



October 2021 CMS Quarterly OASIS Q&As

Category 2

Question 1: An RN goes to a patient home for an anticipated discharge visit. The patient agrees to discontinuing home care services but declines going through the full assessment of items on the OASIS. May this clinician still complete the discharge OASIS in collaboration with other disciplines that have seen this patient within the past 5 days prior to the date of this visit?

Answer 1: The Discharge comprehensive assessment requires a patient encounter and assessment from a qualified clinician per the Medicare CoP §484.55.

The RN may complete the discharge comprehensive assessment including OASIS document based on information from 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. The “last 5 days that the patient received visits” are defined as the date of the last patient visit, plus the four preceding days.

Question 2: Historic OASIS guidance directs agencies to complete a transfer OASIS (*RFA 7 - Transferred to an inpatient facility - patient discharged from agency*) under the following unique circumstances:

- A patient dies less than 24 hours after being admitted to an inpatient facility, or,
- A patient dies in the emergency room (ER), or,
- A patient dies in outpatient surgery.

This means that to meet the new quality measure, Transfer of Health Information to Provider, an agency must send a medication list to the subsequent provider, even for a patient that had died in one of these unique circumstances. Please clarify if this guidance will be modified to accommodate the intent of the Transfer of Health Information to Provider quality measure.

Answer 2: Yes, to satisfy the intent of the Transfer of Health Information to Provider quality measure, the guidance related to use of RFA 7 in the unique circumstances referenced is being modified. Effective immediately, do not use *RFA 7 - Transferred to an inpatient facility - patient discharged from your*

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agency when a patient dies less than 24 hours after being admitted to an inpatient facility, or when a patient dies in the emergency room (ER), or when a patient dies in outpatient surgery or in the care of the recovery room after outpatient surgery. **Effectively immediately, use RFA 8 - Death at home** for these circumstances.

Continue to use *RFA 7 - Transferred to an inpatient facility - patient discharged from your agency* when a patient is transferred from your agency for a qualifying inpatient stay and return to your agency is not expected. A qualifying inpatient stay is defined as a patient being admitted to an inpatient facility for 24 hours or more for reasons other than diagnostic testing.

Question 3: Please provide clarification on what it means that occupational therapists (OTs) can complete the Start of Care (SOC) OASIS for rehab cases. Does this mean that OT's establish eligibility for home care services? Are they allowed to be a stand-alone service from the SOC?

Answer 3: The Medicare Home Health Flexibility Act (H.R.3127/S.1725), effective January 1, 2022 does not alter Medicare's criteria for establishing eligibility for the home health benefit as it relates to occupational therapy (OT). The expanded OT role only applies to rehabilitation cases. Specifically, an occupational therapist may conduct the initial assessment and SOC Comprehensive Assessment if the physician's referral order does not include skilled nursing care but does include (1) occupational therapy, and (2) physical therapy or speech language pathology.

Category 4b

M1306 and M1311

Question 4: I have a question about the current guidance that states: If a pressure ulcer/injury is surgically closed with a flap or graft, it should be considered a surgical wound and not a pressure ulcer/injury. If the flap or graft fails, it should still be considered a surgical wound until healed.

Is this in reference to ANY point in time that the flap/graft fails? For example, if the area of flap/graft heals and has been 100% re-epithelized for greater than 30 days and a patient subsequently develops a wound at the site of the original flap/graft, would it be considered failed surgical site or would it be considered a pressure ulcer/injury?

Answer 4: If a pressure ulcer/injury was closed with a skin graft or flap, the surgical wound healed, and another pressure ulcer/injury forms in the same anatomical location due to pressure, then this would be considered a pressure ulcer/injury. Note it should be staged at the highest stage the pressure ulcer/injury was prior to closure, unless currently presenting at a higher stage or unstageable.

M1340

Question 5: Would a pacemaker or an implantable loop recording device be considered a surgical wound once the initial insertion site has been fully epithelialized for at least 30 days?

Answer 5: The incisions created to implant a pacemaker or loop recording device are surgical wounds until re-epithelialization has been present for approximately 30 days at which time they become scars.

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At that point they would no longer be considered current surgical wounds, as neither the pacemaker nor the loop recording device, are a venous access device nor an infusion device.

M1710 and M1720

Question 6: I am looking for clarification on when to code response 4 for M1710 - When Confused and response 3 for M1720 - When Anxious. I know the look back period is the last 14 days however there is no definition for “4 - Constantly” (for M1710) or “3 - All of the time” (for M1720). For “4- Constantly” (M1710) or “3- All the time” (M1720) to be marked, would the patient have to have been confused or anxious for the entire 14 day look back? Or would Constantly or All of the time apply if the patient was confused or anxious for a period of time shorter than the 14 day look back such as for an entire 24-hour period (constantly for at least one day)?

Answer 6: The intent of M1710 - When Confused (Reported or Observed Within the Last 14 Days) is to identify the time of day or situations when the patient experienced confusion, if at all. M1710 response 4 - Constantly is indicated if a patient was confused at all times during the entire look back period of 14 days.

The intent of M1720 - When Anxious (Reported or Observed Within the Last 14 Days) is to identify the frequency with which the patient has felt anxious within the past 14 days. M1720 response 3 - All of the time is indicated if a patient felt anxious at all times during the entire look back period of 14 days.

M2010

Question 7: If a patient is not taking any high-risk medications at home, but goes to an outpatient oncology clinic for chemotherapy infusions how is M2010 - Patient/Caregiver High-Risk Drug Education answered?

Answer 7: M2010 - Patient/Caregiver High-Risk Drug Education identifies if clinicians instructed the patient and/or caregiver about all of the patient’s high-risk medications. High-risk medications should be identified based on one or more authoritative sources and would be identified from medications included on the patient’s reconciled medication profile.