DEPARTMENT OF HEALTH & HUMAN SERVICES
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Survey and Certification Group

October 21, 2008
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 September 29, 2008 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 future updates to the CMS Q&As posted at https://www.qtso.com/hhadownload.html, and/or in future revisions to the OASIS User Manual, Chapter 8, 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: Debora A Terkay, RN, MS
Office of Clinical Standards and Quality

CMS OCCB Q&As – October 2008

CATEGORY 2 – Comprehensive Assessments

Unplanned DC and Collaborating on an OASIS

Question 1: For unexpected discharges, I understand that it is necessary to complete the DC OASIS assessment (RFA 9) "based on the last visit made"...since it is not possible to do an actual assessment. Is the same true when the physician places the patient on hold mid-episode pending further orders, but at end of episode - gives no further orders?

a. Would the "patient status" items be completed at the end of the episode without an actual patient visit but based on the last patient visit?
b. Would items referring to the "last 14 days" (M0200, M0210, M0220 & M0510) be completed at the end of the episode based on actual DC end of episode date, or 14 days prior to the last actual visit?
c. Would M0090, Date Assessment Completed, be the end of episode discharge date?
d. Would M0903, Date of last (most recent) home visit, be different than M0906, DC Date?

Completion of the Discharge OASIS in this case might take a "collaborative" effort between supervisors and field personnel, but as long as one person signs the OASIS and is responsible for accuracy, would we be compliant?

Answer 1: Only one person can complete an assessment, it is not a collaborative effort between field staff and supervisors. When a clinician signs the assessment, it is an attestation that the data contained in the assessment is accurate and based on the clinician's assessment. If more than one clinician contributed to the assessment, it would not be likely that the signing clinician actually personally assessed and knows the accuracy of every data element.

If a physician places the patient on hold mid-episode and then there is an unexpected discharge, (without opportunity to conduct a final in-home discharge assessment visit), then the last qualified clinician (RN, PT, OT, or ST) that visited the patient should complete the RFA 9, Discharge comprehensive assessment. When the clinician completes the patient status items, it will be based on the patient's condition as it existed on the day the qualified clinician made that last visit. The items referring to the last 14 days should be answered based on changes that occurred during the two week period immediately preceding the last qualified clinician's visit date (See CMS OCCB Q&As 10/07, #13). The M0090 date is the date the assessment was actually completed, but to be compliant should be within 2 calendar days of the discharge date. M0903 would be the date of the last home visit made by anyone from the agency that was included on the plan of care, which in the case of an unplanned discharge means it will likely be different than the M0906 discharge date.

Information in the medical record cannot be "made up" or "created" in an effort to be compliant with the Comprehensive Assessment of Patient Condition of Participation (484.55). There may be situations when a Discharge Assessment cannot be completed if no one clinician has all the information needed to complete it. If it is not possible to complete the Discharge Assessment, careful documentation should be included in the medical record to explain the circumstances that led to the non-compliance.

CATEGORY 3 – Follow-up Comprehensive Assessments

SCIC clarification

Question 2: Now that the Significant Change in Condition (SCIC) payment adjustment is no longer part of home health Prospective Payment System (PPS), please clarify for us the correct documentation for SCIC's now. First, are SCIC's still required, and if so, do we use the Other Follow-Up Assessment (RFA 5) form? And since this won't affect payment, do we still need to transmit this assessment, or keep on file only?

Answer 2: The Other Follow-up (RFA 5) is still expected to be completed when the patient experiences a major decline or improvement in health status, as defined by your agency policy. Information collected as part of this Follow-up assessment will be helpful in ensuring appropriate re-evaluation and revision of the patient's plan of care in the presence of major changes in patient condition. This assessment continues to be a requirement of the Conditions of Participation (CoPs), even though under PPS 2008, data from the RFA 5 assessment will in no way impact the episode payment as it may have under the previous PPS model.

There has been no change in the OASIS reporting regulation. You are required to submit the OASIS data, including the RFA 5 - Other Follow-up, within 30 days from M0090, Date Assessment completed.

CATEGORY 4b – M0 Item Specific

M0460

Question 3: If a patient has a Stage III pressure ulcer on the first episode, and in the second episode it is covered with slough, can it still be reported a Stage III?

Answer 3: A pressure ulcer covered with slough obscuring visibility of the wound bed is considered unstageable. If a pressure ulcer that was previously stageable develops eschar/slough that completely obscures the wound bed, it would no longer be considered stageable in the OASIS data set.

Cemented Surgical Wounds – M0440, M0482, M0488

Question 4: What standards are used to assess cemented surgical wounds when answering OASIS items M0440, Skin lesion/Open wound, M0482, Surgical wound, and M0488, Healing status?

Answer 4:

M0440: If the wound that is cemented meets the OASIS criteria to be a skin lesion or open wound for M0440, (any area of pathologically altered tissue, surgical incisions, traumatic lacerations, etc.), then it would be considered a skin lesion or open wound for M0440. If the OASIS criteria excluded the wound type from being reported in M0440 (i.e., ostomies and peripheral IV sites), then the wound would not be reported on M0440, regardless of the type of closure utilized.

M0482: If the wound that is cemented meets the OASIS criteria to be a surgical wound (e.g., post-op incision from orthopedic procedure, post-op incision from pacemaker placement), then it would be considered a surgical wound for M0482. The presence of the cemented closure (like the presence of sutures) is not, in and of itself, criteria to determine that a wound is or isn't a surgical wound for M0482.

M0488: When assessing a surgical incision that has been cemented rather than sutured, continue to follow the WOCN OASIS Wound Item Guidance applicable to the surgical incision, located at www.wocn.org.

1. If the wound can be visualized, it is not considered non-observable. Only surgical wounds that have a dressing that cannot be removed by physician order and obscures visualization of the incision are considered non-observable.
2. For the purposes of determining the healing status, a surgical wound can be considered fully healed and not reportable as a current surgical wound 4 weeks after complete epithelialization. The incision must be clean, dry and completely closed with no signs or symptoms of infection. The resulting scar continues to be reported as a wound/lesion (M0440) and not a surgical wound (M0482-M0488).
3. The status of the most problematic (observable) surgical wound (M0488) is determined by assessment of the skilled clinician following the WOCN OASIS Wound Item Guidance.

M0482

Question 5: Would an enterocutaneous fistula that developed as a result of a surgery be documented as a surgical wound?

Answer 5: A fistula is a complication of surgery but it is not a surgical wound. Though fistulas are sometimes located within surgical wounds, answering M0482-488 would be based on the condition of the surgical wound, not the fistula, using the WOCN OASIS Guidance document. For example, if the only opening in a 3 month-old closed surgical wound healed by primary intention was an enterocutaneous fistula then the answer to M0482 (Does this patient have a surgical wound?) would be “0-No”.

M0482 - Determining when a surgical wound is healed if the date of complete epithelialization is unknown.

Question 6: Recently released guidance states that a surgical wound becomes "healed" or no longer reportable as a surgical wound on M0482 4 weeks after complete epithelialization. Determining a specific timeframe in regards to complete epithelialization presents some issues. For instance, if we get a post surgery patient who has been in the nursing home and then to home health, we may not know when complete epithelialization occurs. Please provide further clarification.

Answer 6: If, at the SOC or other assessment time points, the clinician assesses the wound to be completely epithelialized (including no sign of infection or separation), and the date of complete epithelialization is unknown, the clinician will have to make a determination regarding the wound status based on the history of the date of surgery, any reported wound healing progress/complications and clinical assessment findings.

Since for the purposes of the OASIS, a surgical wound is considered healed and no longer counted as a current surgical wound 4 weeks after complete epithelialization, (assuming no sign of infection or separation), then if based on the surgery date, it is clear that the wound could not possibly have been fully epithelialized for at least 4 weeks, Response 1 – Fully granulating should be reported.

If the wound appears completely epithelialized (no sign of infection or separation) and the date of epithelialization is unknown, but based on the known wound history and date of surgery it is possible that the wound could have been fully epithelialized for at least 4 weeks, then the wound status is deemed “healed” and no longer reportable as a surgical wound. CMS will remind HHAs of their responsibility to comply with the HH Conditions of Participation, (see 42 CFR 484.18), when a surgery date is not provided on the referral. CMS expects the documentation within the patient’s medical record to reflect consultation with the patient’s physician therefore it is difficult to envision the HHA being unable to ascertain the patient’s date of surgery.

M0488

Question 7: I have a question related to the following CMS Q&A related to scabs:

> *Question 12: Does the presence of a "scab" indicate a non-healing wound? Answer 12: A scab is a crust of dried blood and serum and should not be equated to either avascular or necrotic tissue when applying the WOCN guidelines. Therefore while the presence of a scab does indicate that full epithelialization has not occurred in the scabbed area, the presence of a scab does not meet the WOCN criteria for reporting the wound status as "not healing".*
>
> *This represents a retraction of previous guidance that indicated a scab was considered avascular or necrotic tissue, and therefore an indicator of a non-healing surgical wound. (Note: This new CMS guidance will supersede prior guidance found in CMS OASIS Q&As; Category 4, Questions 112.1, 112.2, and 112.3)*

Does the "superseding" of Questions 112.1, 112.2, and 112.3 include all of the information contained in each answer or just the sections pertaining to 'scabs'. Specifically, in Q112.3, does the following statement still hold true: "Once the needle is removed before a scab has formed, the wound bed may be clean but non-granulating. Based on the WOCN Guidance, the wound would be reported as Response 3 - Not healing for M0488"?

Answer 7: The guidance indicating that a scab equated to non-healing is superseded by the new July 2008 Q&As.

When a needle is inserted and removed from an implanted venous access device, it is possible that the skin that was pierced by the needle could have a resulting wound that would heal by secondary intention. Usually, with good access technique and current needle technology there will be no perceptible wound. Occasionally, if there was an extremely large bore needle or traumatic entry or removal, there may be a resulting wound that heals by secondary intention. In this situation, the accessing clinician would rely on the WOCN's OASIS Wound Guidance document to determine the healing status. Note that a scab is a crust of dried blood and serum and should not be equated to either avascular or necrotic tissue when applying the WOCN guidelines. Therefore while the presence of a scab does indicate that full epithelialization has not occurred in the scabbed area, the presence of a scab does not meet the WOCN criteria for reporting the wound status as "not healing".

M0650 and 660

Question 8: I have a patient who could not obtain his clothes, but could dress without assistance if clothes were laid out (Response 1). If the environment was adapted (a new “usual” storage place for clothing was selected) so that the patient could obtain, put on and remove the clothing without any assistance, would the patient then be considered independent in dressing?

Answer 8: When a patient’s ability varies on the day of assessment, the clinician reports what was true for a majority of the time. If the patient was unable to access clothing, but could put on and remove the majority of clothing items safely when they were laid out for him, the appropriate score would be a “1”. If the environment is modified (e.g., the patient decides to start storing clothing in the dresser instead of hanging in the closet), and the patient can now access clothes from a location without anyone’s help, then this new arrangement could now represent the patient's current status (e.g., clothing’s new “usual” storage area and patient's ability). The appropriate score would be a “0” if the patient was also able to put on and remove a majority of his clothing items safely.

If however, the patient explained that while he is feeling weak, he will temporarily modify his dressing practice (e.g., place his clothes on the chair by his bed instead of putting them in the usual storage area - the closet), since the clothing lying on the chair is not in its “usual” storage

area and the patient does not intend on making the chair his usual storage area for his clothes, then he currently is unable to obtain the clothing from its usual location, and the patient would be scored a “1”. The patient could then work to gain independence in accessing clothing from its usual storage location, or decide to make long-term environmental modifications, and possibly achieve improvement in the outcome if successful.

M0780

Question 9: What is the appropriate response to M0780, Management of Oral Medications, when the nurse sets up a medication dispenser that has a visual alarm (flashing light) and an automated verbal message reminding the patient to take the medication? This medication dispenser also calls to alert a caregiver if the patient does not respond to the alarms by taking the medication from the dispenser.

Answer 9: If the patient requires both the nurse (someone) to prepare the individual doses in advance AND "someone" (e.g., nurse, family member, friend, caregiver) to give them daily reminders they are considered a "2". If an automated system is introduced that provides the reminders and after educating the patient on its setup and operation, the patient no longer needs "someone" to give them the reminders, a "2" response would no longer be appropriate. If the patient is not capable of setting up the machine to provide the reminders but with the reminder system set up by someone else is able to take the correct dose of medication at the correct time, the patient would be a "1". If a patient requires someone to provide more than one of the assistance interventions included in Response 1, Response 2 should be selected.

M0830

Question 10: My patient was seen in the physician's office for application of a cast. Because she lived a distance from the MD office or any routine radiology facility, the physician instructed the patient to be seen in a local urgicenter one week later for x-rays, which she did. Is that urgicenter visit reported as emergent care on M0830 if the patient had called and scheduled the visit 3 days in advance?

Answer 10: Emergent Care for M0830 is defined as all unscheduled visits occurring within 24 hours of the time the patient contacted the medical service. Since the visit to the urgicenter was scheduled 3 days in advance, it would not be reported in M0830. Issues related to coverage for such services in an urgicenter should be directed to the Regional Home Health Intermediary (RHHI) or other applicable insurer(s).

M0840

Question 11: We had a patient who attempted suicide using Coumadin. He was sent to the Emergency Room and then admitted to the hospital. When completing the Transfer OASIS data collection, we reported Response 1 - Improper medication administration, side effects, etc. as a reason for emergent care on M0840. This naturally resulted in the reporting of an adverse event. Was Response 1 the correct answer, since it was a deliberate action chosen by the patient?

Answer 11: The appropriate response for M0840 would be #1 (improper medication administration, medication side effects, toxicity, anaphylaxis) whenever the patient sought emergent care as a result of improper medication administration, regardless of who (patient, caregiver, or medical staff) administered the medication improperly.