



## Home Health OASIS July 2018 Quarterly Q&As

### Category 2

**QUESTION 1:** With the expansion of the One Clinician Convention noted in the **CMS OASIS Q&A August 2017**, information gathered during the last 5 days that visits were provided can be used to contribute to completion of an unexpected discharge. Can this 5-day collaboration lookback also be used for ROC, Recert, or a *planned* discharge OASIS?

**ANSWER 1:** For a planned or unplanned discharge, the assessment must be completed within 2 days of the discharge date, and information from the last five days the agency provided visits may be considered by the assessing clinician when selecting OASIS responses. The “last 5 days that the patient received visits” are defined as the date of the last patient visit, plus the four preceding calendar days. For a Resumption of Care, the current data collection guidance states that the assessment time frame (the maximum number of days in which the assessment must be completed) is within two days of the inpatient facility discharge (or knowledge of the discharge), or on the physician-ordered ROC date; and the time-period under consideration (the period of time in which the patient’s status can be considered when selecting a response) for most items is the “day of assessment”, which is defined as “24 hours immediately preceding the visit and the time spent in the home.” For a Recertification, the assessment time frame is the last five days of the certification period, and the time-period under consideration for most items is the “day of assessment,” which is defined as “24 hours immediately preceding the visit and the time spent in the home.”

**QUESTION 2:** We have a situation with an unexpected discharge. The nurse who was the last qualified clinician to see the patient is out on maternity leave. How do we complete the OASIS discharge?

**ANSWER 2:** In the case of an unplanned or unexpected discharge (an end of home care where no in-home visit can be made), the last qualified clinician who saw the patient may complete the discharge comprehensive assessment document based on information from his/her last visit. The assessing clinician may supplement the OASIS items on the discharge assessment with information documented from patient visits by other agency staff that occurred in the last 5 days that the patient received visits from the agency prior to the unexpected discharge. The “last 5 days that the patient received visits” are defined as the date of the last patient visit, plus the four preceding calendar days.

In your situation, the last qualified clinician who saw the patient is not available. Follow these steps:

1. If possible, send another clinician out to visit the patient and perform the Discharge comprehensive assessment visit.

2. If not possible to visit the patient, look back in the notes to find another qualified clinician who saw the patient (preferably as close to the time of discharge as possible), and who could complete the discharge comprehensive assessment based on their last visit.

The assessing clinician may supplement the discharge assessment with information documented from patient visits by other agency staff that occurred in the last 5 days that the patient received visits from the agency prior to the unexpected discharge.

3. If the clinician on leave was the only qualified clinician to see the patient and it is impossible to make an additional visit to the patient, it may not be possible to complete a Discharge comprehensive assessment. The Discharge comprehensive assessment requires an in-person patient encounter and assessment from a qualified clinician per the Medicare CoP 484.55 Comprehensive assessment. A supervisor or other agency clinician who has not visited the patient cannot complete a discharge comprehensive assessment compliantly using only information documented from patient visits by other agency staff that occurred in the last 5 days that the patient received visits from the agency prior to the unexpected discharge.

**QUESTION 3:** The PT provides the start of care visit and completes the OASIS and identifies a need for nursing to address medication management and wound care. An order is obtained from the physician for SN service, and the RN visit is made days after start of care. What document does the registered nurse (RN) need to complete to initiate nursing care? Is the RN to complete an OASIS follow up document, or a SOC document, or something else?

**ANSWER 3:** You describe a situation where the PT provides the start of care visit and completes the OASIS and identifies a need for nursing to address medication management and wound care.

The type of document that the RN would complete is dependent upon the patient situation and your agency policies. The following are some options that an agency may use in the situation described to document the nurse's first visit:

- Since the SOC comprehensive assessment with OASIS had already been completed by the PT, the RN could document the nursing visit with a non-OASIS nursing evaluation form or other agency documentation form.
- If the RN visit is within the 5-day SOC assessment period, the RN may complete another SOC comprehensive assessment form. Only one SOC OASIS can be submitted.
- If the circumstances surrounding the patient's need for nursing met the agency's policy/criteria for a major decline or improvement in health status, then an RFA 5 - Other Follow up assessment would be required, and the RN could complete that assessment form to document the nursing visit.

## **Category 4b**

### **M0032, M0090, M0102**

**QUESTION 4:** The new HH CoPs state that the comprehensive assessment (including OASIS) must be updated within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician-ordered resumption date. I understand that I must provide the ROC visit on the physician ordered ROC date, but do I need to also complete the entire ROC assessment on that date? Or do I have 48 hours from the physician-ordered ROC date to complete the assessment?

**ANSWER 4:** When the physician specifies a date that home care services must resume (a physician-ordered Resumption of Care date), the agency is expected to conduct the ROC visit on that date. The agency has up to 2 calendar days from the ROC date (M0032) to complete the ROC assessment document (M0090). For example, if the patient is discharged from the hospital on September 1, and the physician orders home care to resume on September 4, the M0102 - Date of Physician-ordered Resumption of Care date is 09-04-XXXX, the M0032 Resumption of Care date is 09-04-XXXX, and the M0090 Date Assessment Completed can be anytime on or between 09-04-XXXX and 09-06-XXXX.

### **M0102, M0104**

**QUESTION 5:** Now that the physician can order a ROC date that goes beyond 48 hours from hospital discharge, can that date ever be extended? Our patient was discharged from the hospital on Tuesday and the referral included orders to resume his care on Friday. When we called to arrange the time of the visit, he said he had other medical appointments on Friday and to come Monday. We called the ordering physician Friday requesting a delay in the ROC and received a call back on Monday approving the delay in ROC. How do we answer M0102?

**ANSWER 5:** To report this new updated/revised physician's ordered resumption of care date in M0102, it must have been received on or before the date of the previous physician's ordered resumption of care. If the order to extend the physician's ordered resumption of care date is received after the date of the previous physician's ordered resumption of care date has passed, report NA for M0102 and report the original referral date in M0104. In your scenario, since you received the updated physician ordered resumption of care date after the original physician ordered resumption of care date had passed, report NA for M0102 and the original referral date (Tuesday) in M0104.

### **M1306, M1340**

**QUESTION 6:** Would a stage 3 pressure ulcer covered with a pig bladder (skin substitute) be considered a skin graft and therefore a surgical wound? Or would it be considered a pressure ulcer that was unstageable? Or something else?

**ANSWER 6:** For OASIS coding purposes, when a pressure ulcer is treated surgically with any kind of graft or flap, it is no longer considered a pressure ulcer and is considered a surgical wound until approximately

30 days after reepithelialization. In your example, as this ulcer was closed with a skin substitute, the wound should be reported as a surgical wound until the graft is completely healed and no longer reportable. If the flap or graft fails, it should continue to be considered a surgical wound until approximately 30 days after reepithelialization.

### **M1340**

**QUESTION 7:** Is a Pleurx catheter considered a surgical wound? Is there a difference if the Pleurx catheter was in the abdomen vs chest cavity?

**ANSWER 7:** The presence of a specific catheter type does not define a surgical wound. A Pleurx catheter inserted as a chest tube is considered a thoracostomy and would not be considered a surgical wound. All ostomies (including those with drains) are excluded as surgical wounds. A surgical procedure that creates a wound that is not an “ostomy”, and that has a drain (for example a Pleurx catheter, a Jackson-Pratt, etc.) would be considered a surgical wound.

### **M2102**

**QUESTION 8:** We have a question about M2102f. Supervision and Safety. The 2018 Guidance Manual included a change in the response-specific instructions for Row f indicating that the patient must have a cognitive impairment or mental health issue although in the item it states, “for example” which has meant in the past that the example given is not all inclusive. Does the patient needing caregiver assistance require a diagnosis of a cognitive impairment or mental health condition to answer this item anything other than “0”?

**ANSWER 8:** The OASIS Guidance Manual states that M2102f should focus on supervision and safety necessary due to cognitive or mental health issues. The OASIS Guidance does not indicate a specific diagnosis is required. The need for supervision and safety due to cognitive or mental health issues may be based on the clinical judgment of the assessing clinician or others contributing to the comprehensive assessment.

**QUESTION 9:** Would reporting that a patient requires supervision and safety due to cognitive impairment in M2102f also be reflected on responses to diagnosis items M1021 and M1023, cognitive items M1740 and M1745, or standardized, validated assessment items M1910 fall risk assessment or M1730 depression screen?

**ANSWER 9:** Each OASIS item should be considered individually, and coded based on the guidance provided for that item.

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