October 2019 CMS Quarterly OASIS Q&As

Please note that guidance Q&As related to PDGM will become effective with assessments with a M0090 date of January 1, 2020 or later.

Category 2

QUESTION 1: OASIS-D1, PDGM and iQIES all start on January 1, 2020. Please confirm if all RFA 4 Recertification assessments that fall between December 27, 2019 and January 1, 2020 should use OASIS-D1 and use the iQIES system to submit?

ANSWER 1: All RFA 4 Recertification assessments with a M0090 Date Assessment Completed on or after December 27, 2019 for a payment period that begins January 1, 2020 or later should use OASIS-D1. This supports the transition to the Patient-Driven Groupings Model (PDGM).
For technical questions, (registration for User IDs, data submission/transmission, iQIES, provider access to quality reports, etc.) consider contacting the Technical Help Desk, E-mail: HELP@qtso.com, Phone: 1--877-201-4721.

QUESTION 2: Since PDGM uses 30-day periods of care rather than 60-day episodes of care as the unit of payment, do the 30-day PDGM payment periods affect when OASIS needs to be collected?

ANSWER 2: While the PDGM case-mix adjustment is applied to each 30-day period of care, other home health requirements will continue on a 60-day basis. Specifically, certifications and recertifications continue on a 60-day basis and the comprehensive assessment will still be completed within 5 days after the start of care date and completed no less frequently than during the last 5 days of every 60 days beginning with the start of care date, as currently required by § 484.55, Condition of Participation: Comprehensive assessment of patients.

QUESTION 3: Which OASIS items are used to determine if the admission source category is community or institutional for PDGM?

ANSWER 3: The OASIS assessment will not be utilized in evaluating for admission source information. Information from the Medicare claims processing system will determine the appropriate admission source for final claim payment.

QUESTION 4: We have an RN that no longer works for the agency. She performed a discharge assessment on May 8th but did not complete an OASIS. Physical therapy was also involved in care but had performed a discipline-specific discharge on April 26th. How do we proceed with this patient?

ANSWER 4: A Discharge comprehensive assessment including OASIS is required within two days of the patient's discharge date. The Discharge comprehensive assessment requires an in-person patient encounter and assessment from a qualified clinician per the Medicare CoP §484.55. If a Discharge comprehensive assessment including OASIS is missed, the agency should complete the discharge assessment as soon as the oversight is identified. There may be situations in which this is not possible (i.e., the discharging clinician does not have sufficient assessment information to complete the discharge assessment and an additional home visit is not possible within two days of the discharge date, or the missed OASIS is not identified until greater than two days after the discharge date). After the discharge assessment timeframe, a missed discharge OASIS may not be created based on previous visits/visit notes.

Failing to complete a discharge assessment should be avoided, as not completing a timely discharge assessment represents non-compliance with the comprehensive assessment update standard (of the Conditions of Participation). For the Medicare PPS patient, payment implications may also arise from a missed assessment based on the QAO threshold calculation. Any questions about payment implications may be directed to your agency's Medicare Administrative Coordinator (MAC).

Category 4a

QUESTION 5: Related to the new "optional items" for 2020, CMS July Quarterly Q&A #5 states that "*vendors are permitted to 'hard code' these items at these timepoints with an equal sign*". By "*hard code*", does CMS mean that the system would auto-populate a response of "(=)" for allowed OASIS items for all client agencies? If the pre-fill option were implemented, could the system allow users to still change the response from (=) to one of the previously allowed values?

ANSWER 5: The vendor may prefill the response with an equal sign "=" and may allow the provider to change the response if the agency chooses not to treat the item as optional.

Category 4b

M0100

QUESTION 6: Per the 2019 Home Health Final Rule and the proposed rule for 2020, it appears that CMS expects HHAs to discharge a patient if the patient requires post-acute care from a SNF, IRF, LTCH or care in an inpatient psychiatric facility (IPF). The HHA could then readmit the patient, if necessary, after discharge from such setting. This goes against the common current practice of completing a transfer and then ROC for patients transferred to any inpatient setting, unless they are not expected to need further home care.

Should we still complete M0100 RFA 6 Transferred to an inpatient facility – patient not discharged from agency when a patient is transferred into any inpatient setting and we expect to receive this patient back after their inpatient stay and RFA 7 Transferred to an inpatient facility- patient discharged from agency when we do not expect to receive the patient back after the inpatient stay? Should we still complete a M0100 RFA 3 (ROC) when a patient is discharged from any inpatient facility while still under the services of the agency?

ANSWER 6: There is no change in the OASIS guidance in how agencies may use M0100 RFA 6 and 7 when a home health patient is admitted for an inpatient hospital stay. In the event that a patient had a qualifying hospital admission and was expected to return to your agency, you would complete RFA 6 – Transferred to an inpatient facility – not discharged from agency. If the patient was not expected to return to your agency after this inpatient facility stay, you would compete RFA 7- Transfer to an inpatient facility- patient discharged from agency.

However, if the patient required post-acute care in a SNF, IRF, LTCH or IPF prior to returning for home health services, CMS expects the home health agency to discharge the patient by completing the internal agency discharge paperwork and then to readmit the patient with a new Start of Care. This will allow appropriate admission status assignment for PDGM. There is no need to update or change the transfer OASIS to reflect this discharge.

If a home health patient is admitted directly to a SNF, IRF, LTCH or IPF for a qualifying stay (stays as an inpatient for 24 hours or longer for reasons other than diagnostic testing), you would complete RFA 7 – Transfer to an inpatient facility – patient discharged from agency, then readmit the patient with a new Start of Care if they were referred for further home health services.

QUESTION 7: With PDGM, when a patient is transferred to an inpatient facility and returns home during the last 5 days of the current episode (days 56-60), can the agency continue to

complete only the Resumption of Care (ROC) to meet the requirements for both the ROC and the recert?

ANSWER 7: When a patient returns home from an acute care hospital stay during the last 5 days of the current episode (days 56-60), the agency may complete only the Resumption of Care, allowing the assessment to serve both resumption and recert functions. However, if the patient required post-acute care in a SNF, IRF, LTCH or IPF prior to returning for home health services, CMS expects the home health agency to discharge the patient by completing the internal agency discharge paperwork and then to readmit the patient with a new Start of Care. This will allow appropriate admission status assignment for PDGM. There is no need to update or change the transfer OASIS to reflect this discharge.

QUESTION 8: Does CMS expect an RFA 5 - Other follow-up OASIS assessment in order to support a change in primary and/or other diagnoses on the claim for the second 30-day payment period under PDGM?

ANSWER 8: When diagnosis codes change between one 30-day claim and the next, there is no requirement for the HHA to complete an RFA 5- Other follow-up assessment to ensure that diagnosis coding on the claim matches to the OASIS assessment. The CoP 484.55(d) does require an RFA 05 when there has been a major improvement or decline in a patient's condition that was not envisioned in the original Plan of Care. CMS expects agencies to have and follow agency policies that determine the criteria for when the Other Follow-up assessment is to be completed.

QUESTION 9: Is the RFA 5 - Other follow-up being used for payment again under PDGM?

ANSWER 9: The Other Follow-up assessment may be used by agencies when a patient experiences a significant change in condition that was not anticipated in the patient's plan of care and would warrant an update to the plan of care. Under PDGM, if the M0090 Date Assessment Completed for the RFA 5 is before the start of a subsequent, contiguous 30-day period and results in a change in the functional impairment level, the second 30-day claim would be grouped into its appropriate case-mix group. HHAs must be sure to update the assessment completion date on the second 30-day claim if a follow-up assessment changes the case-mix group.

QUESTION 10: Under PDGM, if a patient experiences a significant change and we complete an RFA 5 - Other Follow-Up assessment that changes the functional grouping for the initial 30-day period thus resulting in a different case mix grouping, can we resubmit the original claim?

ANSWER 10: No, similar to PPS, the case mix group cannot be adjusted within each 30-day period, but completion of an RFA 5 - Other Follow-up may impact payment for a subsequent 30-day payment period. HHAs must be sure to update the assessment completion date on the second 30-day claim if a follow-up assessment changes the case-mix group to ensure the claim can be

matched to the Follow-up assessment. HHAs can submit a claims adjustment if the assessment is received after the claim has been submitted and if the assessment items would change the payment grouping. Questions related to claims processing may be directed to the HHA's Medicare Administrative Contractor.

M0110

QUESTION 11: Is M0110 Episode Timing going to continue to be used under PDGM to calculate early or late episodes?

ANSWER 11: No. Medicare claims data, not OASIS Assessment data, will be used in order to determine if a 30-day period is considered ''early'' or ''late'' under PDGM**.**

QUESTION 12: Why will agencies continue to collect M0110 Episode Timing if it is not used to calculate Medicare payments under PDGM?

ANSWER 12: While CMS will no longer use M0110 to influence payment under PDGM, other payers may be using this data in their PPS-like payment model. In such cases, agencies should follow instructions from individual payors directing data collection by patient. Agencies may code M0110 Episode Timing with NA – Not Applicable for assessments where the data is not required for the patient's payer (including all Medicare FFS assessments).

M1033

QUESTION 13: What types of hospitals are included when counting hospitalizations for M1033 Risk for Hospitalization, Response 3?

ANSWER 13: Only acute care hospitalizations are included when counting hospitalizations for M1033 Risk for Hospitalization. Inpatient psychiatric hospitalizations and long-term care hospitals (LTCHs) are not included as hospitalizations for M1033.

QUESTION 14: Does a patient have to be admitted to an acute care hospital for more than 24 hours and for reasons of more than diagnostic testing to be considered a hospitalization?

ANSWER 14: Yes, an acute care hospitalization is defined as the patient being admitted for 24 hours or longer to an inpatient acute bed for more than just diagnostic testing. Observation stays are not included as hospitalizations for M1033 Risk for Hospitalization.

QUESTION 15: For M1033 Risk of Hospitalization, if my patient is discharged from the acute care hospital in the morning and readmitted to the acute care hospital that same day, is that counted as two acute care hospital admissions?

ANSWER 15: Yes, if the patient is discharged from an acute care hospital in the morning and readmitted to an acute care hospital that same day and both hospitalizations meet the definition for an acute care hospitalization, that is counted as two hospitalizations. Observation stays are excluded.

QUESTION 16: For M1033 Risk for Hospitalization, response 4 - Multiple Emergency Department Visits – Does this include urgent care centers and walk-in clinics?

ANSWER 16: No, response 4 only includes hospital emergency departments, as defined in M2301 Emergent care.

QUESTION 17: Please provide any definitions or parameters for M1033 Risk for Hospitalization, response 5 – Decline in Mental, Emotional, or Behavioral Status in the past 3 months?

ANSWER 17: A decline in mental, emotional, or behavioral status, is considered a change in which the patient, family, caregiver or physician has noted a decline regardless of the cause. A decline may be temporary or permanent. Physician consultation or treatment may or may not have occurred.

QUESTION 18: What medications are included in M1033 Risk for Hospitalization, response 7 – Currently Taking 5 or More Medications? Are herbals and oxygen included?

ANSWER 18: Medications include prescribed and over the counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route. Medications may also include total parenteral nutrition (TPN) and oxygen (as defined in M2001 Drug Regimen Review).

M1021, M1023

QUESTION 19: I am reaching out for clarification regarding the OASIS-D1 Update Memorandum and OASIS-D1 Data Specification Changes.
For M1021/M1023, is it correct to assume that if a clinician chooses to optionally not answer the question during a Follow-Up assessment, they should do so for all parts of the item? Or is it valid for an agency to submit a code for M1021 - Primary Diagnosis, but submit the new "=" response for Symptom Control Rating portion of M1021?

ANSWER 19: When completing a Follow-up Assessment (M0100 = RFA 04 or 05) with a M0090 Date Assessment Completed of January 1, 2020 or later, a provider may choose to enter a properly formatted ICD-10 code in M1021- Primary Diagnosis and may choose to enter a valid value of [=] in M1021 - Symptom Control Rating on Follow-up Assessments.

QUESTION 20: Please clarify if M1021 and M1023 should include all known diagnoses as stated in the Interpretive Guidelines for HHAs or continue to report only current diagnoses as it is currently defined in the OASIS Guidance Manual for M1021 and M1023? Specifically clarify if M1021 and M1023 should include known diagnoses that are resolved or diagnoses that do not have the potential to impact the skilled services ordered?

ANSWER 20: OASIS guidance states that M1021 Primary Diagnosis and M1023 Other Diagnoses should include only current diagnoses actively addressed in the Plan of Care or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis even if not the focus of any home health treatment itself. M1021 and M1023 should exclude resolved diagnoses or those that do not have the potential to impact the skilled services provided by the HHA. (OASIS Guidance Manual) This description is in accordance with assigning primary and other diagnoses from the ICD-10-CM Official Guidelines for Coding and Reporting.

The Interpretive Guideline for HH CoP §484.60(a)(2*) state that the individualized plan of care must include the following: (i) All pertinent diagnoses;* … further explaining that "All pertinent diagnoses" means all **known** diagnoses.

For M1021 and M1023, continue to report only current medical diagnoses actively addressed in the plan of care or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis even if not the focus of any home health treatment itself. Include comorbidities, a condition coexisting with the principal diagnosis that can affect the Home Health Plan of Care in terms of services provided and time spent with patients. Exclude other resolved diagnoses or those that do not have the potential to impact the skilled services provided by the HHA.

QUESTION 21: With PDGM, diagnosis grouping will come from the diagnoses listed on the claim. I understand that that the OASIS and claim diagnoses codes may not always match. There are 6 spaces for diagnosis on OASIS and 25 spaces for diagnosis on the claim. Can I include additional diagnosis on the claim after matching the first 6 from my OASIS? What kind of diagnoses may I list on the claim? Must they meet the definition of a primary and other diagnosis found in Chapter 3 of the OASIS Guidance Manual, M1021 and M1023? Or may I include any pertinent diagnosis, which means any <u>known</u> diagnosis, per the HH CoP 484.60(a)(2) Interpretive Guidelines?

ANSWER 21: Any additional diagnosis listed on the claim should follow the OASIS definitions for primary and secondary diagnosis found in the OASIS Guidance Manual. Include only current diagnoses actively addressed in the plan of care or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis even if not the focus of any home health treatment itself. Exclude resolved diagnoses or those that do not have the potential to impact the skilled services provided by the HHA, even if they are known/documented diagnoses. Adhere to the ICD-10-CM Official Guidelines for Coding and Reporting when assigning ICD-10-CM

diagnosis codes. Note that the CY2019 Home Health Final Rule has stated that, "Because ICD–10 coding guidelines require reporting of all secondary diagnoses that affect the plan of care, we would expect that more secondary diagnoses would be reported on the home health claim given the increased number of secondary diagnosis fields on the home health claim compared to the OASIS item set."

QUESTION 22: I was recently instructed that with PDGM, the diagnoses used to determine payment will come from the claim and these diagnoses may not necessarily match the diagnoses listed in M1021 and M1023 on OASIS. Please clarify.

ANSWER 22: For case-mix adjustment purposes, the principal diagnosis reported on the home health claim will determine the clinical group for each 30-day period of care. In Change Request 11272, CMS has updated billing instructions to clarify that there will be no need for the HHA to complete an ''Other follow-up'' assessment (RFA 05) just to make the diagnoses match. Therefore, for claim ''From'' dates on or after January 1, 2020, the ICD–10–CM code and principal diagnosis used for payment grouping will be from the claim rather than the OASIS. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases. Additional claims processing guidance, including the role of the OASIS item set will be included in the Medicare Claims Processing Manual, chapter 10.

M1311

QUESTION 23: We had a patient that was admitted with bilateral heel Deep Tissue Injuries coded at SOC as two unstageable - Deep Tissue Injuries. At discharge, the DTIs have some dark eschar tissue on both heels. Should these be considered as present on admission?

ANSWER 23: For each pressure ulcer/injury observed at discharge, consider current and historical levels of tissue involvement. We would like to clarify that discharge coding for the scenario described is dependent upon the clinical progression of the wound during the episode.

If the patient is admitted with two unstageable Deep Tissue Injuries that do not evolve during the home health episode to be numerically staged and are unstageable due to eschar at the time of discharge, then the discharge assessment M1311E1, number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar = 2 and M1311E2 , number of these unstageable pressure ulcers that were present upon admission = 2. M1311F1, number of unstageable pressure injuries presenting as deep tissue injuries = 0.

However, any pressure ulcer/injury that is observed to be unstageable due to slough and/or eschar at the time of discharge but was previously numerically stageable during the home health quality episode, is considered new, and not coded as present at the most recent SOC/ROC.

QUESTION 24: If a pressure ulcer/injury is stageable at SOC, then is unstageable due to a non-removable dressing at discharge, is the unstageable pressure ulcer/injury at discharge considered present on admission?

ANSWER 24: If a pressure ulcer/injury stageable at SOC is unstageable due to a non-removable dressing/device at discharge it would be considered present on admission if it had not 1) increased in numerical stage, or 2) become unstageable due to slough/eschar when the non-removable dressing/device was applied.

M2003

QUESTION 25: On my Tuesday admission visit, my patient reported a new rash which had continually worsened since initiating a new antibiotic 4 days ago. I considered this a potential clinically significant medication issue and contacted the physician the same day. The next morning the physician returned my call to report he had called in a new antibiotic prescription, and to notify the patient to discontinue the old med and start with the new. I notified the patient and family that day and the son agreed to pick up the new medication. On my Thursday visit the patient says she is less itchy and uncomfortable since she started the new medication last night. The rash is still present and therefore this issue has not been resolved, although considerably less severe. How do I code M2003?

ANSWER 25: M2003 identifies if potential or actual clinically significant medication issues identified though the drug regimen review were communicated to the physician (or physician-designee) with prescribed/recommended actions completed by midnight of the next calendar day. In the scenario described, the communication occurred, and the prescribed/recommended action (communicate medication change to patient) was completed prior to midnight of the next calendar day after the issue was identified. Code M2003 1-Yes. It is not necessary for the issue, in this scenario the rash, to be resolved by midnight of the next calendar day, as long as the physician communication and completion of the prescribed/recommended actions were completed.

M2200

QUESTION 26: Why will agencies continue to collect M2200 – Therapy Need if it is no longer being used to calculate Medicare payments under PDGM? Will the number that is entered be used for anything? If no, can we enter "000" or a dash (–) or equal sign (=)?

ANSWER 26: While CMS will no longer use M2200 to influence payment under PDGM, other payers may be using this data in their PPS-like payment models. In such cases, agencies should follow instructions from individual payors directing data collection by patient. Agencies *may* code

M2200 Therapy Need with NA – Not Applicable for assessments where the data is not required for the patient's payer (including all Medicare FFS assessments). However, since M2200 is used for risk adjustment for OASIS-based functional outcomes, agencies may elect to enter the estimated number of therapy visits planned for the 60-day certification period, even for assessments where the data is not required to establish case-mix for payment. Only enter "000" if no therapy services are needed. A dash (–) is not a valid response for M2200. For assessments with a M0090 Date Assessment Completed of January 1, 2020 or later, agencies may enter an equal sign (=) for M2200 at the Follow-up time point only.

QUESTION 27: Beginning with episodes with a M0090 date of January 1, 2020 or later, for M2200, do we count the number of therapy visits anticipated for the 30-day payment period or for the 60-day certification period?

ANSWER 27: As M2200 - Therapy Need will continue to be collected for risk adjustment, and to support other payers who may be using PPS-like payment models, M2200 will continue to report the number of therapy visits that are planned for the 60-day certification period, unless otherwise directed by the individual payer.

GG0100, GG0130, GG0170

QUESTION 28: For coding the GG self-care and mobility items, what devices can the patient use to complete the activities?

ANSWER 28: CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility performance. Clinical assessments may include any device or equipment that the patient can use to allow him/her to safely complete the activity as independently as possible. This may include the use of a **stair lift** for patients who rely on such device to go up and down stairs.

GG0110

QUESTION 29: On GG0110 Prior Device Use, can we code an electric recliner which brings a patient to a standing position as a mechanical lift?

ANSWER 29: GG0110C Mechanical lift includes any device a patient or caregiver requires for lifting or supporting the patient's bodyweight. Examples include, but are not limited to: stair lift, Hoyer lift, bathtub lift, sit-to-stand lift, stand assist, and electric recliner, **if required**.

GG0130C

QUESTION 30: Can we code GG0130C Toileting Hygiene for an incontinent episode if that is the patient's usual performance?

ANSWER 30: Toileting hygiene includes performing perineal hygiene and managing clothing (e.g., undergarments, incontinence briefs, pants) before and after voiding or having a bowel movement. For some patients, this may include assessing the type and amount of assistance needed to complete clothing management and hygiene tasks after episodes of incontinence.

GG0130F, GG0130G

QUESTION 31: How would you code items GG0130F Upper body dressing and GG0130G Lower body dressing if you are working with a patient who typically wears a dress or Mumu robe/dress and prefers not to wear undergarments? Can you code both of these items based on putting on and taking off a dress/Mumu alone?

ANSWER 31: We interpret your question to indicate that the patient does not wear underpants/briefs. If the patient does not wear underwear, nor any other type of clothing that just covers her lower body, code GG0130G Lower body dressing with the appropriate activity not attempted code. Any assistance provided by a helper to put on or remove the dress or Mumu would be considered when coding GG0130F Upper body dressing.

QUESTION 32: If a patient can complete upper and lower body dressing tasks, but the helper must help with fastening the bra or pants, how would GG0130F Upper body dressing and GG0130G Lower body dressing be coded?

ANSWER 32: GG0130F Upper body dressing includes the ability to dress and undress above the waist; including fasteners, if applicable. If the patient needs assistance with upper body dressing, including assistance with her bra clasp, code according to type and amount of assistance required to complete the ENTIRE upper body dressing activity. If the helper providers LESS THAN HALF of the effort for the upper body dressing tasks, code 03, Partial/moderate assistance. If the helper does MORE THAN HALF the effort for the upper body dressing tasks, code 02, Substantial/maximal assistance.

The same guidance applies to buttoning pants for GG0130G Lower Body Dressing.

GG0130H

QUESTION 33: Does GG0130H Putting on/taking off footwear need to consider type and amount of assistance to put on/take off both socks AND shoes?

ANSWER 33: The activity of putting on/removing footwear refers to footwear that is appropriate for safe transfer and/or ambulation (mobility). If the patient wears footwear that is safe for mobility (e.g., grip socks), then the data elements may be coded. If the patient's sock is not considered safe for mobility, then code the appropriate "activity not attempted" code.

GG0170G

QUESTION 34: How should GG0170G Car Transfer be coded for a patient who transfers in a wheelchair into an accessible van using a lift?

ANSWER 34: The car transfer activity focuses on transferring into and out of a car or van **seat.** If the patient is not transferring into a **seat** (e.g., a patient transferring into a van, seated in a wheelchair), the Car Transfer activity is not being completed and an appropriate "activity not attempted" code would be used.

GG0170I, GG0170J, GG0170K, GG0170L

QUESTION 35: If a patient cannot walk 50 feet without a rest break, how would you code the GG0170J Walk 50 feet with two turns?

ANSWER 35: The patient may take a brief **standing** rest break (e.g., "a breather") during the walking activities and continue on to complete the walking distance. If the patient needs to **sit** to rest during a GG walking activity, consider the patient unable to complete that walking activity.

GG0170Q

QUESTION 36: How do you answer GG0170Q Does the patient use a wheelchair/scooter?

ANSWER 36: The intent of the item GG0170Q Does the patient use a wheelchair/scooter? is to document whether a patient uses a wheelchair or scooter at the time of the assessment. This includes patients who are learning how to self-mobilize using a wheelchair or scooter, those who require assistance from a helper to mobilize using a wheelchair/scooter, and those who require a helper to push them in a wheelchair. Only **code 0 - no** if at the time of the assessment the patient does not use a wheelchair or scooter under any condition.