



## October 2016 CMS Quarterly OASIS Q&As

### Category 4a

**QUESTION 1:** We have discovered a discrepancy in the OASIS-C2 documents that are published. The revised medication item M2005 has been added to the Death at home assessment. The 'Go to' item in the posted OASIS-C2-Item-Set-Effective\_1\_1\_17a.pdf indicates '8 Death at home [Go to M0903]' and in the OASIS-C2-Guidance-Manual-6-29-16.pdf indicates '8 Death at home [Go to M2005]'. Please advise which is correct?

**ANSWER 1:** Assuming the assessment incorporates the data items into the comprehensive assessment in the same order as presented in the OASIS data set, the correct "go to" language for response 8 - Death at home should be [Go to M2005]. This error will be corrected once OMB approval is received, and the OASIS-C2 data is reposted as final.

**QUESTION 2:** In looking at the OASIS-C2 data set posted on the CMS website, I notice that in the "Items to be used at Specific Time Points" table presented in the C2 data sets, the table suggest that M1025 is not collected at the "Follow-up" time point. However, M1025 is present in the Follow-Up version of the data set, and Chapter 3 of the OASIS-C2 Guidance Manual identifies Follow-up as one of the M1025 data collection time points. Please advise.

**ANSWER 2:** An error exists in the "Items to be used as Specific Time Points" table present in the posted OASIS-C2 data set. M1025 should be collected at Follow-up as outlined in the OASIS-C2 Guidance Manual. This error will be corrected once OMB approval is received, and the OASIS-C2 data is reposted as final.

**QUESTION 3:** Traditionally, aside from M0080, M0090, and M0100, the only items that appear on the time point 8 Death at Home assessment are M0903 (Date of Last Home Visit) and M0906 (Discharge/Transfer/Death Date). In OASIS-C2, M2005 (Medication Intervention) has been added to the RFA 8 assessment. This seems like an odd item to add to the Death at Home assessment, especially since no other items are being added to this assessment. Can you explain why M2005 was added, and/or verify that this wasn't a mistake?

**ANSWER 3:** Per the OASIS-C2 Guidance Manual, effective January 1, 2017, M2005 Medication Intervention will be collected at the following time points: Transfer to inpatient facility, Death at home, and Discharge from agency - not to an inpatient facility. M2005 is a data source for a new cross-setting

IMPACT Drug Regimen Review process measure, and the quality measure specifications required data collection for all home care episodes, including those ending in a patient death at home.

**QUESTION 4:** Must the OASIS data items (on the screen and when printed) match the data set language and format exactly?

**ANSWER 4:** The OASIS hard copy information for the chart printed out by a point of care system must use the exact language of the items from the current data set. If the printout of the assessment (i.e., the "hard copy" to be retained in the patient's clinical record) does not contain the same assessment data entered and submitted to the OASIS system, that may be problematic for the following reasons: 1) State surveyors will likely review records and compare the record on site in the agency with the data submitted to the OASIS system; 2) If a patient record was requested by the Fiscal Intermediary for medical review, it would be imperative that the printed record contain the data collected and submitted to the OASIS system (since the same data were used to document the Plan of Care and calculate the billing codes); and 3) One way for an agency to monitor quality is to review responses to OASIS items in clinical records and compare those responses with data collected at prior and subsequent visits to the same patient. If any of these processes would be complicated by the printouts received from your system, it could create problems for the agency.

Due to the size and complexity of some of the items (e.g., M1021/1023/1025/1311/1313/2102/2250/2401) the formatting may be modified to fit the computer screen as long as the data set language is not modified, and any format variances in no way impact the accuracy of the item scoring

#### **Category 4b**

#### **M1028**

**QUESTION 5:** For M1028 (Active Diagnosis) and other IMPACT ACT added items, what do I record on the paper instrument if I could not assess or did not have the information at the time of the assessment? I realize I would submit a dash (-) in the electronic submission. I understand the circumstances in which a dash is appropriate per the Guidance Manual. So I don't need any guidance of when to use the dash. However, there is NO dash on the paper instrument. I would feel uncomfortable submitting something electronically that does not appear on the paper instrument. So, which takes precedence? The paper instrument, which does NOT allow a dash, OR the electronic data specs which allow a dash?

**ANSWER 5:** For OASIS items that allow the dash (–) as a valid option, the clinician should enter a dash in the applicable box on the agency's paper or electronic assessment. CMS expects dash use to be a rare occurrence.

**QUESTION 6:** Regarding M1028, the way M1028 is displayed on the instrument, you either check box 1 (patient has PVD/PAD) or check box 2 (patient has diabetes) or check both boxes (patient has both PVD/PAD and diabetes) or check neither box (patient has neither PVD/PAD nor diabetes). If my clinician leaves both boxes unchecked, how am I to know whether she truly assessed the patient (and the patient has neither diagnosis) or she just forgot to answer this question? All the other "Mark all that apply" items in the instrument have an "out", like a "None of the Above", but this item does not.

**ANSWER 6:** The current guidance for completion of M1028 directs the clinician to select a response if the condition is an active diagnosis or to use a dash if the information is not available or could not be assessed.

If the assessment is completed and it is determined that the patient does not have a diagnosis of diabetes, PVD, or PAD, both boxes should be left unchecked. Implementation of documentation or auditing strategies to ensure accurate completion of the comprehensive assessment are at the discretion of your organization.

**QUESTION 7:** Regarding M1028, according to the OASIS-C2 Guidance Manual, if information regarding active diagnoses is learned after the M0090 Assessment Completed Date, the OASIS Data Set should not be revised to reflect this new information. The OASIS Data Set should reflect what was known and documented at the time of the assessment.

Does the assessment timeframe (e.g., 5 days at SOC) apply in this situation? The patient referral states that the patient is pre-diabetic. On the third day (still within the 5 days for the assessment) new information is received that the patient is being considered diabetic and orders are received. Can M1028 be changed based on this new information? Or should it not be changed because information was obtained after the admission?

**ANSWER 7:** Each assessment type has a defined timeframe for completion as specified in Appendix A of the OASIS Guidance Manual. Information collected by the assessing clinician during the timeframe for the specified assessment type should be documented and M0090 Date Assessment Completed would reflect the date when the final assessment data are collected.

In the scenario cited, if the clinician confirmed the diagnosis of diabetes during the assessment timeframe and before the assessment was completed, reporting M1028 Active Diagnoses as Response 2 – Diabetes Mellitus (DM) would be appropriate.

**QUESTION 8:** In M1028, I need clarification on the term "active diagnoses." Specifically, when would a diagnosis of DM, PAD or PVD that is reported in M1021 or M1023 not be reported in M1028 as well? Are active interventions (treatments) on the POC required, or is it enough that the diagnosed condition justifies general monitoring/assessment?

For example, a patient is admitted to home health for physical therapy s/p total hip arthroplasty. The patient is also a type 2 diabetic. Her diabetes is controlled by her diet & she is independent with monitoring her blood sugars. She is knowledgeable about diabetic foot care & checks her own feet daily using a mirror. Because her change in activity could affect her blood sugar levels and because the diabetes could affect her ability to heal from her surgery, DM meets the selection criteria for a secondary diagnosis and would be reported in M1023. While the PT will be monitoring the patient holistically to identify problems and modify the plan of care as appropriate with physician collaboration, the PT orders do not list any active interventions related to her DM. Should DM be reported in M1028 as an Active Diagnosis?

**ANSWER 8:** "Active diagnoses" are diagnoses that have a direct relationship to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment. Diseases or conditions that have been resolved are not included for M1028.

In the scenario cited, it is stated that the patient has a diagnosis of diabetes which could be affected by the patient's currently limited mobility, and/or could impact the healing of the patient's surgical incision(s). The home health provider's monitoring of the patient/wound healing with specific knowledge that the patient is a diabetic, would make diabetes an active diagnosis for this patient.

**QUESTION 9:** Is it possible that DM, PAD or PVD would be identified as an Active Diagnosis in M1028 but not be included as a primary or secondary diagnosis in M1021 or M1023? For example, a patient is referred to home health for speech language pathology interventions related to her dysphagia. The patient also has PAD which is documented in the patient's medical history. However, the PAD, while identified in the physician's summary/notes, does not meet the selection criteria for inclusion as a primary or secondary diagnosis as the SLP has no interventions related to the patient's PAD nor is it felt to have an impact on the patient's prognosis related to her dysphagia. Should the PAD be reported in M1028?

**ANSWER 9:** In the scenario cited, you ask if it is possible for DM, PAD or PVD to be considered an Active Diagnosis in M1028, but not be reported as a primary (M1021) or other (M10123) diagnosis. In the scenario cited, while the patient has the diagnosis of PAD, the clinician is determining that the PAD is not the chief reason for home health services (not the primary diagnosis), and is not a comorbid condition that is addressed in the plan of care, and isn't felt to have the potential to affect the patient's responsiveness to treatment (not a secondary diagnosis). Therefore, for this patient, PAD does not appear to have a direct relationship to the patient's current functional, cognitive, mood or behavior status, medical treatment, nurse monitoring or risk of death at the time of assessment, and therefore would not be reported as an Active Diagnosis in M1028.

Note that OASIS item M1023 provides space for the listing of up to 5 Other (secondary) diagnoses. If DM, PAD or PVD were considered to be a comorbid condition that is addressed in the plan of care, with the potential to affect the patient's responsiveness to treatment, then it would be considered an active diagnosis in M1028, even if it ends up not being listed in M1023, due to the limited number of coding spaces available in the OASIS.

## M1060

**QUESTION 10:** For the new OASIS item M1060, can the agency gather the patient's height and weight by patient/caregiver report? M1060a requests most recent height measure since SOC/ROC, but M1060b allows most recent weight measurement in last 30 days. So does that mean that height must be actually measured after the home health admission, but weight can be entered based on hospital discharge paperwork documented within the last 30 days? Can we ask the patient or caregiver the patient's height and/or weight?

**ANSWER 10:** The assessing clinician should measure the patient's height and weight in accordance with the agency's policies and procedures, which should reflect current standards of practice (shoes off, etc.). The assessing clinician is expected to weigh and measure the patient as part of the comprehensive assessment. Data collection for M1060 by self-report or from paperwork from another provider setting is not acceptable. If a patient cannot be weighed/measured, enter the dash value ("-") and document the rationale on the patient's medical record. A dash (-) value indicates that no information is available and/or an item could not be assessed. CMS expects dash use to be a rare occurrence.

## M1306-M1322

**QUESTION 11:** My patient spends many hours at the kitchen table with his elbows propped on the table as he eats, reads, and drinks coffee. He has developed a serum filled blister on his right elbow that I believe is a result of unrelieved pressure. The area immediately surrounding the ulcer is slightly reddened but no bruising is present.

Currently, in OASIS-C1, I would report this as a Stage 2 pressure ulcer, however we noticed in the new OASIS-C2, the definition for stage 2 has changed and excludes the word "serum" from serum filled blister. Would this wound still be identified as a stage 2 when OASIS-C2 starts?

**ANSWER 11:** The determination of whether a lesion is a pressure ulcer, or what stage a pressure ulcer should be reported as should not be determined solely by the presence of a serum-filled blister. If a serum-filled blister is caused by pressure, the area adjacent to or surrounding the intact blister should be assessed for evidence of tissue damage. If the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage (e.g., color change, tenderness, boggy or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury (sDTI) rather than a Stage 2 Pressure Ulcer. If the tissue under/around the serum-filled blister is reddened or pink, and the wound etiology is unrelieved pressure, the wound would be reported as a Stage 2 Pressure Ulcer.

**QUESTION 12:** If a pressure ulcer or a burn is covered with a skin graft, does it become a surgical wound?

**ANSWER 12:** Yes, covering a pressure ulcer with a skin graft changes it from a pressure ulcer to a surgical wound. Applying a skin graft to a burn results in a surgical wound. In either case, a donor site, until healed, would also be considered a surgical wound.

**QUESTION 13:** M1306-M1322. On SOC, the RN assesses a scar from a closed pressure ulcer. Upon further interview and assessment, the patient's family states that the patient had a pressure ulcer but they are not able to give the RN any staging information. How would this pressure ulcer be documented in M1311, Current Number of Unhealed Pressure Ulcers at Each Stage?

**ANSWER 13:** If the assessing clinician becomes aware that the patient had a full-thickness (Stage 3 or 4) pressure ulcer in the past that is now closed, the ulcer is considered healed and no longer reportable as a pressure ulcer.

**QUESTION 14:** M1311. If a patient has an unstageable pressure ulcer due to black stable eschar at SOC and during the episode it peels off and leaves an area of newly epithelialized tissue, how should this be staged at Discharge on M1311?

**ANSWER 14:** Once the full thickness pressure ulcer is completely covered with new epithelial tissue, the wound is considered healed and no longer reportable as a pressure ulcer on the OASIS.

**QUESTION 15:** M1306, M1311, M1313, M1320 & M1324. How do I categorize a pressure ulcer that has been sutured closed?

**ANSWER 15:** 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 2 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 M1311 – Current Number of Unhealed Pressure Ulcers at Each Stage, it would be reported in row D1 as Unstageable due to non-removable dressing or device.

For M1313 – Worsening in Pressure Ulcer Status since SOC/ROC, report the unstageable pressure ulcer as new or worsened if a pressure ulcer was not present in that location at the most recent SOC/ROC assessment, otherwise, do not report the unstageable pressure ulcer as new or worsened.

For M1320 – Status of Most Problematic Pressure Ulcer that is Observable, 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 Unhealed Pressure Ulcer that is Stageable, select Response “NA-Patient has no pressure ulcers or no stageable pressure ulcers” 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.

**QUESTION 16:** M1307. If the patient had a Stage 1 pressure ulcer at SOC that progressed to a Stage 2, how do we answer M1307 at discharge?

**ANSWER 16:** If a patient had a Stage 1 pressure ulcer at SOC/ROC and it advanced to a Stage 2 by discharge, Response “2-Developed since the most recent SOC/ROC assessment” would be appropriate due to the fact that the ulcer, caused by pressure, was not present as a Stage 2 at the most recent SOC/ROC assessment.

**QUESTION 17:** M1320. What is the healing status (M1320) of a pressure ulcer that presents as an intact serum filled blister?

**ANSWER 17:** An intact serum-filled blister resulting from pressure would be reported as a Stage 2 pressure ulcer, as long as examination of the area adjacent to or surrounding the blister did not demonstrate signs of tissue damage indicative of a deep tissue injury. Since Stage 2 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.

## GG0170C

**QUESTION 18:** The patients we see in our agency often sleep in a recliner and not in bed. We currently have a patient who sleeps on a mattress on the floor. The new GG0170c item is about bed mobility and describes a patient who sleeps in a bed and requires sitting at the side of the bed, with feet flat on the floor. How do we assess this new GG0170C item for our patients who do not sleep in a bed, like the ones I described? Or patients who are unable to reach the floor sitting at the bedside, due to bed height/leg length?

**ANSWER 18:** If the patient uses a recliner, sofa, or mattress on the floor as the patient’s “bed” (preferred or necessary sleeping surface), assess the patient’s need for assistance using that sleeping surface when determining ability in GG0170C - Lying to sitting on side of bed.

If the patient’s feet do not touch the floor because the patient’s feet do not reach the floor, and the patient performs the activity of getting from lying to sitting independently and safely, the patient can be scored as 06 – Independent. If the assessing clinician feels the patient is not safe sitting at the bedside without their feet on the floor and requires assist to lower the bed prior to the transfer, or to place a foot stool prior to the transfer, the patient can be scored as 05 – Setup or clean-up assistance.

Report the help that the patient needs to complete the lying to sitting transfer, understanding that in some cases, clinical judgement will be required.

**QUESTION 19:** M2001. Can we answer M2001, 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 19:** You must perform a complete drug regimen review, as defined in current OASIS Guidance Manual, M2001 Response-specific Instructions, in order to select Response "0-No - no issues found during review" or "1-Yes - Issues found during review". If elements of the drug regimen review were skipped, for example, as you stated, drug-to-drug interactions, a dash (–) should be reported, indicating the drug regimen review was not completed.

**QUESTION 20:** M2001 & M2003. 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 M2001 that there is no clinically significant problem, eliminating the need to address it in M2003 Medication Follow-up?

**ANSWER 20:** If a medication related problem is identified and resolved by the agency staff not requiring physician/physician-designee contact by midnight of the next calendar day, the problem does not need to be reported as an potential or existing clinically significant medication issue in M2001.

**QUESTION 21:** M2003. If a clinically significant medication issue is identified on a weekend, and the agency phones the physician on-call, who does respond but because he doesn’t really know the patient directs the agency to contact the primary care physician on Monday, can the clinician select Response 1 Yes – Physician or physician-designee was contacted by midnight of the next calendar day and prescribed/recommended actions were taken in response to the identified clinically significant medication issue?

**ANSWER 21:** When completing M2003, Medication Follow-up, if the physician or physician designee responds by midnight of the next calendar day and there is a resolution to the clinically significant medication issue, Response "1-Yes" should be entered. In your scenario, you describe a situation where the physician was contacted and informed of the medication issue, but the due to the contacted physician’s unfamiliarity with the patient, you were directed to contact the primary care practitioner on Monday. In cases where the physician/physician-designee recommends an action that will take longer than the allowed time to complete, then Response “1-Yes” should be entered as long as by midnight of the next calendar day the agency has taken whatever actions are possible to comply with the recommended action.



**QUESTION 22:** M2003. I am aware that in order to mark response “1 - Yes”, the two-way communication AND prescribed/recommended actions must be completed by midnight of the next calendar day after the problem was identified. Does that “next calendar day” have to be within the 5 days after the SOC? That is if the nurse finds a problem with the patient’s meds while completing the comprehensive assessment on day 5 after the SOC, and the physician is notified and the problems are resolved but not until day 6 after the SOC, (although it is within the one calendar day), can “1 - Yes” be marked on M2003?

**ANSWER 22:** M2003, Medication Follow-up, is only collected at the SOC and ROC. The item must be answered within the timeframe allowed at the SOC/ROC to ensure compliance with the Condition of Participation regarding the completion of the comprehensive assessment. If a problem is identified, the communication and completion of prescribed/recommended actions must occur by midnight of the next calendar day after identification and before the end of the allowed timeframe in order to answer "1 - Yes."

If a medication issue is identified on day 5 after the SOC, the physician is contacted by midnight of the next calendar day and responds back with a plan to resolve the problem on day 6 after the SOC, this 2-way communication could not be captured at the SOC.

*This document is intended to provide guidance on OASIS questions that were received by CMS help desks. Responses contained in this document may be time-limited, and may be superseded by guidance published by CMS at a later date.*