April 20, 2010
Linda Krulish, PT, MHS, COS-C
President
OASIS Certificate and Competency Board, Inc
850 Kaliste Saloom Road, Suite 123
Lafayette, LA  70508

Dear Ms. Krulish:
Thank you for your letter of April 6, 2010 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 the OASIS Certificate and Competency Board, Inc. (OCCB) or general posting for access by all interested parties. Thank you for your interest in and support for enhancing OASIS accuracy.

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

Cc: Robin Dowell, RN, BSN
    Nurse Consultant
    Office of Clinical Standards and Quality
Question 1: Would it be acceptable if we have the clinician complete the discharge comprehensive assessment in the home for those items that require direct observation and/or interview of the patient and then ask office-based staff to research and document those items requiring only a review of the record, (e.g., M1510 Heart Failure Follow-up, M2004 Medication Follow-up, M2015 Patient Caregiver Drug Education Intervention, M2400 Intervention Synopsis)?

Answer 1: The comprehensive assessment must be completed by one clinician. The assessing clinician responsible for completing the comprehensive assessment may work collaboratively with others in the office to complete items that are not within their scope of practice or educational preparation, e.g. components of the drug regimen review. Another individual with the qualifications necessary to gather the information may perform a record review and communicate the findings to the assessing clinician, who would be responsible for confirming and validating that non-assessment information is accurate. In these collaborative situations, it is still the single assessing clinician that will conduct the actual face-to-face assessment of the patient, and complete the comprehensive assessment after any appropriate collaboration has occurred.

Category 4b

M0080

Question 2: Can an OT establish the plan of care and perform the SOC assessment when a Medicare Advantage plan is the payer?

Answer 2: OT does not establish eligibility for the Medicare Traditional Home Health benefit. Therefore, an OT may not perform the initial assessment or complete the SOC comprehensive assessment on Medicare traditional fee-for-service (PPS) patients. Other payers, such as Medicaid, Medicare Advantage plans, or private insurers, may have different coverage guidelines that would allow OT to establish eligibility for each respective home health benefit. It will be necessary to contact the payer to find out if the Occupational Therapy discipline establishes program eligibility for that payer, to determine if OT may perform the initial assessment visit and the SOC comprehensive assessment.

M0090

Question 3: As long as the RFA 4, Recertification OASIS M0090 date is within the 5 day window, can you visit on day one and complete (M0090) any of the other days if you were still gathering data?

Answer 3: Per the Condition of Participation, 484.55, the agency must perform a comprehensive assessment of the Medicare patient every second calendar month beginning with the start of care. The time period for the RFA 4, Recertification, has been
further clarified in a number of references, Category 3 CMS OASIS Q&As, OASIS Assessment Reference Sheet, to mean the last 5 days of every 60 days, i.e. days 56-60 of the current 60-day period. A clinician may start the comprehensive assessment on day 56 and complete it on any day on or before day 60. Only one clinician may complete a comprehensive assessment though, so if Nurse A begins it on day 56, Nurse A must be the clinician who completes it.

**M0104**

**Question 4:** When completing M0104, Date of Referral, can we use the date of actual authorization from the Medicare Advantage plan rather than the date of referral from the inpatient facility or the MD office?

**Answer 4:** M0104, Date of Referral, reports the date the agency received authorization from the physician to initiate or resume home care services. The authorization may come directly from the physician, or on the physician's behalf through the hospital or SNF discharge planner. It is not the date authorization was received from the patient's payer. To address your question specifically, the date the Medicare Advantage case manager authorized service is not considered a referral date.

**M1010**

**Question 5:** If a patient is hospitalized (or in a SNF) and is given his/her routine medications BUT some of those medications are for diagnoses that are not the reason for the hospitalization, are the diagnoses for which the routine meds are given considered as being "treated" during the stay. For example: the patient is admitted to the hospital for surgery. While in the hospital, he is given his routine medication for HTN, atrial fib, GERD, etc. Should those dx be listed at M1010?

**Answer 5:** When completing M1010, Inpatient Diagnoses, only include the diagnoses actively treated during the inpatient facility stay within the past 14 days, not all the diagnoses the patient may have. "Actively treated" should be defined as receiving something more than the regularly scheduled medications and treatments necessary to maintain or treat an existing condition. In the scenario you provided, Hypertension would not be included in M1010 if the patient only received their maintenance dose of antihypertensive.

**M1045**

**Question 6:** Our agency does not provide flu shots. They are readily available in the community – so most of our patients have received from another health care provider (Response #1). If a patient has declined/refused a flu shot in the community – is the correct answer #3 - Offered and declined, (though not offered by our agency); or is it #7 – None of the above, with explanation since our agency was not the health care provider offering the flu shot.

**Answer 6:** When completing M1045, Response 3-Offered and declined is appropriate if the patient or their healthcare proxy refuses the vaccine. It is not required that your agency offered the vaccine, just that the patient was offered the vaccine and they refused.
**Question 7:** If our agency immunized a patient during a mass immunization provided at an ALF or other setting can we report it in M1045 even though the residents were not registered members of our HHA at the time of immunization.

**Answer 7:** If you gave a current home health agency patient a flu shot during a previous roster billing situation during this year’s flu season, then Response "2-Received from your agency previously during this year's flu season" would be appropriate when completing M1045, Reason Influenza Vaccine not received.

**M1240**

**Question 8:** Do all the OASIS pain items refer to severe pain? If not, how are they different?

**Answer 8:** The home care clinician assesses for and is concerned about any and all pain the patient experiences. All pain is documented in the clinical record and addressed in the plan of care. Remembering that the OASIS items are just a part of the comprehensive assessment for patients who require data collection helps to put all the OASIS items and their focused data collection into perspective.

M1240, Pain Assessment, is assessing if the patient had a formal pain assessment during the allowed assessment time period utilizing a standardized pain assessment tool, as defined in Chapter 3 of the OASIS-C Guidance Manual. The response options then report either “No” that the standardized assessment was not conducted or “Yes” that the assessment was conducted and whether it indicated severe pain or not.

When answering M2250, Plan of Care Synopsis, Row e, the assessing clinician is reporting whether the physician ordered plan of care included interventions to monitor and mitigate pain, any pain, not just severe pain. ‘NA” is an option if the comprehensive assessment, not necessarily the formal assessment, revealed the patient had no pain. “Yes” or “No” can be selected for M2250 based solely on the presence or absence of interventions on the physician ordered plan of care to monitor and mitigate pain, regardless of whether or not the patient was assessed for pain. “NA”, however, may not be selected unless the patient was assessed to have no pain. Therefore, if orders are included on the POC that address both the assessment and plans for mitigation of pain, M2250 may be answered as “yes”, even though the comprehensive assessment did not reveal any pain.

When answering M2400, Intervention Synopsis, Row d, the same principles apply except for two major differences. First, you may not select “NA” unless the formal pain assessment utilizing a standardized tool as defined in M1240 was conducted at the time of or since the last OASIS assessment and it revealed no pain. Second, in order to answer “Yes” or “No”, the orders to monitor and mitigate the pain not only have to be present, but there must be evidence in the clinical record that they were implemented.

**Question 9:** Is the intention of M1240 – Pain Assessment to identify whether a clinically significant pain is present at the time the pain assessment is conducted regardless of the activity level at the time (i.e., using a numeric pain scale ask the patient to rate his pain this moment) or the presence of clinically significant pain on the day of assessment (i.e., using a numeric intensity pain scale, ask the patient to rate his pain on the average for the day of assessment)?
Answer 9: M1240 - Pain Assessment, reports if the patient had a formal pain assessment during the allowed assessment time period utilizing a standardized pain assessment tool, as defined in Chapter 3 of the OASIS-C Guidance Manual. The response options then report either “No” that the standardized assessment was not conducted or “Yes” that the assessment was conducted and whether it indicated severe pain or not, at the time of the standardized assessment, per the assessment's scale and the Ch. 3 Response-Specific Instructions. The response selected is not necessarily a reflection of an average or summary of the pain experienced on the day of assessment.

The home care clinician assesses for and is concerned about any and all pain the patient experiences. All pain is documented in the clinical record and addressed in the plan of care. Remembering that the OASIS items are just a part of the comprehensive assessment for patients who require OASIS data collection helps to put all the M items and their focused data collection into perspective

M1310/1312/1314

Question 10: How do we measure a pressure ulcer if the wound lies on a slant? Is it literally from head to toe no matter what? If that is true, our measurement may not include longest and widest parts of wound.

Answer 10: For the purposes of completing M1310/1312/1314, identify and report the longest head-to-toe measurement and the longest measurement perpendicular to the head-to-toe measurement. You may choose to include other measurements in your clinical documentation, for situations where the OASIS requirement does not meet your needs.

M1324

Question 11: What is the stage of an unstageable pressure ulcer that is a suspected deep tissue injury (SDTI) in evolution?

Answer 11: Until the SDTI evolves and opens, the Stage will be considered NA, as the wound bed cannot be visualized.

M1342

Question 12: I am confused by one of the CMS OASIS Q&As. The answer to Q105.3 states that an implanted venous device is considered a surgical wound until it has been epithelialized completed for 30 days at which time it becomes a scar. The next sentence of the answer says that the site is considered a surgical wound as long as the device is in place. Can you clarify this?

Answer 12: An implanted venous access device is considered a current surgical wound as long as it is implanted in the patient's body.

When first implanted, the incision is the surgical wound. The assessing clinician will follow the 12/09 WOCN guidance to determine the healing status of the incision. Once it is fully epithelialized, the site due to the implanted device will remain a current surgical wound with a status of "Fully epithelialized" for as long as it is present in the patient's body, unless it later develops complications. This guidance clarifies and supersedes CMS OASIS Q&A Category 4b, Q105.3.
Question 13: In reference to M1342, Status of Most Problematic (Observable) Surgical Wound, for surgical incisions healing by primary intention is it true that the only correct responses are “0-newly epithelialized” and “3-Not healing” as there are no open wound beds with granulation tissue?

Answer 13: Surgical incisions healing by primary intention do not granulate. Because of this the only response that could be appropriate for a surgical wound healing by primary intention would be 0-Newly epithelialized or 3-Not healing. “Newly epithelialized” should be chosen if the surgical incision has epidermal resurfacing across the entire wound surface, and no signs/symptoms of infection exist.

Question 14: How do I mark the healing status of a Q-port that has needle access always in place? Would it be “non-healing”?

Answer 14: The assessing clinician must determine the healing status of a wound following guidance in Chapter 3 of the OASIS-C User’s Manual and the latest version of the WOCN’s OASIS Guidance Document. Some sites, because they are being held open by a line or needle, cannot fully granulate and may remain "non-healing" while the line or needle is in place.

M1350

Question 15: How do I answer M1350 if a patient is admitted with CHF, has no edema at SOC, but we include a plan to monitor for edema and s/s of CHF during the episode of care. Edema is considered a skin lesion or open wound. At discharge, the patient once again does not have any edema. Item intent states: “Identifies the presence or absence of a skin lesion or open wound NOT ALREADY ADDRESSED IN PREVIOUS ITEMS that is receiving clinical assessment or intervention from the home health agency.” At discharge is there ever a time when you WOULD answer this question “YES”?

Answer 15: M1350 is reporting if the patient has a skin lesion or open wound that is receiving intervention by the home health agency (other than those previously described in the pressure ulcer, stasis ulcer and surgical wound items, excluding bowel ostomies).

If there are no wounds or lesions receiving intervention on the day of the Discharge Assessment, the correct response to M1350, Skin Lesion or Open Wounds, would be "No". In the scenario you provided above, the M1350 response would be "No" because the patient did not have a lesion that required assessment. The clinician was monitoring for the potential development of edema (which is considered a lesion), but the patient never developed the lesion, therefore the patient did not HAVE a lesion that required intervention from the agency.

M1350 could be answered "Yes" at Discharge. It is possible, that a patient discharged from the agency received (on the day of the Discharge assessment), intervention(s) for a wound that was not described in a previous OASIS wound item, e.g. a patient is being discharged as they are no longer home bound and had burn wounds requiring home health intervention on the day of assessment.

M1500

Question 16: How do we answer M1500 and M1510 if our patient has a diagnosis of Heart Failure, but the clinician believes the patient’s dyspnea is related to pneumonia?
**Answer 16:** M1500, Symptoms in Heart Failure Patients, is intended to report whether or not a patient with a diagnosis of heart failure exhibited symptoms of heart failure at the time of or since the previous OASIS assessment. Dyspnea is a symptom of heart failure and while it may also be a symptom of another co-existing disease process, such as pneumonia, it would still be reported in M1500 and M1510, Heart Failure Follow-up, if the patient has a diagnosis of heart failure.

**Question 17:** Explain the response “Not assessed” and give an example of when it might be used when completing M1500.

**Answer 17:** When completing M1500, Symptoms in Heart Failure Patients, the response "Not assessed" means the patient with a diagnosis of heart failure was not assessed for symptoms of heart failure at the time of or since the previous OASIS assessment. This would not be a best practice. As stated in the Item Intent, the best practices/assessments stated in the item are not necessarily required in the Conditions of Participation.

An example of when "Not assessed" would be used would be a situation where the assessing clinician is completing a Transfer OASIS on a heart failure patient shortly after recertification, where CHF was not the focus of care, and there is no evidence in the clinical record that an assessment of lung sounds, weight gain, dyspnea, orthopnea or lower extremity edema was performed at the time or since the recertification. Another example: a patient with CHF is admitted to the hospital and discharged with a new diagnosis such as hip fracture. The ROC visit and next visit focused on interventions related to the hip fracture, and no documentation of the heart failure assessment. Patient is unable to remain in the home and is transferred to a SNF. No CHF assessment between ROC and Transfer would mean that M1500 at Transfer would be "2-Not assessed".

**M1730**

**Question 18:** We are seeking clarification about the PHQ2 depression screening tool and whether it can be used in certain situations. Instructions for PHQ2 imply that screening entails interview of the patient. However, the “Specific Instructions” in the OASIS manual state: “depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or other.”

1. Is it acceptable to use the PHQ2 to screen for depression by asking the questions of a caregiver if the patient is unable to respond to the two questions?

2. Is it acceptable for the home health clinician to complete the PHQ2 based on observations if the patient is unable to respond to the two questions?

**Answer 18:** No, it is not acceptable to use the PHQ-2 to screen for depression by asking the questions of a caregiver, or to respond to the two questions based on clinician observations. The PHQ-2 tool is a standardized, validated screening tool in which the patient is the source of report. The PHQ-2 instructions clearly define how the tool should be administered. The clinician is to ask the patient a specific question related to two problems. The information may also be self-reported, precluding the need for the interview.

When evaluating the patient, the clinician must first assess whether the PHQ-2 is the
appropriate depression screening tool. If the PHQ-2 is appropriate (the patient appears to be cognitively and physically able to respond), then the instrument may be used. If, however, the clinician is then unable to elicit responses to either of the PHQ-2 questions from the patient during the assessment, the clinician can report in M1730 that the PHQ-2 was administered (Response 1), and select N/A - unable to respond.

If the PHQ-2 is not appropriate due to limitations such as cognitive status or communication deficits, the clinician may choose to administer a different standardized depression screening tool with instructions that may allow for information to be gathered by observation and caregiver interview as well as self-report. In this case, the clinician would select Response 2 or 3 for M1730, depending on the outcome of the assessment. If the clinician chooses not to assess the patient (because there is no appropriate depression screening tool available or for any other reason), Response 0, “No” should be selected.

Note that patients who have been assessed as “unresponsive”, based on M1710, When Confused and/or M1720, When Anxious, will not be included in the process measure for depression screening.

**M1840 & M1850**

**Question 19:** Regarding M1840 Toilet Transferring– Response 1 (reminded, assisted, or supervised by another person) & M1850 Transferring– Response 1 (minimal human assistance or with assistive device), what exactly do the terms “assisted” & “minimal human assistance” mean? In the therapy world, minimal assistance means the caregiver must provide less than 25% of the effort required to assist the patient in completing the task safely. Is this what the clinician is suppose to look at or could minimal human assistance mean verbal cueing or stand by assist only?

**Answer 19:** The OASIS-C Guidance Manual, Chapter 1, Conventions explains "When an OASIS item refers to assistance, this means assistance from another person unless otherwise specified within the item. Assistance is not limited to physical contact, but includes both verbal cues and supervision."

When completing M1840, Toilet Transferring, if the patient requires any degree of hands-on assistance and/or standby assistance and/or verbal cueing/reminders to get to/from the toilet and/or transfer on/off the toilet safely, select Response 1. An example of Response "1" could be a patient who requires verbal cues regarding safe use of walker while ambulating to the toilet.

When completing M1850, Transferring, minimal human assistance referenced in Response 1 would include a minimal degree of any combination of verbal cueing, environmental set-up and/or actual hands-on assistance. In order for the assistance to be considered minimal, it would mean the individual assisting the patient is contributing less than 25% of the total effort required to perform the transfer.

An example of Response "1" could be a patient that requires hands-on assistance during the change in position from supine to sitting at the edge of bed, where the effort contributed by the individual assisting is less than 25% of total effort required to change position.
**M1910**

**Question 20:** Some agencies are using the Missouri Alliance for Home Care (MAHC) fall risk assessment (10 points total/a score of 4 means fall risk) in combination with the TUG. If a patient scores a 4 or more on MAHC’s Fall Risk which indicates a risk for falls and scores as a "no or low risk" on the TUG test – should the patient be considered at risk for falls?

**Answer 20:** Since the validated standardized test (the Timed Up and Go or “TUG”) shows the patient is not at risk, they are considered to be not at risk. The OASIS-C Guidance Manual Chapter 3, M1910 Response Specific Instructions state you are to score based on the results of the standardized test. While the MAHC tool (Home Care Fall Reduction Risk Assessment Tool) is standardized, it is not validated at this time, so it would be impossible to know if the cutoff point included in the tool is a valid threshold for fall risk. If it were a matter of two validated, standardized tests being in conflict, an “at risk” score on either tool would indicate the presence of fall risk. As a provider, even though the standardized test revealed no risk, you may want to look at what caused them to score “at risk” on the MAHC and intervene in those areas.

**Question 21:** If an agency adds the TUG to a multifactor fall risk assessment, can the agency decide on how to administer the tool by selecting any one of the many publicly available administration protocols?

**Answer 21:** The CMS requirement is that a standardized validated assessment is used, which would include use of the accompanying validated protocol for administration, including any validated protocol or scoring variations.

**Question 22:** I’m looking for guidance related to answering M1910 in a patient who is nonambulatory, bedbound and/or cognitively impaired. Would it be appropriate to use a standardized, validated tool that measures cognition or another factor of falls risk, such as the Folstein Mini-Mental Status Exam or the Gloth Frail Elderly Functional Assessment questionnaire, instead of the Tinetti, Functional Reach or Timed Up and Go, which aren’t appropriate in this population?

**Answer 22:** For an assessment tool to meet the criteria for a “yes” response on M1910, the assessment would need to have been validated as a tool that specifically measures risk for falls. If the patient is not able to participate in tasks required to allow the completion and scoring of the assessment(s) that the agency chooses to utilize, “0 – No multi-factor fall risk assessment conducted” should be reported. The agency should be aware there are a number of validated fall risk assessment tools, some which allow the use of assistance, assistive devices, and even provide risk assessment options for non-ambulatory patients. A single tool may not meet the fall risk assessment needs of all patients in the agency.

**Question 23:** How do we handle M1910, Fall Risk Assessment, for the patient who is ambulatory at home on their own, but based on clinician judgment, appears to require assistance to ambulate in order to be SAFE. For example, we know the patient is at risk for falls and balance is precarious enough that the clinician needs to guard the patient during the assessment. Should the clinician ask the patient to complete the TUG regardless and use the fact that they require assist of another person to complete the
test to claim “Yes” on M1910 - standard test completed and indicated risk for falls even if they completed in < 14 seconds, or should we report “No” to M1910, formal assessment not completed, and document that the patient could not safely participate in the assessment. We are afraid to answer No, because the patient is not safe or at best marginally safe to perform the test, concerned it will negatively impact our process measure outcomes for this item.

Answer 23: The CMS requirement is that a standardized validated assessment is used, which would include use of the accompanying validated protocol for administration, including any validated protocol or scoring variations. If the patient is not able to participate in tasks required to allow the completion and scoring of the assessment(s) that the agency chooses to utilize, “0 – No multi-factor fall risk assessment conducted” should be reported. The agency should be aware there are a number of validated fall risk assessment tools, some which allow the use of assistance, assistive devices, and even provide risk assessment options for non-ambulatory patients. A single tool may not meet the fall risk assessment needs of all patients in the agency.

M2020

Question 24: The patient is on multiple medications which span 3 times a day. Yesterday, the doctor started her on a varying dose of Prednisone. The patient admits to being confused about the directions and right dosage. The clinician observes that the med box the patient set up is filled correctly with all usual medications, but not correctly with the prescribed Prednisone administration. The clinician also notes that the medication for last evening remained in the pill planner. Upon questioning, the patient admits to being tired and forgetting to take her evening medication. The clinician discusses the use of an alarm clock to remind her to take her evening medication and fixes the Prednisone dosage for the rest of the week. Considering this patient needed help with setting up one medication (Response 1) and a reminder for another (Response 2) in the last 24 hrs, what is the correct scoring with rationale for this situation?

Answer 24: The patient you described would be scored a "3-Unable to take medication unless administered by another person because on the day of the assessment, the patient did not possess the ability to take the Prednisone at the correct time and dose and demonstrated that through her report and actions. The pill planner had not enabled her to take the medications as ordered and a reminder could not have enabled the patient to take a medication when she didn't have any idea what time and dose she needed to take the medications.

Rationale: First, note you are to report your patient's ability on the day of the assessment (24 hours prior to the visit, and the time while in the home) and if ability varied, you report what was true regarding the medication that required the most assistance during that timeframe. This would mean you would not report ability after skilled intervention, as this is not a reflection of what was true in the most dependent medication during the day of assessment.

Many factors impact a patient's ability to take all medications safely and reliably at the correct dose and time on the day of assessment, including physical and mental/emotional/cognitive status, activities permitted, and environment. Another
imperative component is the required knowledge of the drug's dose and administration schedule. A patient who does not possess this knowledge, does not have the ability to take the correct dose at the correct time as they lack the required education, unless other compensatory mechanisms have been placed in the home and assessed to be successful. A patient who does not have the requisite knowledge and no existing compensatory mechanisms would be scored a "3" until after they received the required education and demonstrated to the clinician that they were able to take ALL medications at the correct dose and time or until the clinician has introduced an assistive device, such as a pill planner, and the patient has demonstrated success at taking meds as ordered, at all times.

**Question 25:** Please further explain and provide examples for M2020 Response 3.

**Answer 25:** Response 3, unable to take medication unless administered by another person, describes a patient who does not have the physical or cognitive ability on the day of assessment to take all their medications at the correct dose every time it is ordered to be administered, and it has not been established (and therefore the clinician cannot assume) that set up, diary, or reminders have already been successful. The clinician would need to return to assess if the interventions, such as reminders or a med planner were adequate assistance for the patient to take all medications safely, so therefore, Response 3 would be appropriate until this is known.

Some examples of Response 3, (but not a finite list) include:
- A patient who decided not to take her new medications, because the varying doses worried her, and she was unsure of the instructions. There had not been a med-set up, nor reminders tried. The clinician would select Response 3 because it is unclear until reassessment if the interventions will be successful.
- A patient who, upon assessment, was not able to take prescribed medications at the correct time and doses even though reminded.
- A patient who, on the day of assessment, was prescribed oral medications, but was unable to safely swallow.

**M2030**

**Question 26:** If we give a physician ordered one-time influenza vaccination and the patient does not have any injectable medications otherwise, is the answer to M2030 NA or #3.

**Answer 26:** If there is an order for the patient to receive the influenza vaccine SQ in the home, it would be included when responding to M2030, Management of Injectable Medications, even if it was a one-time injection. Anytime the physician has ordered the RN to administer an injection, the patient's ability would be reported as a "3-Unable to take injectable medication unless administered by another person." as you must report the patient's ability to inject the medication for which the most assistance is needed and an order for the RN to administer the injection is viewed as a medical restriction, preventing the patient from self administering.
M2100

Question 27: When completing M2100 for a patient with a Foley catheter, what areas, under type of assistance, should be considered?

Answer 27: The types of assistance that a Foley catheter patient might need may be captured in multiple rows in M2100, Types and Sources of Assistance, as described below:

- **a-** ADL assistance as part of toileting hygiene? - Examples: cleansing around the catheter/peri care
- **d-** Medical procedure? Examples: insertion/removal of catheter, e.g. self cath or intermittent catheterization
- **e-** Management of equipment? - Examples: emptying the bag, changing the bag

Note that if a patient needs assistance with multiple tasks included in one of the broad categories of assistance, the response selected should be based on the area requiring the most need.

Question 28: Do the responses for M2100, Types and sources of assistance, reflect the patient’s needs on the day of assessment or another time period, like the recent past?

Answer 28: When completing M2100, Types and Sources of Assistance, at the SOC/ROC, the assessing clinician will determine, to the best of his/her ability through observation and interview, what is known on the day of assessment regarding the availability and ability of caregivers to provide help in the various categories of assistance for the upcoming episode of care. For example, if Monday is the day of assessment and the patient reports her son pays her bills and brings in groceries every Friday. Even though the assistance will not be provided until Friday, the assistance is reported, as it is the anticipated availability and ability of caregiver assistance. At Discharge, the assessing clinician is reporting what is known on the day of assessment regarding the availability and ability of caregivers to provide assistance to the patient at the time of the discharge.

Question 29: When answering M2100 b, our clinicians often answer “1” - Caregivers currently provide assistance, based on the patient’s “greatest need” for assistance with housekeeping and/or shopping.

Please confirm if “0” is the correct response for M2100 b in situations where the patient is independent with eating, planning/ prep meals and phone use – as documented in OASIS Assessments M1780 (Feeding/Eating) = “0” (independent) and M1880 (Plan/Prep Meals) = “0” (independent) and M1890 (Phone use) = “0” (independent).

We are having a problem with agency computer system not allowing us to enter “1” response to M2100 when M1780, M1880 and M1890 are all assessed as “0”. This seems contradictory to clinical guidance.

Answer 29: For M2100b, IADL assistance, if more than one response applies, you are to report the response that reflects the patient's "greatest need". In your example, the patient needs help with housekeeping and/or shopping, and with these needs met by the caregivers, the response should be "1" "Caregivers currently provide assistance". Software vendors can add edits or flags in the comprehensive assessments to aide clinicians in their consistency of data collection. An edit in the instance you described...
may be an appropriate warning, directing the clinician to confirm the response selected, but should still allow the clinician to still choose Response "1" when appropriate. You are encouraged to contact your software vendor in cases where provided edits are questionable.

M2110

Question 30: Will the answer to M2110 always correlate to the M2100 Types and Sources of Assistance response? For example, if a patient needs assistance with ADLs and IADLs but the caregiver is unable/unwilling to assist with bathing and medications, would the scoring be based on the items that the patient needs the most assistance with but the caregiver is unable/unwilling to provide or would it be based on what assistance the caregiver provides regardless of patient need?

Answer 30: M2100, Types and Sources of Assistance, reports the source of assistance in a number of broad categories of activities (including ADLs, IADLs, Medication administration, Equipment Management, etc.) M2110, Frequency of Assistance, only addresses ADLs and IADLs, and provides more specific information related to the frequency with which assistance is provided for these broad tasks. You are correct that in M2100 you report the response that represents the most need and the availability and ability of the caregiver to meet that need. In M2110, simply report the frequency that the patient receives assistance with any ADLs/IADLs. Because of the different approaches with these items, a logical "tie" between the two may not always be apparent.

M2250

Question 31: Regarding the physician-ordered plan of care, when documenting that orders were obtained in the Plan of Care Synopsis, is it acceptable to incorporate the general wording of the current process measures into the plan of care or are orders expected to be more specifically documented? (e.g. SN to monitor and mitigate pain, instruct on fall prevention measures, etc.)

Answer 31: When completing M2250, Plan of Care Synopsis, it is not required that you include the exact words used in the M2250 item, just that interventions representing the specified best practice be included in the physician-ordered plan of care. In some cases, if all you included were the exact words, it would not meet the requirements. For example, if the order read “Monitor and mitigate pain”, the phrase “mitigate pain” would not be a specific intervention that could be followed in an effort to relieve pain. It would be expected that an order for a specific intervention be included, e.g. Tylenol 500 mg q6h, teach guided imagery techniques to relieve pain, etc. However, in other cases, using the exact words from the M item would suffice, e.g. “Monitor lower extremities for lesions and teach patient/caregiver proper diabetic foot care.”

Question 32: When referring to the plan of care in M2250, are you just referring to the original Plan of Care (e.g. 485) or are you referring to Interim Physician orders that are sent during the episode as well?

Answer 32: The physician plan of care includes all additional orders as an extension of the original Plan of Care.
**Question 33:** Please clarify the timeframe allowed for completing M2250 at the ROC. Chapter 3, Response-Specific Instructions reference “the 2-day ROC window”. Is that within 2 days of the ROC date, M0032, as our OASIS data specs allow or within 2 days of the patient's discharge from the inpatient facility?

**Answer 33:** When completing M2250 at the ROC, orders for the specified best practices must be obtained within 2 calendar days of the patient's discharge from the inpatient facility, or within 2 calendar days of knowledge of the patient's return home in order to answer "Yes".

**M2250a**

**Question 34:** I am confused about when I will pick NA for M2250a.

**Answer 34:** When completing M2250a - Patient-Specific parameters, at the Start of care or Resumption of the Care, the clinician will answer:

- "Yes" if the plan of care includes specific parameters ordered by the physician for this specific patient or after reviewing the agency's standardized parameters with the physician, s/he agrees they would meet the needs of this specific patient.
- "No" if there are no patient specific parameters on the plan of care and the agency will not use standardized physician notification parameters for this patient.
- "NA" if the agency uses their own agency standardized guidelines, which the physician has NOT agreed to include in the plan of care for this particular patient.

**M2250g; M2400f**

**Question 35:** For M2250g - Plan of Care Synopsis and 2400f – Intervention Synopsis, Is a protective skin barrier considered a moist wound treatment for a pressure ulcer? Can you provide specific examples of moist wound healing treatments for pressure ulcers?

**Answer 35:** Moist wound healing treatment is basically any primary dressing that hydrates or delivers moisture to a wound thus promoting an optimal wound environment and includes films, alginates, hydrocolloids, hydrogels, collagen, negative pressure wound therapy, unna boots, medicated creams/ointments. CMS cannot provide you with specific products.

**Question 36:** For M2250g – Plan of Care Synopsis and M2400 – Intervention Synopsis, may I answer "Yes" if either the physician ordered plan of care has orders for pressure ulcer treatments based on the principles of moist wound healing, OR if I requested these orders from the physician, but s/he refused to agree to them or have not been established yet?

**Answer 36:** M2250, Plan of Care Synopsis, Row g. may be answered "Yes" if, by the end of the allowed assessment time period (5 days after SOC date/2 days after inpatient facility d/c for ROC) the physician-ordered plan of care includes orders for pressure ulcer treatment based on the principles of moist wound healing. The assessing clinician may also answer "Yes" in cases where the moist wound healing treatment was requested of the physician, by the end of the allowed assessment time period. It would not be required that the response from the physician be obtained in order to qualify as a "Yes". If the physician response is "No, moist wound healing is not appropriate for this patient” NA would be the correct response.
The parallel item in M2400 does not offer any option that an order for treatment using principles of moist wound healing was requested from the MD. So at M2400 if the MD does not order treatment based on principles of moist wound healing, "no" must be reported on line f unless the patient meets the criteria listed to mark NA.

**Question 37:** Is it the clinician's clinical decision or the physician's that will determine the patient has no pressure ulcers with need for moist wound healing at M2250 and M2400?

**Answer 37:** A physician ordered plan of care means that the patient condition has been discussed and there is agreement as to the plan of care between the home health agency staff and the physician. The clinician would discuss the patient's pressure ulcers with the physician and not make the decision regarding appropriate treatment alone. While clinicians caring for patient with pressure ulcers may be cognizant of wound care guidelines for pressure ulcer management and understand that certain pressure ulcers are not appropriate for moist wound healing, each patient status is to be discussed with the physician who ultimately makes all treatment plan decisions. When it is determined by the clinician/physician team or solely by the physician that moist wound healing is not appropriate for the patient, the response "NA" would be chosen, and the clinician would then document the rationale behind not utilizing the moist wound healing techniques.

**M2400**

**Question 38:** Please clarify the use of the “NA” response option in M2250 rows c-f, and M2400 rows b-e, specifically when the previous/most recent assessment was a Recert assessment, where items related to pain, pressure ulcers, depression and fall risk assessment are not collected. The Chapter 3 guidance states this: "For rows b-e, a formal assessment (as defined in the relevant OASIS item M1240, M1300, M1730, and M1910) must have been performed to select "Not Applicable." My question is then if the recert assessment did not contain these fields, am I correct to assume that the answers for each row would be "No", and not “NA”.

**Answer 38:** When collecting OASIS data at transfer or discharge where the most recent assessment was a recertification, M2400 rows b-e do not necessarily need to be reported at “No” because the formal assessments for pain, pressure ulcers, depression and fall risk are not collected on the Recert assessment. The clinician may have conducted a formal assessment either at the recert time point, or since that time, indicating that the patient was not at risk for falls (or did not have pain, etc.), in which case “NA” might be the appropriate response, depending on all other available information.

The following two flowcharts guide M2250 and M2400 decision making:
Determining Response for M2250 C – F at SOC/ROC
Definitions of FORMAL assessment are found in M1240, M1300, M1730, and M1910. An evaluation of clinical factors is not considered a formal assessment for pressure ulcer risk.

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Determine whether a formal or informal assessment was completed during the timeframe the SOC/ROC assessment was completed.</td>
</tr>
<tr>
<td>2</td>
<td>If no formal or informal assessment was conducted, determine whether interventions were included in the physician-ordered Plan of Care.</td>
</tr>
<tr>
<td>3</td>
<td>If no interventions were included in the physician-ordered Plan of Care, the M2250 response is NO.</td>
</tr>
<tr>
<td>4</td>
<td>If interventions were included in the physician-ordered Plan of Care, the M2250 response is YES.</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>If a formal or informal assessment was conducted, determine whether one or more of the assessments were positive.</td>
</tr>
<tr>
<td>Step</td>
<td>Action</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td>10</td>
<td>If one or more of the assessments were positive, determine whether interventions were included in the physician-ordered Plan of Care. If no interventions were included in the physician-ordered Plan of Care, the M2250 response is NO. If interventions were included in the physician-ordered Plan of Care, the M2250 response is YES.</td>
</tr>
<tr>
<td>11</td>
<td>If one or more of the assessments were not positive, the M2250 response is NA.</td>
</tr>
<tr>
<td>12</td>
<td>If one or more of the assessments were not positive, the M2250 response is NA.</td>
</tr>
</tbody>
</table>
Determining Response for M2400 B – E at TRF/DC

Definitions of FORMAL assessment are found in M1240, M1300, M1730, and M1910. An evaluation of clinical factors is not considered a formal assessment for pressure ulcer risk.

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Determine whether a formal assessment was completed at or since the last OASIS assessment was completed.</td>
</tr>
<tr>
<td>2</td>
<td>If no assessment was conducted, or only informal assessments were conducted, determine whether interventions were included in the physician-ordered Plan of Care and whether those interventions were implemented.</td>
</tr>
<tr>
<td>3</td>
<td>If interventions were included in the physician-ordered Plan of Care and implemented, the M2400 response is YES.</td>
</tr>
<tr>
<td>4</td>
<td>If no interventions were included in the physician-ordered Plan of Care and implemented, the M2400 response is NO.</td>
</tr>
<tr>
<td>5</td>
<td>Yes, one or more FORMAL assessment(s) conducted.</td>
</tr>
<tr>
<td>6</td>
<td>M2400 Response = NO</td>
</tr>
<tr>
<td>7</td>
<td>M2400 Response = YES</td>
</tr>
<tr>
<td>8</td>
<td>M2400 Response = NO</td>
</tr>
<tr>
<td>9</td>
<td>Yes, one or more FORMAL assessment(s) conducted.</td>
</tr>
<tr>
<td>10</td>
<td>Were one or more of the formal assessments positive?</td>
</tr>
<tr>
<td>11</td>
<td>Yes</td>
</tr>
<tr>
<td>12</td>
<td>No</td>
</tr>
<tr>
<td>13</td>
<td>M2400 Response = NA</td>
</tr>
</tbody>
</table>

*Definitions of FORMAL assessment are found in M1240, M1300, M1730, and M1910. An evaluation of clinical factors is not considered a formal assessment for pressure ulcer risk.
<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>If one or more formal assessment(s) was conducted, determine whether one or more of the formal assessments were positive.</td>
</tr>
<tr>
<td>10</td>
<td>If one or more of the formal assessment(s) was positive, determine whether interventions were included in the physician-ordered Plan of Care and implemented.</td>
</tr>
<tr>
<td>11</td>
<td>If no interventions were included and implemented, the M2400 response is NO.</td>
</tr>
<tr>
<td></td>
<td>If interventions were included and implemented, the M2400 response is YES.</td>
</tr>
<tr>
<td>12</td>
<td>If one or more of the formal assessments were not positive, the M2400 response is NA.</td>
</tr>
</tbody>
</table>
**M2310**

**Question 39:** OASIS-C reflects changed wording for the Emergent Care Reason Response 2 - Injury Cause by Fall. OASIS B-1 previously indicated Injury Caused by Fall or Accident at Home in answer 3 (M0840). When reviewing the response-specific instructions in Chapter 3 for M2310 an example is given indicating a fall at home. Is the intent of M2310 Response 2 for all falls or falls at home?

**Answer 39:** M2310, Response 2 “Injury caused by fall” is no longer restricted to a fall at home. It should be selected when the patient sought care in the emergency room for an injury caused by any fall, anywhere, e.g. while at home, at the physician's office, church, etc. The home health agency should educate the patient and caregiver on fall prevention measures applicable to any location where the patient may be. The home health agency is responsible for preparing the patient for safety and function after discharge.

**M2420**

**Question 40:** For M2420, if the patient is discharged home and the family has arranged for a paid caregiver that is not through a private duty agency, is this a "formal assistive service" or "without formal assistive service"?

**Answer 40:** The "formal assistive services" referenced in Response options 1 and 2 refer to those services provided through organizations or by paid helpers. Examples: Personal care services provided by a home health agency, paid assistance provided by an individual, meals provided by Meals on Wheels.

Informal services are provided by friends, family, neighbors, or other individuals in the community for which no financial compensation is provided. Examples: Assistance with ADLs provided by a family member, transportation provided by a friend, meals provided by church members (i.e., meals not provided by the church organization itself, but by individual volunteers).