# April 2022 CMS Quarterly OASIS Q&As

## Category 2

**Question 1: I have a question about completing an RFA 8 - Death at home. We completed a Resumption of care with Recert (ROC/Recert) in the last 5 days of a patient's first certification period after they returned home from a qualifying inpatient stay. The patient expired at home in the new certification period, and no visits had been provided since the ROC/Recert visit. What is the correct course of action in terms of OASIS completion? Should we complete an RFA 8 - Death at home and transmit as the final OASIS in the sequence? Or because no care was rendered during the subsequent certification period, should we not complete/submit the RFA 8 - Death at home and have the final OASIS submission be the ROC/Recert OASIS?**

**Answer 1:** In situations where only one visit was performed in a quality episode, such as the situation described, the OASIS does not have to be submitted to the OASIS system. Therefore, it is acceptable to not submit the ROC/Recert assessment to the OASIS system, but rather to maintain the completed ROC/Recert assessment in the patient's clinical record, with documentation explaining the situation. It would also be acceptable to submit the ROC/Recert and Death at Home assessments to the OASIS system.

The Death at home OASIS is never mandated in situations of single visits in a quality episode (SOC/ROC date to DAH).

**Question 2: Our patient was transported to the hospital and was placed in observation where they expired. Would we complete the RFA 7 - Transferred to an inpatient facility - patient discharged from agency or RFA 8 - Death at home?**

**Answer 2:** Following updated guidance from October 2021 CMS OASIS Quarterly Q&As Q2, complete an RFA 8 - Death at home OASIS when a patient dies anywhere other than after being admitted for a qualifying inpatient stay. 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.

Only use RFA 7 - Transferred to an inpatient facility - patient discharged from agency when a patient is transferred from your agency for a qualifying inpatient stay and return to your agency is not expected

## Category 4b

### M2020/M2030

**Question 3: I would like further clarification regarding the patient's ability to take their medications when they do not have them in the home. My patient has unreliable transportation and was unable to get their medications from the pharmacy when needed. The lack of transportation caused the patient to miss three doses of a new oral medication, and one dose of a prescribed injectable that they were unable to refill timely. The new guidance from the January 2022 Quarterly Q&As stated that we assess a patient's ability based on "patient characteristics, including cognitive status, vision, strength, manual dexterity and general mobility." The patient's lack of consistent transportation is impacting access to their medications. Do we consider this as part of our assessment of M2020 - Management of Oral Medications and M2030 - Management of Injectable Medications?**

**Answer 3:** M2020 - Management of Oral Medications identifies the patient's ability to take all oral (p.o.) medications reliably and safely on the day of assessment. M2030 - Management of Injectable Medications identifies the patient's ability to take all injectable medications reliably and safely on the day of assessment. Note that any assistance or transportation required to get the medication(s) into the home is not considered when coding M2020 and M2030.

Include assessment of the patient's ability to obtain medications from where they are routinely stored in the home, the ability to read the labels (or otherwise identify the medications correctly, for example patients unable to read and/or write may place a special mark or character on the label to distinguish between medications), open the containers, select the appropriate dose (pill/tablet, milliliters of liquid, etc.) and orally ingest (or inject) at the correct times.

Once the medication(s) is/are in the home, if someone other than the patient must do some part of the task(s) that are required for the patient to access and/or take the medication at the prescribed times, then the assistance required would be considered when determining the code for M2020 and M2030.

**Question 4: Can a patient residing in an assisted living facility (ALF) be coded 0 - Able to independently take correct oral medication(s) for M2020 - Management of Oral Medications if the ALF staff must unlock the medications to allow patient access at each administration time?**

**Answer 4:** M2020 - Management of Oral Medications is not automatically assigned a specific code just because a patient resides in an assisted living facility (ALF). M2020 should report the patient's ability to take the correct dose(s) of the correct oral medication(s) at the correct times. The assessing clinician uses clinical judgment to determine the patient's current ability based on observation and assessment of the complexity of the patient's overall drug regimen, as well as patient characteristics, including cognitive status, vision, strength, manual dexterity, and general mobility. Assessment of a patient in an ALF includes consideration of whether a patient can get to the location where the medications are routinely stored at the correct times, can recognize the correct medication dose(s), and take their oral

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medications, recognizing that someone would need to make the medication available to the patient once they are at the location (e.g., nursing office or medication cart).

A patient residing in an ALF could be coded with a response 0, 1, 2 or 3 depending on the level and timing of assistance required on the day of assessment to allow the patient to take the correct dose(s) of all oral medications reliably and safely at the correct times.

Code 0 - Able to independently take the correct oral medications(s) and proper dosages at the correct times, if at each administration time, the patient can independently get to the location where the medications are routinely stored, confirm the correct dose, and take all oral medications safely. This is true even though a staff member must unlock and make the medication available at each administration time.

Apply this same guidance for M2030 - Management of Injectable Medications when access to a patient's injectable medications is restricted by ALF policies.

**GG0130A**

**Question 5: A patient is independent with self-feeding but requires encouragement for adequate intake. Would the encouragement to increase food and/or fluid intake be considered when scoring GG0130A - Eating?**

**Answer 5:** The intent of GG0130A - Eating is to assess the patient's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient. The adequacy of the patient's nutrition or hydration is not considered for GG0130A - Eating.

When coding activities in Section GG, clinicians should code based on the type and amount of assistance required allowing the patient to perform the activity as independently as possible, as long as they are safe. If the patient is able to meet the intent of the activity with no assistance (physical, verbal/nonverbal cueing, setup/clean-up) then code 06 - Independent.