HOME HEALTH QUALITY REPORTING PROGRAM
PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON MAY 3 AND 4, 2017

Current as of October 2017

#	Question Category	Question	Proposed Response
1	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened and Associated OASIS-C2 Items: M1311 and M1313	Which item is used in the pressure ulcer measure? M1311 or M1313? What was said today in the Quality Reporting Program (QRP) training was said differently then what has been reported previously.	The item used in the calculation of the quality measure is M1313. We trained on M1311 because understanding how to code M1311 helps to understand how to code new or worsened pressure ulcers at M1313.
2	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened and Associated OASIS-C2 Items: M1311 and M1313	The guidance that the response to M1311 cannot be updated when the pressure ulcer is unstageable at SOC/ROC has great impact on payment for care of that pressure ulcer. Does that same guidance apply to M1324?	The first clinical skin assessment is the assessment used to complete the Outcome and Assessment Information Set (OASIS). This is to ensure consistency of data collection across all post-acute care (PAC) providers. For example, even though the standard assessment timeframe for the Minimum Data Set (MDS) is 7 days and up to 5 days after SOC to complete OASIS, guidance for both MDS and OASIS includes that providers are required to use the initial clinical skin assessment to code the presence of a pressure ulcer. The guidance to assess and report the pressure ulcer stage and status as close to SOC/ROC as possible applies to all OASIS pressure ulcer items.
3	Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened and Associated OASIS-C2 Items: M1311 and M1313	If a patient with a Stage 4 pressure ulcer has a skin graft that is captured as a surgical wound and then heals and remains epithelized for more than 30 days, the wound is now considered a scar and not captured on OASIS. If this same area reopens due to pressure and clinically “looks like” a Stage 2 pressure ulcer, can we capture it as a Stage 4 since the underlying tissue was not replaced, as would happen with a muscle flap?	Skin grafts are considered surgical wounds because skin grafting is a surgical procedure during which skin is sewn into a defect to close the wound. If a Stage 4 pressure ulcer was closed with a skin graft, the surgical wound healed, and another pressure ulcer formed in the same anatomical location due to pressure, then this pressure ulcer would be staged as a Stage 4 (i.e., the highest stage the pressure ulcer was prior to closure). It is important to remember that regardless of whether the Stage 3 or 4 ulcer is closed using a skin graft or via granulation tissue, the original tissues are never replaced. These ulcers can be closed using a skin graft, yet they are more likely to have recurrent breakdown even after such closure. To prevent a recurrence of skin breakdown, preventative efforts should be adhered to .

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4	Data Submission and Reporting	Is there a plan to address all of the statistically "topped out" quality measures that are impacting the star measure ranking of home health agencies (HHAs)? Patients are used to seeing five stars as good (five-star restaurants, hotels, etc.). If the statistical data continues to rise rapidly such as influenza vaccination requiring 100% to achieve a five-star rating, how does a HHA truly report 100%? Is the data being submitted in the QRP truly accurate? Are there other ways to rate HHAs? Potential examples: • Include patient satisfaction in just one-star ratings. Is what patients are saying about a HHA more important than data that HHAs submit that could be falsely altered to show better numbers? • Use claim-based information. Is there a way to have a star rating that is more familiar to patients, perhaps something similar to hospitals or skilled nursing facilities? Why is it necessary to use a bell curve? Does it matter that more than 5% of HHAs become five star?	We evaluate all measures for continued public reporting on Home Health Compare as well as for use in the Quality of Patient Care star ratings. As more measures become available for consideration for use in star ratings, we will evaluate whether replacing them with the existing measures results in a better summary of agency performance. Additional information regarding the Home Health Quality of Patient Care star rating can be accessed at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings.html.
5	Data Submission and Reporting	Can you explain why we see warnings on our validation report showing there was a Health Insurance Prospective Payment System code change from what was originally submitted on the extract file?	This question should be referred to the payment policy staff at HomeHealthPolicy@cms.hhs.gov.

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6	Data Submission and Reporting	Current Q&A guidance states that if a patient is unexpectedly discharged, the last clinician to see the patient is allowed to complete OASIS and must complete the Discharge OASIS based on the last visit findings. For OASIS items where a dash is a valid response, should a dash be used on the Discharge OASIS, or should the item be answered based on findings from that last visit? Or do we answer based on findings from the last visit, unless it is something not assessed at that visit, and then use the dash only in these instances? For example, a physical therapist (PT) may not have assessed an ulcer at the most recent visit if it was under a dressing, but may have visualized an ulcer that was not covered by a dressing.	In the case of an unexpected discharge, the last qualified clinician to see the patient should complete the Discharge OASIS based on his or her last visit findings. If the clinician did not assess an issue on that last visit, a dash—indicating that no information is available or the item was not assessed—could be used for those limited OASIS items where a dash is a valid response. In situations where it is discovered that there is no one person at the agency who has all the information needed to complete the assessment, it may not be possible to produce a Discharge assessment. This, of course, means you are noncompliant with the Condition of Participation 484.55, Comprehensive Assessment of Patients. The Centers for Medicare & Medicaid Services (CMS) has announced an expansion to the one clinician convention that could assist the last qualified clinician in completing discharge items that may have been assessed by other agency staff. This new guidance becomes effective January 1, 2018, and additional details are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html.

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7	Home Health QRP Requirements, Definitions, and Assessments	Slide 57 references the HHA Q&As. My question is as follows: When are the January 2017 and April 2017 Q&As coming out? This is of great concern that Medicare has not completed them or offered HHAs the ability to ask and receive answers back. Running a company in multiple States, we rely on the opportunity to ask, receive clarification, and learn what we are to do to stay within the regulations. This is especially true right now, as there are new conditions of participation. Agencies need to have the Q&As up-to-date so we can follow regulation, report correct data to CMS, and have a proper QRP.	Due to contractual changes, the OASIS Q&A data collection Help Desk and the related OASIS Quarterly Q&A releases are no longer available. The last published CMS Quarterly Q&As available are from October 2016. Questions related to OASIS data collection may be forwarded to your State OASIS Education Coordinator (OEC). A list of OECs by State is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/EducationCoord.html. For OASIS data collection questions that your OEC is not able to address, please contact Peggye Wilkerson at Peggye.Wilkerson@cms.hhs.gov.
8	Home Health QRP Requirements, Definitions, and Assessments	When will we again have a centralized and standardized resource for OASIS Q&As? Right now, it takes up to 3 weeks to get an answer for an OASIS question. In speaking with an OEC, I learned the process now is for the OEC to try to answer using current resources. If no current guidance is available, then the OEC emails all OECs in other States for their opinions. This communication can go back and forth with discussion over several points, and the OEC finally pulls together the various opinions and responds to the question for the requesting agency. There have been situations of different answers in different States, which threatens standardization of data collection. It is essential for agencies to have a resource for timely and consistent answers to OASIS questions, especially as we get new items for the dataset.	Due to contractual changes, the OASIS Q&A data collection Help Desk and the related OASIS Quarterly Q&A releases are no longer available. The last published CMS Quarterly Q&As available are from October 2016. Questions related to OASIS data collection may be forwarded to your State OEC. A list of OECs by State is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/EducationCoord.html. For OASIS data collection questions that your OEC is not able to address, please contact Peggye Wilkerson at Peggye.Wilkerson@cms.hhs.gov. HHAs will be notified of any changes to this process.
9	Home Health QRP Requirements, Definitions, and Assessments	Is the other follow-up used for risk adjustment?	No, the other follow-up is not used for risk adjustment. Only the SOC and ROC are used for risk adjustment.

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10	Home Health QRP Requirements, Definitions, and Assessments	What is the best way to be compliant with transfers to an inpatient acute facility when you are unsure if the patient is being held for observation or will be admitted to the inpatient facility?	When a home health patient goes to an inpatient facility, the HHA should make efforts to communicate with the facility to determine the patient status (e.g., whether the patient is admitted as an inpatient or in observation status). Based on information available to the agency at the time of the transfer, a transfer assessment should be completed when the criteria for a qualifying patient admission has been met.
11	Home Health QRP Requirements, Definitions, and Assessments	Are star ratings calculated from each quality episode (SOC to ROC and ROC to discharge) or from the time of SOC to the final discharge of the episode?	Star ratings are calculated for all quality episodes: from SOC to transfer, from SOC to discharge, from ROC to transfer, and from ROC to discharge.
12	Home Health QRP Requirements, Definitions, and Assessments	Who sets and requires OASIS-C2? Fee for services? Medicaid? What about Medicare Advantage? Or Medicare HMO?	CMS requires OASIS data collection and submission for all skilled Medicare and Medicaid patients, excluding pediatric and maternity. This would also include managed Medicare and Medicaid.
13	Other	Can a nurse practitioner following a patient at home sign a clinician's verbal orders, or must a medical doctor cosign it? Can the nurse practitioner order lab tests for patients?	This is a payment policy question that should be referred to HomeHealthPolicy@cms.hhs.gov.
14	Other	When will Interpretive Guidelines be out for the July regulations that are now delayed until January? Having Interpretive Guidelines can assist in policy decisions.	This question is outside the scope of the purpose of this OASIS-C2 training. Please refer your question to Peggye Wilkerson at Peggye.Wilkerson@cms.hhs.gov.
15	Other	There have been discrepancies among surveyors and regulatory education regarding diagnoses related to a plan of care (POC). Some still insist that if a patient is on a medication, there should be a diagnosis to substantiate the medication. Others educate us to use the diagnosis appropriate for the patient's current medical issue. As an example, hypothyroidism does not need to be on a POC unless it is not under control.	Only current medical diagnoses should be reported as primary or secondary diagnoses in M1021 and M1023. Diagnoses should be excluded if they are resolved or do not have the potential to affect the skilled services provided by the HHA or the patient's responsiveness to treatment and rehabilitative prognosis. Additional questions related to survey implications for diagnoses and POC should be referred to Peggye Wilkerson in the Survey and Certification Group. Her email address is Peggye.Wilkerson@cms.hhs.gov.

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16	Other	Is it enough for a physician to sign the 485 to confirm diagnoses? Is the interim order absolutely necessary?	These questions are outside the scope of this OASIS-C2 training. However, the question regarding the reporting of a diagnosis is a topic that Peggye Wilkerson (Peggye.Wilkerson@cms.hhs.gov) can best address.
17	Other	For CMS: Patients have rights, including the right to refuse. I would like to know why HHAs either get "dinged" in quality star ratings for patients who get their flu shots in the physician's office or are unable to be weighed (e.g., weight greater than 400 lbs), and financially dinged for face-to-face and lack of medical office records. Agencies spend a lot of time/money trying to get physicians to supply what we need. We have no control over physicians' actions, yet we are the ones who will have financial implications for not getting what we need.	If a patient receives a flu shot in the physician's office, the HHA should respond by entering code 3, Yes; received from another healthcare provider (e.g., physician, pharmacist) in item M1046. Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season? Questions related to quality measures and the quality of patient care star rating may be directed to HomeHealthQualityQuestions@cms.hhs.gov. Questions related to face-to-face should be directed to payment policy staff at HomeHealthPolicy@cms.hhs.gov.
18	Drug Regimen Review Conducted with Follow-Up for Identified Issues	How should we complete M2003 if the SOC occurs on a Sunday, the registered nurse (RN) finds a medication issue, and the physician is unavailable within the 24-hour period?	In completing M2003, select response "1 – Yes" when the two-way communication with the physician or physician designee AND completion of the prescribed/recommended actions have occurred by midnight of the next calendar day after the potential clinically significant medication issues were identified, regardless of the assessment's day of the week or the physician's availability.
19	Drug Regimen Review Conducted with Follow-Up for Identified Issues	During medication reconciliation, how far do we look back when the patient has multiple longstanding medications? What is the CMS regulation on the timeframe?	The Drug Regimen Review should consider all medications that the patient is currently using.

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20	Drug Regimen Review Conducted with Follow-Up for Identified Issues: M2001, M2003, and M2005	Please expand on directing clinicians on using clinical judgement to determine if an issue is clinically significant. 1. Our electronic medical record (EMR) has numerous alerts; some are things like "may require dose adjustment." I would not think that is significant. 2. I would hesitate to recommend clinicians entering all meds into a secondary system or application (increase time, may be more confusing). 3. Physicians are complaining when they are informed about medication combinations the patient has been on for years as an issue. 4. Therapists are especially hesitant not to inform the physician about every alert. 5. Could it be that the physician should be aware of an issue, but may not require the 24-hour timeframe, and therefore is not clinically significant?	Determination of whether a situation is considered a potential clinically significant medication issue is completely up to the clinical judgement of the assessing clinician. This includes interpreting EMR drug review alerts. It is possible for a clinician to determine the physician should be notified of an issue that does not require the timing of "by midnight of the next calendar day," and therefore the issue would not meet the definition of a potential clinically significant medication issue as defined for this item.
21	Drug Regimen Review Conducted with Follow-Up for Identified Issues: M2001, M2003, and M2005	The drug regimen review is done at SOC/ROC. With what frequency should medication updates be made during weekly visits?	The drug regimen review is a required part of every mandatory comprehensive assessment. Agencies may complete a drug review more frequently, as needed, which would be considered a best practice. If, at any time during the quality episode, a potential clinically significant medication issue is identified, information related to this issue (or issues, if there are more than one) and subsequent communications and actions taken would determine the response to M2005 at the next Transfer/Discharge/Death time point.

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22	Drug Regimen Review Conducted with Follow-Up for Identified Issues: M2001, M2003, and M2005	If a patient is missing a medication at SOC and there is a plan for the medication to be picked up, can a clinician use judgment and select "0 – NO"? For example, a patient ran out of a Calcium 600 mg supplement today, but the caregiver is picking up more later in the day. The clinician determines this is not of a level of significance that requires contact with the medical doctor by midnight of the next calendar day. Can "0 – NO" be selected?	Determination of whether a situation is considered a potential clinically significant medication issue is completely up to the clinical judgement of the assessing clinician. In your example, the clinician determined that this was not a potential clinically significant issue, making "0, No – No issues found during review" an appropriate response for M2001.
23	Drug Regimen Review Conducted with Follow-Up for Identified Issues: M2001, M2003, and M2005	What is the rationale for the 24-hour window for physician response time?	Note that the time for action is not "24 hours," but rather "by midnight of the next calendar day" from the time the potential clinically significant medication issue is identified. A potential clinically significant medication issue is an issue that, in the care provider's clinical judgment, requires physician/physician-designee notification by midnight of the next calendar day (at the latest). This approach and timeframe was informed by input from a cross-setting technical expert panel to provide a standardized definition to identify medication-related issues that need timely notification and collaboration with the physician.
24	Percent of Patients with Pressure Ulcers That Are New or Worsened Covariates: M1028, M1060, and M1620	M1060 reads SOC/ROC. However, if a patient is discharged and readmitted within 30 days, can we use the weight from the previous episode? If the patient was discharged from a HHA episode and then readmitted 10 days later to the same agency, can the agency use its own last recorded weight that was obtained within the 30-day period?	The HHA should attempt to obtain a new weight because the condition of the patient and the reason for readmission to the HHA may have changed since the previous home health episode. If weighing the patient at the new SOC is not possible and a previous agency obtained weight from an M1060 reporting within the 30-day window, that weight can be used at the new SOC.
25	Percent of Patients with Pressure Ulcers That Are New or Worsened Covariates: M1028, M1060, and M1620	During a response to a question from the floor, Ms. Roby indicated that you would leave "weight" blank if unable to obtain it. Chapter 3 does not include instruction to leave either measure blank. Rather, we are to use the dash value when unable to obtain. Please clarify.	M1060 cannot be left blank. Providers should use the dash in M1060b if unable to obtain the weight.

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26	Percent of Patients with Pressure Ulcers That Are New or Worsened Covariates: M1028, M1060, and M1620	I am wondering why CMS did not use urinary incontinence as a risk adjustment covariate for the risk of a pressure ulcer that is new or worsened since this condition is more frequently encountered in home care?	The measure "Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened" will be risk-adjusted based on an evaluation of potential risk factors and their statistically significant impact on the outcome. The anticipated risk factor covariates found in the measure specifications (March 2017) are proposed to standardize risk adjustment across the four PAC settings. However, the risk model for this measure, including the final determination of which items will be used as covariates, has not yet been fully developed. During testing and research related to this quality measure, bowel incontinence was determined to be a more reliable risk adjuster.
27	Percent of Patients with Pressure Ulcers That Are New or Worsened Covariates: M1028, M1060, and M1620	Is there an opportunity now or in the near future to move toward standardization of height and weight assessment across PAC settings? This would be especially helpful for HHAs, the one uncontrolled setting as compared to the other three inpatient settings. Would it be possible to use height and weight collected in another setting, say within the past 30 days? This would help decrease burden and possibly move us toward standardization as a healthcare system in collecting these data.	The height and weight items added to the OASIS already exist on other assessments across PAC settings and are collected using standardized guidance that requires reporting of height and weight measurements taken by the treating facility/agency. CMS appreciates stakeholder feedback and welcomes provider engagement in developing and refining the QRP.
28	Percent of Patients with Pressure Ulcers That Are New or Worsened: OASIS-C2 Covariate GG0170C	Regarding item GG0170C, a patient used her bed prior to a fall. After discharge from the hospital, she sleeps in a recliner. How do we score this?	If the patient uses a recliner, sofa, or mattress on the floor as a "bed" (preferred or necessary sleeping surface), assess the need for assistance using that sleeping surface when determining ability for GG0170C.

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29	Percent of Patients with Pressure Ulcers That Are New or Worsened: OASIS-C2 Covariate GG0170C	Within the SOC (5-day window), the RN goes in and the patient refuses to perform the task of lying to sitting that day. The PT goes in for an evaluation visit the next day and the patient agrees. Can both disciplines collaborate upon the PT assessment, and can the RN complete GG, or does it have to be the RN going in again within the 5-day window? In our agency, the PT cannot do SOC OASIS.	Based on current (2017) guidance, the comprehensive assessment must be completed by one clinician. Therefore, the RN may not use the PT assessment findings to complete GG0170C. CMS has announced an expansion to this one clinician convention that would allow the type of collaboration referenced in the posed question. This new guidance becomes effective January 1, 2018, and additional details are available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html.
30	Overview of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014	I have been reviewing the proposed PAC questions by RAND. Will the current OASIS questions on the same topics (e.g., pain) be removed when the new PAC questions are added?	Public comment will inform modifications to the OASIS dataset, with notification provided to stakeholders through formal rulemaking. CMS considered provider burden carefully when proposing new assessment instrument data elements. We will consider removal of items as appropriate. It is important to remember that some items are currently used for different purposes and cannot be changed until new data elements are in place and being used by providers. Therefore, some items may remain even though they are similar to newer data elements, with the eventual goal to reduce redundancy wherever feasible.