

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Center for Clinical Standards and Quality/Survey & Certification Group

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Dear Ms. Krulish:

The accompanying questions and answers have been reviewed by CMS staff, selected content experts and contractors. Consensus on the responses has been achieved.

We understand that you will share the Questions and Answers (Q&A's) with the provider community and the OASIS Education Coordinators (OEC).

Sincerely,

Je'annine O'Malley
Captain, USPHS
Nurse Consultant
Division of Continuing Care Providers
Survey and Certification Group
Office of Clinical Standards & Quality
Centers for Medicare & Medicaid Services



April 2016 CMS Quarterly OASIS Q&As

Category 4a

Question 1: I would like to better understand the rules on how to collect the OASIS as part of a comprehensive patient assessment. What are the best resources?

Answer 1: CMS provides several key resources to support OASIS data accuracy. The OASIS Guidance Manual contains an item-by-item review with key instructions within Chapter 3 of the manual. Chapter 3 is organized by M-item number for easy reference. Chapter 1 of the OASIS Guidance Manual contains the general and ADL/IADL specific conventions for completing OASIS items.

There are also 12 categories of OASIS Q&As available at <https://www.gtso.com/hhatrain.html>. Categories 1-4 are most relevant for OASIS data collection activities. At the same site, CMS posts quarterly Q&A updates with new and/or refined guidance related to OASIS items. The user may conduct a key word search in these .pdf documents to expedite the search for information. CMS also provides web-based training that providers can utilize to support accuracy.

The modules are available at

<http://surveyortraining.cms.hhs.gov/pubs/ClassInformation.aspx?cid=0CMISOASISCWBT> and are expected to be updated for OASIS-C2 guidance prior to implementation in January 2017.

Questions not otherwise answered in published CMS OASIS resources may be submitted to the CMS OASIS Helpdesk at CMISOASISquestions@oasisanswers.com.

OASIS-C2

Question 2: When will the final version of the OASIS-C2 data set be available? I see the OASIS-C2 form is available on the CMS website, but am not certain if this is a final version.

Answer 2: On December 22, 2015, the OASIS-C2 All Items Data Set was posted on the CMS Home Health Quality Initiatives webpage at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-Data-Sets.html>.

The OASIS-C2 version of the data set is scheduled to go into effect for all assessments with a M0090 Date Assessment Completed on or after January 1, 2017. Once this new version of the data set is approved by the Office of Management and Budget, an OMB approval number will be added to the data set and it will be reposted as Final.

Category 4b

M0040

Question 3: Can/should an apostrophe be included in a patient's name in M0040?

Answer 3: The OASIS Guidance Manual, Chapter 3, M0040 Response-Specific Instructions state the patient's name should appear exactly as it does on the Medicare card or other insurance card. Per the data specifications for M0040, the item may contain a (') single quote/apostrophe.

For additional information, please refer to the data specifications located at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/DataSpecifications.html>.

Question 4: The Guidance Manual states that the patient's name for M0040 should match the Medicare or insurance card, but what should I do if the patient's last name has more letters than M0040 allows?

Answer 4: For M0040 Patient Name, the OASIS Guidance Manual states the name should appear exactly as it does on the Medicare card or other insurance card. The OASIS item provides a maximum length of 12 characters for the first name, 1 character for the middle initial, and 18 characters for the last name. The length of the text submitted must not exceed the maximum length specified or it will result in a fatal Format Edit when submitted to the CMS ASAP system.

In cases where a patient's name has more letters than the OASIS submission allows, enter the first 12 letters (for first name), the first letter (for middle initial), and the first 18 letters (for last name), and disregard any additional letters/characters for the purposes of M0040. This approach should be used for all time points throughout the patient's episode of care.

Note that this M0040 limitation should not be applied to other documentation (clinical records, claims, etc.) where the patient's full name should be used.

M1100

Question 5: My patient lives in a large continuum of care community. In this community, he lives in a single family home with his wife and at this point, does not receive any support, assistance or oversight because he lives there. He phones 911 for an emergency and has access to shared recreational areas within the community. For the purposes of M1100, does he live with other persons in the home, or in a congregate living situation?

Answer 5: Assuming that the option for the patient to receive assistance, supervision or oversight is **not** a part of the living arrangement with the continuum of care community, a response from Row b - Patient lives with other person(s) in the home would be appropriate. If assistance, supervision, or oversight is provided to the patient as part of the living arrangement, (for example weekend brunches in the main dining hall, or a morning check-in call), but the patient doesn't need and/or chooses not to utilize the available services, a response from Row c - Patient lives in congregate situation would be appropriate.

M1200

Question 6: M1200 Vision references “newsprint” in Responses 0 – Normal Vision and Response 1 – Partially Impaired. Is this intended to specifically refer to the patient’s ability to see the general 12 point font-size in a newspaper? If the patient can see larger font (>12 point), but not smaller font (< 12 point) would the response be 0 or 1? Also, the guidance states to “consider ability to differentiate between medications”. Is this referring solely to reading the medication label, or just identifying the medication by any visual method?

Answer 6: The intent of M1200 is to identify the patient’s “functional vision”, meaning the patient’s ability to see and visually manage (or function) safely within his/her environment, wearing corrective lenses if usually worn. M1200 is not intended to be a formal screen for visual acuity, nor is it a reporting of the patient’s ability to read. And differentiating medications is offered only as an example of a daily activity that the clinician could use to assess the patient’s functional vision. The item’s responses provide descriptions of varying levels of functional vision. The clinician would also consider any physical deficits or impairments (like limited neck range of motion, or facial swelling) that may be present, affecting the patient’s ability to use their existing vision in a functional way.

Newsprint is intended to serve as an example of the size and type of print found in a newspaper, magazine or book, on medication or food labels, and on other products or documents that might be routinely encountered for day-to-day functioning. Rather than focusing on specific font sizes, the clinician should use clinical judgment to select the response to M1200 that best represents the patient’s vision status, as it relates to managing in their home environment safely. Rather than determining if the patient can read the medication labels, the clinician could use a determination of the patient’s ability to differentiate between medications, especially if medications are self-administered, as a possible assessment strategy. Functional vision may involve assessing the patient’s ability to read the label, identify colored medication bottle caps, differentiate medications based on pill size, color or shape and/or the use of other visual cues to carry out the daily activity of medication identification.

M1340, M1342

Question 7: If a surgical wound dehisces at opposite ends, with an area of intact/healed skin between, is this still addressed in OASIS as one surgical incision? Secondly, if still considered a single surgical wound - if one of the dehisced areas is granulating, and the other covered in slough - would the overall percentage of wound bed be considered when determining healing status, rather than applying percentages to two separate wounds?

Answer 7: When a portion of the surgical wound is intact/healed, and a portion of the wound is open and healing by secondary intention, to determine the healing status consider the portion of the wound bed that is healing by secondary intention when applying the WOCN criteria of “% of the wound bed covered with granulation tissue” or “% of wound bed covered with avascular tissue”. If the surgical wound has more than one area healing by secondary intention, separated by one or more areas of intact/healed tissue, all open areas healing by secondary intention would be included as the “wound bed”, when applying the percentages to determine healing status. See the WOCN Guidance on OASIS Skin and Wound Status Items at www.wocn.org.

M1830

Question 8: Please confirm something I heard during OASIS training at my office. They said that getting to the bathroom for bathing is also included in the data collection for bathing even though the responses for M1830 Bathing only address the transfer in and out of the shower/tub and washing the body. Is that true? For example, my patient needs assistance to get down his hallway to the bathroom, but once he is in the bathroom he can safely transfer in and out of the shower and wash his body without assistance or equipment. Until the meeting today, I would have scored him a 0 for independent, but now it seems I should be scoring him a 2-needs intermittent assistance. Which score is correct?

Answer 8: The OASIS ADL/IADL items consider the patient's ability to access the needed items and/or location where the task is performed unless item guidance specifically excludes these from consideration. For M1830 Bathing, the amount of assistance the patient requires to get to the location bathing occurs would be considered. In the scenario cited, the patient requires assistance (another person to provide verbal cueing, stand-by or hands-on assistance) to safely ambulate down the hallway and no other assistance with transfer and bathing. This is intermittent assistance, therefore M1830 Response 2 - Able to bathe in shower or tub with the intermittent assistance of another person should be reported.

M1840

Question 9: My patient lives alone. He can safely get to/from and use his bathroom toilet by himself without difficulty during the day. His daughter insists that he use the bedside commode at night in his bedroom because his vision and balance are compromised at night, resulting in a previous nighttime fall. He demonstrates safe transfers on and off the bedside commode. I think he would be safe walking to his bathroom at night with supervision but he lives alone. Do I score him based on the use of the bedside commode, or based on the need for supervision?

Answer 9: For M1840, if the patient's ability or status varies on the day of assessment, report the patient's usual status, or what is true greater than 50% of the day of assessment. Day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home for the visit.

If the patient is able to get to and from the toilet safely and independently during the daytime; and if, for this patient, this represents more than 50% of the day of assessment, then M1840 would be Response 0 - Able to get to and from the toilet and transfer independently with or without a device, regardless of what the patient's status is for the remainder of the day of assessment.

If the factors that make the patient not safe getting to/from the bathroom safely (vision and balance in this scenario) were to be present for more than 50% of the day of assessment, and if in your clinical judgment, during these times the patient would be safe walking to the bathroom with supervision, then Response 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer would be the appropriate response, even if the patient does not have a caregiver available.

M1860

Question 10: My patient does not have an assistive device, but demonstrates the ability to walk safely constantly holding on to his caregiver. His neighbor loaned him a walker to try out during our assessment visit. My patient liked it and was safe walking on level surfaces with no help, but still needed help on the stairs. I have ordered a walker for the patient, and it will be delivered in 2 days. How do I score M1860 for the day of assessment? With or without the use of a walker?

Answer 10: For M1860, the clinician must consider what the patient is able to do on the day of the assessment, which is the 24 hours that precedes the visit plus the time in the home. If at the time of assessment, (and prior to any teaching or interventions), the patient demonstrates the ability to ambulate safely with a walker and no assistance, then Response 2 - Requires use of a two-handed device to walk alone on level surfaces should be reported, as this is the patient's status on the day of assessment. This is true even if the walker does not belong to the patient and may not remain in the home. The clinician should not assume that the patient would be safe walking with a walker if no walker is available to allow assessment of the patient's status.