

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850



Center for Clinical Standards and Quality/Survey & Certification Group

July 17, 2013

Linda Krulish, PT, MHS, COS-C
President
OASIS Answers, Inc.
PO Box 2768
Redmond, WA 98073

Dear Ms. Krulish:

Thank you for your letter of July 8, 2013 in which you requested review of a number of questions and scenarios related to data collection and accurate scoring of Outcome and Assessment Information Set (OASIS) items. The accompanying questions and answers have been reviewed by CMS staff, selected content experts and contractors, and consensus on the responses has been achieved.

As deemed valuable for providers, OASIS Education Coordinators and others, CMS will consider incorporating these questions and answers into current OASIS-C preparation and education activities, and may include them in future updates to the CMS Q&As posted at <https://www.qtso.com/hhdownload.html>, and/or in future releases of item-by-item tips.

In the meantime, you are free and encouraged to distribute these responses through educational offerings sponsored by OASIS Answers, Inc. (OAI) or general posting for access by all interested parties. Thank you for your interest in and support for enhancing OASIS accuracy.

Sincerely,

Patricia A. Sevast, BSN, RN
Nurse Consultant
Survey and Certification Group
Centers for Medicare & Medicaid Services

CC: Robin Dowell, RN, BSN Nurse Consultant and Kim Roche, RN, BSN, MA Nurse Consultant, Quality Measurement and Health Assessment Group, Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services
Tara McMullen, MPH, PHD (C), Health Insurance Specialist, Quality Measurement and Health Assessment Group, Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services



July 2013 CMS Quarterly Q&As

Category 2

Question 1. I was told that if the ROC OASIS was done after the CMS-allowed 48 hour time frame that all the best practice questions need to be answered NA. Exactly which OASIS items does this apply to?

Answer 1. The ROC comprehensive assessment must be completed within 48 hours of discharge following a qualifying inpatient stay or within 48 hours of knowledge of a qualifying stay in an inpatient facility. If the assessment is late, "Yes" cannot be selected for best practice process measure items M2250, Plan of Care Synopsis, M1240, Pain Assessment, M1300, Pressure Ulcer Risk Assessment, M1730, Depression Screening, or M1910, Falls Risk Assessment.

For late assessments, meaning they were completed greater than 48 hours after inpatient facility discharge or greater than 48 hours after gaining knowledge of a qualifying stay in an inpatient facility, M1240, M1300, M1730 and M1910 must be answered "No".

For late assessments, M2250 Plan of Care Synopsis responses would be "No" unless the best practice is not applicable to the patient in which case the response would be "NA". Refer to Ch. 3 of the OASIS-C Guidance Manual for qualifiers that indicate the best practice is not applicable, (e.g. Row b, Diabetes best practice, the patient must be free of the diagnosis of diabetes mellitus or have no lower extremities.)

Category 3

Question 2. We are seeing an increasing number of patients "held" in emergency rooms as "observation" patients for periods of 24 hours up to 7 days without admission to inpatient status. A Transfer assessment is not completed on these patients since they were not admitted to the hospital as an inpatient. If this patient is released from the emergency room or from observation status in the next certification period (i.e., on Day 61 or later) and returns to home health without ever being admitted to the hospital as an inpatient, is it appropriate for the agency to complete a Follow-up or Recertification assessment or must the agency discharge the patient and readmit them to home care services? If a Recertification assessment is completed, what date should be used for the M0090 date and what documentation should the agency include in the record?

Answer 2. Treat this situation as a missed Recertification and complete the Recertification as soon as possible after the patient's return home. M0090 is the actual date the comprehensive assessment was completed. Clinical documentation will explain the events leading to the late Recertification.

M0100

Question 3. If a patient was admitted to the hospital at 3 pm yesterday and then transfers directly to a hospice inpatient unit at 11 am today, are the inpatient hours additive? Should we do a Transfer at 3 pm today, after a full 24 hours of inpatient care, or does the clock start again at 11 am when the patient was admitted to the hospice inpatient? The same could happen with other inpatient settings- such as hospital and NF.

Answer 3. A Transfer OASIS is required when the patient has been transferred to an inpatient bed for 24 hours or longer for reasons other than diagnostic testing. If the patient was admitted to one inpatient facility bed then transferred to another, the Transfer OASIS would be required once a total of 24 hours have been spent as an inpatient, under an inpatient billing status. In the situation described, a Transfer is required once the patient was inpatient for a total of 24 hours, in one or more inpatient facilities.

M1016

Question 4. Please provide clarification and guidance related to M1016 and the Response-specific Instructions to "Mark NA if changes in the medical or treatment regimen were made because a diagnosis improved." If we admit a patient following a hospital stay for exacerbation of CHF and at SOC, the patient's CHF is still a current diagnosis that requires monitoring, evaluation, and/or active treatment by the agency to prevent readmission of the patient to the hospital; can we list CHF in M1016 even though it "improved"?

Answer 4. M1016 is utilized in the risk adjustment of outcomes. The Ch. 3 Item Intent explains, "The purpose of this question is to help identify the patient's recent history by identifying new diagnoses or diagnoses that have exacerbated over the past 2 weeks. This information helps the clinician develop an appropriate plan of care, since patients who have recent changes in treatment plans have a higher risk of becoming unstable."

The intent of the item is not to identify diagnoses where all medical or treatment regimen changes in the last 14 days were related to improvements in a condition. If at any time in the last 14 days the patient requires a medical or treatment regimen change due to development of a new condition or lack of improvement or worsening of an existing condition, the diagnosis should be reported in M1016, even if the condition also showed improvement or stabilization during that time, or is improved at the time of the SOC/ROC.

M1055

Question 5. If your agency does not immunize patients, would the answer to M1055, Reason PPV not received, always be "5-None of the above"? What if another provider offered and the patient refused, could we select Response "2-Offered and declined"?

Answer 5. It is not required that the agency offer to administer the pneumococcal vaccine in order to select "2-Offered and declined", only that the patient was offered the vaccine by any healthcare provider and he/she refused. All response options are available for selection regardless of whether or not the agency immunizes their patients.

M1240

Question 6. We are requesting clarification regarding the time frame used to assess pain for the response to M1240.

Answer 6. When completing M1240, Pain Assessment, the period of time that the clinician should consider when determining if the pain assessment reveals severe pain ("Response 2") or not ("Response 1"), is determined by the administration protocols associated with the exact standardized tool that the clinician uses to assess pain. Examples of time frames stated in protocols include "at the present time", and "at its worst during the past 24 hours". If the tool selected has multiple sets of validated administration protocols, in order to standardize data collection agency policy may state which protocol the agency prefers the clinicians use. If no standardized pain assessment is conducted within the SOC or ROC assessment time frames, Response "0 - No standardized assessment conducted" must be reported."

M1242

Question 7. For M1242, could you define the term "All of the time"? Does pain have to keep a patient awake all night long in order to select it?

Answer 7. M1242 Response "4-All the time" is selected, when the patient reports and/or the clinician observes that pain is interfering with the patient's ability to move and/or perform desired activities at all times. "At all times" means constantly throughout the day and night with little or no relief. Pain is also considered to be interfering if a patient stops performing an activity in order to avoid the pain. For the pain to be interfering "all the time" the frequency of the activity that was stopped in order to avoid pain must collectively represent all the hours of the day/night. Pain must wake them frequently at night. The clinician must use judgment based on observation and patient interview to determine if pain is interfering all the time.

M1306; M1340

Question 8. If the patient had a pressure ulcer and the post-op surgical report states it was surgically excised and closed without placement of a muscle flap, do we still have a Stage 4 pressure ulcer-the original etiology or did this become a surgical incision?

Answer 8. If all the tissue damaged by pressure is removed surgically, e.g. amputation or surgical excision, there is no longer a pressure ulcer. It becomes a surgical wound until healed.

M1308

Question 9. Our patient has a Stage 3 pressure ulcer that we have been treating during the episode. At the reassessment, it is covered with a scab. I know it's unstageable if it has a non-removable dressing or is covered with eschar or slough but I do not know how a scab would affect the staging.

Answer 9. Refer to WOCN guidance on pressure ulcers. If, in a pressure ulcer with full thickness tissue loss, the clinician can visualize bone, muscle or tendon, the pressure ulcer has advanced to a Stage 4, and should be reported as such, regardless of the presence of eschar, slough or a scab.

If, however, no bone, muscle or tendon (Stage 4 structures) are visible, and some degree of necrotic tissue (eschar or slough) or scabbing is present that the clinician believes may be obscuring the visualization of bone, muscle or tendon, then the pressure ulcer is unstageable. If in a full thickness pressure ulcer, no bone, muscle or tendon is visible, and in the clinician's judgment the amount and/or placement of any necrotic tissue or scabbing present could NOT be obscuring visualization of Stage 4 structures, the clinician should report the pressure ulcer as Stage 3.

In the unusual situation of an unstageable scabbed pressure ulcer, when completing M1308, Current Number of Unhealed Pressure Ulcers at Each Stage, report the pressure ulcer in row d.2, Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar. Note that a scab is not slough or eschar, but due to the constraints of the data set, the unstageable scabbed pressure ulcer must be reported in this manner. Documentation in the patient's medical record will describe the clinical findings.

M1320

Question 10. How do you define the healing status of a Stage IV pressure ulcer that has closed to the point it has a scab on the surface? It is not eschar or slough.

Answer 10. Refer to the WOCN Guidance on OASIS-C Integumentary Items for the definitions of the healing status of pressure ulcers. If a scab is obscuring the wound bed, you would not be able to assign the status of "0-Newly epithelialized" because the wound bed is not completely covered by new epithelium. If you identify that the scab is raised and appears to be covering a wound that has filled with granulation to the same level as the surrounding skin surface, you would report "1-Fully granulating". You might not be able to assign the status of "Fully granulating" if the scab prevents you from visualizing if the wound bed is filled with granulation tissue to the level of the surrounding skin. If the scab is present in a wound bed which is sunken below the level of the surrounding skin, then you could not select "0-Newly epithelialized" or "1-Fully granulating". If there are no s/s of infection and you can visualize that at least 25% of the wound bed is covered with granulation tissue, then select "2-Early/partial granulation". Note that

a scab is NOT avascular tissue (eschar or slough), so the "<25% of the wound bed is covered with avascular tissue" criteria for the "Early/partial granulation" healing status does not apply to a scab. If the scab covered wound could be observed to meet ANY of the criteria for "3-Not Healing", Response 3 should be reported.

M1340

Question 11. Is an arteriovenous (AV) fistula considered as a current surgical wound? Does it matter if it is still utilized for dialysis?

Answer 11. While the surgical connection of a vein to an artery is not a synthetic access/device, an AV fistula is considered a current surgical wound once it is surgically created and as long as it is present in the patient's body. This is true even if the fistula never matures, and/or is not currently used for vascular access.

In addition to AV fistulas, the sites of implanted venous access devices or other implanted infusion devices such as medication pumps, catheters for peritoneal dialysis, AV shunts or AV grafts should all be considered surgical wounds for as long as they are present, whether functional or not.

M1340

Question 12. Is the Vantas implanted device considered a surgical wound?

Answer 12. The VANTAS® Implant is inserted just under the skin in the upper arm and provides a continuous 12-month administration of histrelin acetate for the palliative treatment of advanced prostate cancer. Once the surgical incision that was created to implant the device is made and until the implant device is removed, it is considered a surgical wound for M1340.

M1620

Question 13. Please clarify what time frame we are looking at when assessing bowel incontinence in M1620, Bowel Incontinence Frequency. Our agency has been told the SOC is day 0 and we look back 7 days to answer this question. Is that correct?

What about this scenario? At the SOC assessment no bowel incontinence is reported for the past 7 days, at a repeat visit within the 5 day window, the patient has experienced bowel incontinence since the SOC. Can we amend M1620 to #1 or #2 and also update the M0090 date to reflect this additional assessment information?

Answer 13. The timeframe under consideration is day of assessment and relevant past. This timeframe is directed by Response options "0-Very rarely or never has bowel incontinence" and "1-Less than once weekly." Considering these two options, the assessing clinician would need

to consider bowel incontinence that was experienced beyond the past 7 days. The assessing clinician must use clinical judgment to determine how far into the past would be relevant to this home care admission.

The SOC comprehensive assessment must be completed within 5 days after the SOC date, M0030. In the scenario above, the assessing clinician may elect to re-assess bowel incontinence within the allowed timeframe and change her/his original response as well as M0090, Date Assessment Completed.

M1810; M1820

Question 14. Are wound dressings included as an upper and lower body dressing task when determining a patient's ability for M1810 and M1820, Ability to Dress Upper/Lower Body?

Answer 14. Wound dressings are NOT one of the included dressing items when scoring M1810, Upper Body Dressing and M1820, Lower Body Dressing. Note that elastic bandages, including ACE Wrap brand, worn for support and compression should be considered as a lower body dressing item, but wraps utilized solely to secure a wound dressing would not be considered a dressing (clothing) item for M1810 or M1820.

M1850

Question 15. When answering M1850, Transferring, do the responses that reference weight bearing and pivoting include an individual that uses a sliding board and would be weight bearing and pivoting using only the upper extremities, not the lower?

Answer 15. The term "bear weight and pivot" in M1850, Transferring, may include both a standing pivot transfer and multiple sitting pivot transfers, such as those utilized when performing a bed-to-chair transfer with a sliding board.

If the patient does not have use of the lower extremities and transfers with the use of a sliding board, but no human assistance, select Response "1-Able to transfer with minimal human assistance or with use of an assistive device." If the patient requires both minimal human assistance and the sliding board to transfer safely, select Response "2-Able to bear weight and pivot during the transfer process but unable to transfer self." If the patient can bear weight and pivot utilizing their upper extremities, but requires more than minimal human assist, Response 2 should be marked. The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, select Response "3-Unable to transfer self and is unable to bear weight or pivot when transferred by another person."

M2000

Question 16. Can we answer M2000, Drug Regimen Review, “Yes” if we did not check for drug-to-drug interactions? We did most of the review, so it seems like we should get credit.

Answer 16. There is no “Yes” response in M2000, Drug Regimen Review. You must perform a complete drug regimen review, as defined in OASIS-C Guidance Manual, M2000 Response-specific Instructions, in order to select Response "1-No problems found during review" or "2-Problems found during review". If elements of the drug regimen review were skipped, for example, as you stated, drug-to-drug interactions, Response "0-Not assessed/reviewed" is appropriate, as a complete drug regimen review was not performed.