

# OASIS Questions and Answers 2nd Quarter 2010 dated July 21, 2010 (click on to jump to item)

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## CATEGORY 4a – General OASIS Questions

### **M0102; M0104 ( Change in payor source requiring new SOC)Question 1:**

How should M0102 - Date of Physician-ordered SOC (ROC) and M0104 - Date of Referral, be answered when you discover that the patient's insurance changed months ago and the new payer requires a new SOC with OASIS data? We have orders for the care but not for a specific date and we do not have a paper referral for that new episode. Do we just use the SOC date as the M0102 date?

**Answer 1:** In the situation you present, there is no need to obtain either a physician's ordered start of care date or a referral date as you are not initiating care, just changing payers. In the specific situation where a new SOC comprehensive assessment is completed for the sole purpose of changing payers, M0102 – Date of Physician-ordered SOC would be “NA”. For M0104 -Date of Referral, enter the day prior to the new Start of Care date. If you know the date the insurance is changing, then actual dates can be used. [\[Return to Table of Contents\]](#)

### **M1012 (Inpatient diagnosis pertinent to POC)Question 2:**

If a patient's inpatient diagnosis was a Hemorrhagic Bleed, should the CT Scan of Brain be considered a procedure relevant to the home health plan of care and be reported in M1012 – Inpatient Procedures?

**Answer 2:** A diagnostic procedure that confirmed a diagnosis that is addressed in the home health plan of care is relevant and would be reported in M1012 – Inpatient Procedures. Assessing clinicians need to use their judgment in determining if a procedure is relevant to the home health plan of care. [\[Return to Table of Contents\]](#)

### **M1306, M1308, M1310, M1312, M1314, M1320 and M1324 (Pressure ulcer suture closed)Question 3:**

How do I categorize a pressure ulcer that has been sutured closed? **Answer 3:** Since it is relatively uncommon to encounter direct suture closure of a pressure ulcer, it is important to make sure that the pressure ulcer was not closed by a surgical procedure (such as a skin advancement flap, rotation flap, or muscle flap). A pressure ulcer that is sutured closed (without a flap procedure) would still be reported as a pressure ulcer. While this approach (direct suture closure) may rarely be attempted due to a low success rate, home care providers are reporting occurrence.

For M1306, Any Unhealed Stage II or Higher or “unstageable” pressure ulcers? select Response “1 – Yes”, since the wound bed of a pressure ulcer sutured shut is obscured, it would be reported as an unstageable pressure ulcer.

For M1308 – Current Number of Unhealed Pressure Ulcers at Each Stage, it would be reported in row d.1 as unstageable due to non-removable dressing or device.

For M1310, M1312 & M1314 – Pressure Ulcer Length, Width, & Depth, leave each item blank.

For M1320 – Status of the Most Problematic (Observable) Pressure Ulcer, select “NA-No observable pressure ulcer”, since in this unusual situation for the purposes of OASIS data collection, we are treating the pressure ulcer closed with sutures as a pressure ulcer that is covered with a dressing that cannot be removed.

For M1324, Stage of Most Problematic (Observable) Pressure Ulcer, select response “NA-No observable pressure ulcer or unhealed pressure ulcer” because the ulcer cannot be staged as it is closed and because for the purposes of OASIS data collection, we are considering this to be a pressure ulcer that is unstageable due to a non-removable dressing or device. [\[Return to Table of Contents\]](#)

**M1308 (How to answer when ROC in last 5 days of episode) Question 4:**

If a patient has pressure ulcers and a Resumption of Care (ROC) is being completed and used as both a ROC and a Recertification (within the 5-day window), is M1308 column 2 completed or left blank?

**Answer 4:** M1308, Current Number of Unhealed Pressure Ulcers at Each Stage, Column 2 is left blank when the ROC assessment is completed during the 5-day recertification window. Even though the ROC assessment will also serve as the Recertification assessment, it is a Resumption of Care. [\[Return to Table of Contents\]](#)

**M1308 (Resolved DTI) Question 5:**

At admission, a deep tissue injury (DTI) was suspected and reported in M1308, Current Number of Unhealed Pressure Ulcers at Each Stage. At discharge there are no signs or symptoms of DTI. How should I answer M1308, Row d3, column 2? **Answer 5:** At Discharge, if the patient has no pressure ulcers and the suspected DTI had not evolved and is now resolved, enter “0” in all rows and columns in M1308. [\[Return to Table of Contents\]](#)

**M1308; M1320; M1324 (Pressure ulcers with skin grafts) Question 6:**

How do we answer the OASIS pressure ulcer items (M1308, M1320, and M1324) for a pressure ulcer treated with a skin graft, as described in the two scenarios below?

**Answer 6: First Scenario:** Patient admitted for aftercare post skin graft of a Stage III pressure ulcer of the hip with orders for the pressure dressing to remain in place until the patient’s first office visit.

**At the SOC assessment,** what is the appropriate response for M1308, M1320, and M1324?

**CMS Response:**

M1308 - Current Number = Column 1, all Zero's except for Row d1 = 1 M1320 - Status = NA - No observable pressure ulcer M1324 - Stage = NA -No observable pressure ulcer or unhealed pressure ulcer

**At Discharge,** the patient’s graft site has healed with some contracture and discoloration of the grafted site, what is the appropriate response for M1308, M1320, and M1324?

**CMS Response:**

M1308 - Current Number = All Zero's except for Row b Column 1 & 2 = 1 M1320 - Status = 0 - Newly epithelialized, if covered with epithelial tissue M1324 - Stage = 3 - Stage III

**Second Scenario:** Patient admitted for aftercare post skin graft of a Stage III pressure ulcer of the hip. The autologous graft is noted to be sutured in place and the bed of the ulcer is not visible. The graft appears to be healthy, without signs or symptoms of infection, breakdown, or rejection and with complete re-epithelialization at the edges.

At the SOC, what is the appropriate response for M1308, M1320, and M1324?

**CMS Response:**

M1308 - Current Number = All Zero's except for Row b Column 1 = 1 M1320 - Status = 0 - Newly epithelialized M1324 - Stage = 3 - Stage III [\[Return to Table of Contents\]](#)

**M1314 (Measuring depth of pressure ulcers with tunneling) Question 7:**

Does M1314 - Pressure Ulcer Depth, include the depth of a tunnel? **Answer 7:** For M1314 - Pressure Ulcer Depth, report the depth from the visible surface to the deepest area in the base of the wound, which does not include the depth of any tunneling present. Best practice, as recommended by the WOCN pressure ulcer guidelines ([http://www.wocn.org/pdfs/WOCN\\_Library/Position\\_Statements/PressureUlcerStaging.pdf](http://www.wocn.org/pdfs/WOCN_Library/Position_Statements/PressureUlcerStaging.pdf)) would encourage documentation within the comprehensive assessment of additional details regarding the wound that are not reported in specific OASIS items, including presence, location and depth of sinus tracts or undermined areas. [\[Return to Table of Contents\]](#)

**M1342 (Scabbed surgical incision) Question 8:**

Please clarify how to report the healing status of a scabbed surgical incision. **Answer 8:** First, the clinician should evaluate if the surgical incision is healing by primary intention, with edges well approximated, or by secondary intention due dehiscence or interruption of the incision. If the wound is healing solely by primary intention, the assessing clinician will observe if the incision line has re-epithelialized. (If there is no interruption in the healing process, this generally takes from a matter of hours to three days.) If there is not full epithelial resurfacing, such as in the case of a scab adhering to underlying tissue, then the correct response would be "not healing" for the wound healing by primary intention.

The presence of a scab does not automatically equate to a "not healing" response. The clinician must first assess if the wound is healing entirely by primary intention (complete closure with no openings), or if there is a portion healing by secondary intention. If it is determined that there is incisional separation, healing will be by secondary intention, and the clinician will then have to determine the status of healing, which may be "Not healing", "Early/partial granulation", "Fully granulating" and eventually "Newly epithelialized".

"Epidermal resurfacing" means the opening created during the surgery is covered by epithelial cells. If epidermal resurfacing has occurred completely, the correct response in the OASIS would be "Newly epithelialized", until 30 days have passed without complication, at which time it is no longer a reportable surgical wound. [\[Return to Table of Contents\]](#)

**M1410 (Oxygen ordered but not being used) Question 9:**

When completing M1410 - Respiratory Treatments utilized at home, on the Discharge assessment, what do we do if the patient was ordered to use oxygen intermittently but never used it. Can you please define utilize in the item? **Answer 9:** M1410 - Respiratory Treatments utilized at home, identifies respiratory treatments (oxygen, ventilator, CPAP, BiPAP) being used by the patient in the home. On the day of the assessment, if oxygen is ordered to be used intermittently and the patient has not experienced the need to utilize the oxygen, 1 – Oxygen would not be reported in M1410. [\[Return to Table of Contents\]](#)

**M1510 (Same day and physician's response) Question 10:** In order to select M1510 - Heart Failure Follow-up "Response 1-Patient's physician contacted the same day", must the physician respond back the same day also? If so, is "same day" interpreted as by the end of the next calendar day as in other similar M items? **Answer 10:** When completing M1510 - Heart Failure Follow-up, Response 1 is an appropriate response only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions on the *same day*. Same day in this item means by the end of *this* calendar day, and is not the same as "within one calendar day", which is defined in M2002, Medication Follow-up as "until the end of the next calendar day". [\[Return to Table of Contents\]](#)

**M1740; M1745 (Clarification of behaviors) Question 11:**

Is M1745 - Frequency of Disruptive Behavior Symptoms, only based on disruptive behavior: physical, verbal or other disruptive/dangerous symptoms? Or is this item based on what we answer with M1740? **Answer 11:** M1740 - Cognitive, behavioral, and psychiatric symptoms, and M1745 - Frequency of Disruptive Behavior Symptoms are not directly linked to one another. There may be behaviors reported in M1740 that are not reported in M1745 and vice versa. For example, a patient may express excessive profanity or sexual references that cause considerable stress to the caregivers and be reported in M1740, but in the clinician's judgment, the behavior does not jeopardize the safety and well-being of the patient or caregiver, therefore is not reported in M1745. Answer each question individually. M1740 contains a list of specific behaviors associated with significant neurological, developmental, behavioral or psychiatric disorders and asks if they are demonstrated by the patient at least once a week. M1745 is not reporting on a specific list of behaviors, but rather any behaviors that are disruptive or dangerous to the patient or the caregivers. [\[Return to Table of Contents\]](#)

**(Clarification of behaviors and caregivers status) Question 12:**

When completing M1745 - Frequency of Disruptive Behavior Symptoms, do we have to take into consideration if the patient has a fulltime caregiver to watch over her, or do we address it without including the caregiver's presence? **Answer 12:** The environment in which the patient lives and the skills of the caregiver may impact the scoring of M1740 - Cognitive, behavioral, and psychiatric symptoms, and M1745 -Frequency of Disruptive Behavior Symptoms. For example, if a patient has dementia, they may exhibit a number of behaviors listed in M1740, but may not be reported in the OASIS item if they live in a setting specifically designed to care for patients with dementia. The same would be true for M1745. Look to the descriptors for the behaviors that are reportable for both M1740 and M1745 to determine if the behavior would be reportable. [\[Return to Table of Contents\]](#)

**M1800 – M1900 (Willingness and compliance) Question 13:**

About M1800 – M1900 - ADLs/IADLs: I don't understand the difference between "willingness" and "compliance" (which do not impact OASIS scoring) and "cognitive/mental/emotional/behavioral impairment" (which may impact OASIS scoring). For instance, if a person is unwilling to bathe appropriately, resulting in poor hygiene, an offensive odor and increased risk for infection, isn't the patient suffering from some sort of cognitive, mental, behavioral or emotional problem that would cause this unwillingness and noncompliance? It seems that such unwillingness is a symptom of a deeper psychological problem. Please clarify. **Answer 13:** In absence of pathology, patients may make decisions about how and when they perform their activities of daily living that may differ from what the clinician determines to be acceptable. A patient may choose to shave and brush his teeth infrequently because he doesn't value doing it at a frequency that the clinician deems as socially appropriate. There are differences in the frequency at which grooming or bathing is performed, or expected to be

performed based on age, religion, culture and familial practices, and this is not necessarily indicative of pathology.

A patient may demonstrate that they can safely ambulate while using a walker, but then as a *matter of choice*, decide to walk without it. Another patient may demonstrate that they can safely ambulate while using a walker, but then consistently walk without it, *forgetting* that they have a walker. For the purposes of OASIS scoring, non-conformity or non-compliance should not automatically be considered indicative of a deeper psychological impairment. The assessing clinician will have to use clinical judgment to determine if the patient's actions are more likely related to impairment, or to personal choice made in awareness of the potential related risk. [\[Return to Table of Contents\]](#)

#### **M2000 (Oxygen as a medication) Question 14:**

For the purposes of answering M2000 - Drug Regimen Review, is oxygen considered a medication?  
**Answer 14:** Yes, oxygen is included as a medication when answering M2000 - Drug Regimen Review.

#### **(Patient clinically significant medication issues) Question 15:**

In M2000 - Drug Regimen Review, are ALL drug interactions considered "potential clinically significant medication issues"? **Answer 15:** No, the OASIS-C Guidance Manual states that potential clinically significant medication issues include serious drug-drug, drug-food and drug-disease interactions.

The Manual further states that potentially clinically significant medication issues are defined as those that "pose an actual or potential threat to patient health and safety". The determination of whether a medication issue meets this threshold should be based on the clinician's judgment in conjunction with agency guidelines and established standards for evaluating drug reactions, side effects, interactions, etc. Online resources for these standards can be found in Chapter 5 of the OASIS-C Guidance Manual. [\[Return to Table of Contents\]](#)

#### **(Potential clinically significant medication issues) Question 16:**

In M2000 - Drug Regimen Review, are ALL potential medication side effects considered "potential clinically significant medication issues"? **Answer 16:** No, the OASIS-C Guidance Manual states that M2000, Response 2 - Problems found during review, should be selected if the "Patient has signs/symptoms that could be adverse reactions from medications". It further defines a side effect as "an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence." A side effect would be considered "a potential clinically significant medication issue" if it "poses an actual or potential threat to patient health and safety". The determination of whether a medication issue meets this threshold should be based on the clinician's judgment in conjunction with agency guidelines and established standards for evaluating drug reactions, side effects, interactions, etc. Online resources for these standards can be found in Chapter 5 of the OASIS-C Guidance Manual. [\[Return to Table of Contents\]](#)

#### **M2015(Patient/Caregiver drug education intervention) Question 17:**

If a Transfer OASIS was done 2 days after the completion of a SOC or ROC OASIS comprehensive assessment, would the answer to M2015 - Patient/Caregiver Drug Education Intervention, be "Yes" or "No" if the drug education occurred on the admission visit (Yes to M2010). **Answer 17:** M2015 - Patient/Caregiver Drug Education Intervention, reports if, at the time of or since the previous OASIS

assessment, the patient and/or caregivers were educated regarding ALL their medications (not just the high risk medications), including how and when to report problems that may occur. If this specified education was accomplished for all medications at the time of the previous OASIS assessment, the appropriate response for M2015 would be "Yes". [\[Return to Table of Contents\]](#)

**(Patient/Caregiver drug education intervention. All education provided in 1<sup>st</sup> episode and none in 2<sup>nd</sup> episode) Question 18:** When answering M2015 - Patient/Caregiver Drug Education Intervention, if you provide education intervention on all medications during the first episode, but no education in the second episode because the patient had no new medications and there was no need to reteach on all medications, do you have to answer "No" for M2015 at Transfer/Discharge? **Answer 18:** The Condition of Participation 484.55 requires a Drug Regimen Review (DRR) at every comprehensive assessment time point. When performing the DRR, at the Recertification, if the assessing clinician evaluated the patient's retention of prior teaching and determined and documented that the patient possessed all the required knowledge related to all medications, then M2015 would be answered "Yes" at Transfer/Discharge. If the assessing clinician had not re-assessed the patient's medication knowledge and found the patient to be fully knowledgeable or not provided drug education related to all medications at the time of or since the previous OASIS assessment, the M2015 response would be "No" at Transfer/Discharge. [\[Return to Table of Contents\]](#)

**M2100c (Medications administered outside the home) Question 19:**

How do I answer M2100 c - Medication Administration, at Discharge for a patient who has a caregiver assisting with management of oral medication but will now receive their B12 injections at the physician's office? **Answer 19:** M2100 Row c - Medication Administration, includes all medications, by any route administered in the home and does not include medications received at physician's offices or other locations outside the home setting. [\[Return to Table of Contents\]](#)

**M2100e (Examples of equipment) Question 20:**

For M2100-e - Types and Sources of Assistance, Management of Equipment, are canes and walkers considered equipment? **Answer 20:** Yes, if the patient requires assistance with their cane or walker it would be included in M2100e. CMS is not intending to provide an exhaustive list of all medical equipment that could be used in the home health setting, but rather expects the clinician to determine what is considered medical equipment, using the examples provided in the item and good clinical judgment. [\[Return to Table of Contents\]](#)

**M2250 (Do orders present at SOC count after ROC?) Question 21:**

When you are completing M2250 - Plan of Care Synopsis, at the ROC and the initial orders for fall risk, pressure ulcers, etc. were received at SOC from the physician and have not been discontinued, meaning they remain as a current order, does the RN doing the ROC need to rewrite these orders? Does the RN need to contact the physician to see if it is OK to continue them? **Answer 21:** The OASIS-C process measures are not changing the expectations and requirements related to physician's orders. If, at ROC, orders received at SOC remain as current orders, then the presence of those orders can be reported in M2250. [\[Return to Table of Contents\]](#)

**M2250a (Standardized agency parameters) Question 22:**

If we are using standardized agency parameters, do they have to be listed specifically in the plan of

care or can the order read “Notify MD of VS as per agency’s patient clinical parameter guidelines”?

**Answer 22:** The specific parameters must be included. The physician has to be aware of what he/she is agreeing to and cannot possibly be aware of every home health agencies standardized parameters.

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**(Standardized agency parameters) Question 23:** If we add our agency's standardized parameters to every plan of care for every patient we admit, without first communicating with the physician, we can always answer "Yes" to M2250a - Plan of Care Synopsis, Patient Specific Parameters? **Answer 23:** No. In order to answer "Yes" to the responses, the plan of care must include patient-specific parameters provided/approved by the physician, or inclusion of your agency specific parameters, which the physician has agreed meet the individual needs of this specific patient. As with any physician orders, these must be approved either through verbal or written approval by the physician prior to providing care. If the agency utilizes agency standardized guidelines without specific physician approval and orders, then "NA" should be reported for M2250a.

**M2250b (Diabetes insipidus) Question 24:**

If a patient has Diabetes Insipidus, would the appropriate response be "NA" for M2250b - Plan of Care Synopsis, Diabetic foot care? **Answer 24:** Yes, "NA" is the appropriate response for a patient that has Diabetes Insipidus, not Diabetes Mellitus. M2250b best practice interventions are intended for patients with Diabetes Mellitus.

**M2250 (No formal assessments/formal assessments showing no risk) Question 25:**

I need clarification about the flowchart included in the April CMS OCCB Q&As Question 38. Can I answer "Yes" to M2250, Plan of Care Synopsis, and M2400, Intervention Synopsis, if the physician-ordered plan of care includes the specified intervention and they were implemented by Transfer/Discharge, even though the assessment revealed no risk? **Answer 25:** You may answer M2250, Plan of Care Synopsis, "Yes" if the physician-ordered plan of care includes the specified best practice intervention by the end of the allowed assessment time frame. This is true even if the formal or informal assessment revealed no risk. You may answer M2400 - Intervention Synopsis, "Yes" at Transfer/Discharge if the physician-ordered plan of care includes the specified best practice intervention and there is evidence in the clinical documentation that they were implemented. This is true even if the formal assessments were negative.

**M2400 (Teaching done but orders not included in POC) Question 26:**

If a clinician teaches Diabetic foot care, Prevention of falls, and/or pressure ulcers etc. on the discharge visit and then finds out that these were not included on the Plan of Care Synopsis, what would be the best way to answer M2400 - Intervention Synopsis? **Answer 26:** The response would have to be "No" if there were no orders for these best practices. In order to answer M2400 – Intervention Synopsis "Yes", the physician-ordered plan of care at the time of or since the previous OASIS assessment must have included the specified best practice intervention, in addition to evidence that the interventions were implemented. Please remember that the physician plan of care includes the plan of care for certification/recertification in addition to all other addendum orders.