.E.D hose, prosthetic devices, orthotic devices, or other supports are considered dressing tasks for the OASIS upper and lower body dressing items, for M2100, these devices that have a medical and/or therapeutic impact should be considered Medical procedures/treatments (row d). [\[Return to Table of Contents\]](#)

**Question 38: For M2100, Types and Sources of Assistance, do I only include equipment, treatments or procedures ordered by the physician when considering types and sources of assistance in M2100? For example, if my therapy only patient has a dressing on a chronic wound that needs no skilled intervention and is not included in the plan of care, do I include it when selecting a response to M2100 d. Medical procedures?**

**Answer 38:** M2100, Types and Sources of Assistance includes all tasks included in the broad categories included, even if there is not a specific physician’s order for the task. For example, a patient may need a caregiver’s assistance with eating, but there may very well not be a specific physician’s order for the caregiver to provide the assistance. [\[Return to Table of Contents\]](#)

### **M2100, Types and Sources of Assistance & M2110, Frequency of ADL/IADL Assistance**

**Question 39: If food is delivered by Meals on Wheels or other similar community organizations, how does that impact the scoring in M2100, Types and Sources of Assistance and M2110, How Often Patient Receives ADL or IADL Assistance?**

**Answer 39:** A community based service, like Meals-on-Wheels, that is providing needed assistance with meals would be considered when answering M2100 and M2110. Note that if the patient needs assistance with any aspect of a category of assistance, such as IADLs, you are to consider the aspect that represents the most need and the availability and ability of the caregiver to meet that need. If the patient, who is receiving delivered meals, is also receiving other IADL assistance, the clinician must determine the IADL that requires the most need and then the availability and ability of the caregiver to meet that need. [\[Return to Table of Contents\]](#)

### **M2250, Plan of Care Synopsis**

**Question 40: For row a of M2250, Plan of Care Synopsis, If “NA-Physician has chosen not to establish patient-specific parameters for this patient” is selected, should there be additional documentation in**

**the record specifically stating the physician chose not to establish patient-specific parameters for the patient?**

**Answer 40:** Selecting response “NA” on M2250a indicates that the physician has chosen not to establish patient-specific parameters for this patient. This implies that the physician was contacted by the agency with a request for patient-specific parameters, and none were given. It would be expected that such communication would be present in the clinical record in the form of a communication note, or otherwise documented in the clinical record. [\[Return to Table of Contents\]](#)

#### **M2250 Plan of Care Synopsis and M2400 Intervention Synopsis**

**Question 41: If I included an appropriate intervention in the plan of care and implemented it during the episode of care, can I mark “Yes”, even though a formal assessment was not completed during the assessment time frame?**

**Answer 41:** Yes, M2250 reports if the physician-ordered plan of care includes specific interventions and should be marked “No” or “Yes”, depending on the presence of the orders, whether or not a formal assessment for the related issue was conducted. M2400 reports if specific interventions were BOTH included in the physician-ordered plan of care AND implemented. M2400 should also be marked “No” or “Yes” based on the presence of the orders and documentation of their implementation, whether or not a formal assessment for the related issue was conducted. If no orders were present, “NA” may be appropriate to mark, if the situation meets the conditions stated in the specific NA statements (e.g., “NA, Patient has no diagnosis or symptoms of depression). [\[Return to Table of Contents\]](#)

#### **M2310, Reason for Emergent Care**

**Question 42: When completing M2310, Emergent Care Reason, if a patient seeks emergent care in the ER for a new wound that was not a result of a fall, should the reason be Response 15-Wound infection or deterioration or Response 19-Other than above reasons?**

**Answer 42:** The appropriate response would be “19-Other than above reasons” as Response 15 applies to an existing wound that becomes infected or deteriorates. [\[Return to Table of Contents\]](#)

#### **M2400, Intervention Synopsis**

**Question 43: In M2400, Intervention Synopsis, how is “since the previous OASIS assessment defined?**

**Answer 43:** For the purposes of reporting data in M2400, “since the previous OASIS assessment” should be interpreted to mean “at the time of the last OASIS assessment, or since that time”. The last OASIS assessment could have been a SOC, ROC, Recertification, or Other Follow-up assessment type. [\[Return to Table of Contents\]](#)

**Question 44: Row c of M2400, Intervention Synopsis includes “referral for other treatment” as a “qualifying” intervention to report related to depression. If I obtain a referral, can I consider the intervention to be implemented when answering M2400, Intervention Synopsis, regardless of whether or not the ordered referral ever occurs?**

**For example, I obtained an order for a psychiatric nursing evaluation for a patient who exhibited symptoms of depression, and then before the psych nurse could visit, the patient moved out of the service area. When completing the discharge assessment, how should M2400 row c be answered?**

**Answer 44:** Since “referral for other treatment” is specifically listed as a qualifying intervention in item M2400, then “Yes” should be reported for the situation in which the referral is made for other treatment for depression, even if the treatment is never actually provided before the Transfer or Discharge time point. Obtaining the order for the referral is considered to be an implementation of the intervention, whether or not the order was carried out. This is only specifically stated and true for

interventions related to depression (row c), not for other treatment areas (e.g., falls prevention interventions, pressure ulcer prevention interventions, etc.) [\[Return to Table of Contents\]](#)

**Question 45: If I included a physician-ordered intervention in my plan of care and attempted to implement it, but the patient either refused or did not need the intervention, can I report the education as being implemented in M2400 Intervention Synopsis?**

**For example, my plan of care included diabetic foot care including monitoring and patient education on proper foot care. I provided the foot care, monitored the feet throughout the episode, but when evaluating the patient’s knowledge base prior to educating, I discovered there was no identified need for education.**

**Answer 45:** If the education component of the intervention was ordered, attempted and not provided because of a documented lack of need for the education, the clinician can answer “Yes” to the Intervention Synopsis item. The intervention was implemented when the attempt to provide it was made, and the lack of need identified. This is distinctly different than stating an attempt was made to educate and the patient refused or otherwise declined to receive the needed instruction with no further attempt, in which case, the refused education should not be reported as being “implemented” on M2400. [\[Return to Table of Contents\]](#)