

OASIS Updates:

Get Guidance on the Recent Q&As
Spring 2020



OASIS Updates - Spring 2020 Presentation Materials

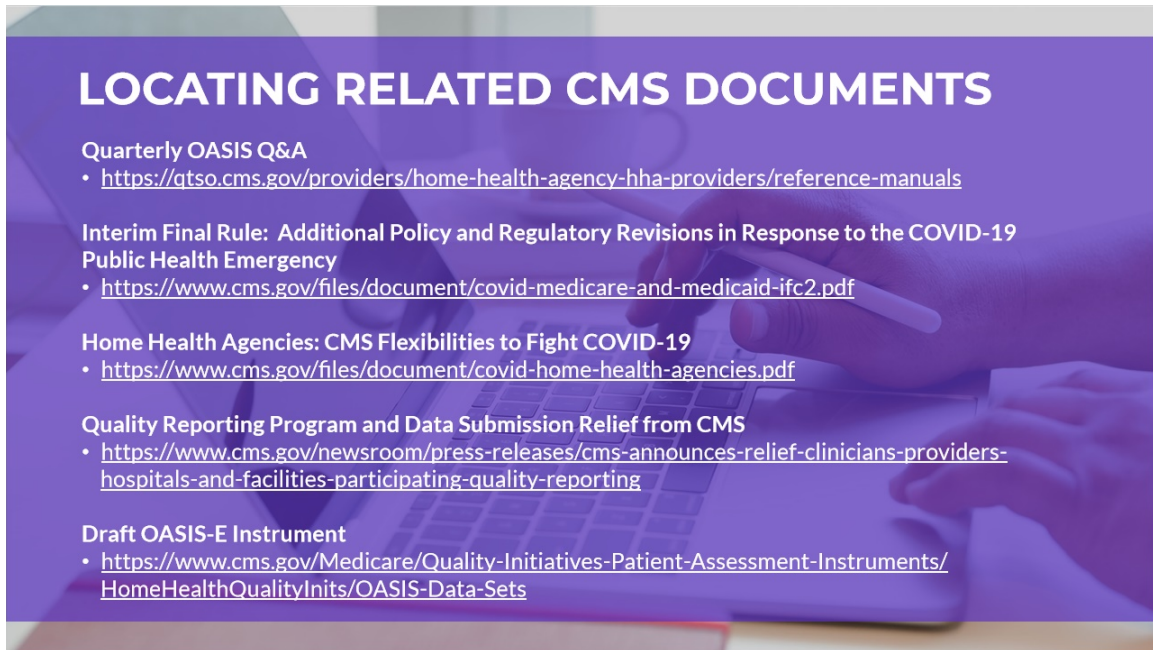
1.1 WellSky



1.2 Welcome



1.3 Locating Related CMS Documents



LOCATING RELATED CMS DOCUMENTS

Quarterly OASIS Q&A

- <https://qtso.cms.gov/providers/home-health-agency-hha-providers/reference-manuals>

Interim Final Rule: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

- <https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf>

Home Health Agencies: CMS Flexibilities to Fight COVID-19

- <https://www.cms.gov/files/document/covid-home-health-agencies.pdf>

Quality Reporting Program and Data Submission Relief from CMS

- <https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting>

Draft OASIS-E Instrument

- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-Data-Sets>

1.4 CMS OASIS Q&A:

Category 2 – Comprehensive Assessment

CMS OASIS Q&A:
Category 2 – Comprehensive Assessment

1.5 Unplanned/Unexpected Discharges

April 2020 Q&A #1

Unplanned/Unexpected Discharges April 2020 Q&A #1

THE TAKE-AWAY:

A visit should be completed for the discharge comprehensive assessment whenever possible. When this is not possible, follow prior CMS Q&A guidance for unplanned/unexpected discharges.

QUESTION 1: An in-person discharge visit is not always possible (e.g., patient moves out of the area or refuses a discharge visit). When is a “non-visit” discharge comprehensive assessment with OASIS allowed?

ANSWER 1: There is no OASIS guidance that allows for a “non-visit” discharge comprehensive assessment with OASIS. The OASIS Manual coding instructions for M0100 - Reason for Assessment, Response 9 - Discharge state: “This comprehensive assessment is conducted when a patient is discharged from the agency for any reason other than transfer to an inpatient facility or death at home. **A patient visit is required to complete this assessment.**” The discharge comprehensive assessment with OASIS requires an in-person patient encounter and assessment from a qualified clinician per the Medicare Home Health Conditions of Participation (CoP §484.55).

For details on how to complete a discharge assessment in the case of an unplanned/unexpected discharge, see additional guidance in the Home Health July 2018 CMS Quarterly OASIS Q&As, Cat. 2, Q2 at:

https://qtso.cms.gov/system/files/qtso/CMS_OAI_2nd_Qtr_2018_QAs_July_2018_FINAL_508.pdf

1.6 Unplanned/Unexpected Discharges

Pt. 2

Unplanned/Unexpected Discharges April 2020 Q&A #1

July 2018 Q&A #2 <As referenced in April 2020 Q&A #1>

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 (Paraphrased):

- 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.

(continued...)

1.7 Unplanned/Unexpected Discharges

Pt. 3

Unplanned/Unexpected Discharges April 2020 Q&A #1

July 2018 Q&A #2 <As referenced in April 2020 Q&A #1>

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 (Paraphrased - continued):

- If the last qualified clinician who saw the patient is not available follow these steps:
 - 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.
 - 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.
 - A supervisor or other agency clinician who has not visited the patient cannot complete a discharge comprehensive assessment compliantly

1.8 CMS OASIS Q&A:

Category 3 – Follow-Up Assessments

CMS OASIS Q&A:
Category 3 – Follow-Up Assessments

1.9 Late Recertification in PDGM – April 2020 Q&A #2

Late Recertification in PDGM – April 2020 Q&A #2

THE TAKE-AWAY:

A missed recertification comprehensive assessment/OASIS should be completed as a 'late recert' rather than discharging and readmitting the patient. Contact your Medicare Administrative Coordinator for payment implications.

QUESTION 2: With PDGM, if a patient needs to have a recertification completed, but it is beyond the 60-day certification period, should we discharge the patient or complete a late recertification?

ANSWER 2: When an agency does not complete a recertification assessment within the required 5-day window at the end of the certification period, **the agency should not discharge and readmit the patient.** Rather, the agency should **send a clinician to perform the recertification assessment as soon as the oversight is identified.** For the Medicare PDGM patient, payment implications may arise from this missed assessment. **Any payment implications may be discussed with the agency's Medicare Administrative Coordinator (MAC).**

1.10 CMS OASIS Q&A:

Category 4B – OASIS Data Items

CMS OASIS Q&A:
Category 4B – OASIS Data Items

1.11 M0090: Assessment Completion Date

January 2020 Q&A #2

M0090: Assessment Completion Date January 2020 Q&A #2

THE TAKE-AWAY:

M0090 reflects the last date comprehensive assessment data is obtained AND documentation is completed. This may be a date later than when OASIS-related information is received if a clinician didn't document the day the information is received. This means collaboration with team members AND related documentation of information/OASIS responses must be completed during the OASIS completion window.

QUESTION 2: In the answer for OASIS Q&A Cat. 4b, Q18, it states: "The assessment completion date (to be recorded in M0090) should be the last date that data necessary to complete the assessment is collected." But in OASIS, Cat. 4b, Q17.1.1. it states "M0090, Date Assessment Completed, is the actual date the assessing clinician completed the SOC assessment document." If the last date data is collected is not the same date that the clinician completes the assessment document, what date is correct for coding M0090?

ANSWER 2: M0090-Date Assessment Completed, is [the last date that information used to complete the comprehensive assessment and determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed.](#)

1.12 M0100: Transfer With or Without Agency Discharge

April 2020 Q&A #3 and #5

M0100: Transfer With or Without Agency Discharge April 2020 Q&A #3 and #5

THE TAKE-AWAY:

Complete a Transfer without Agency Discharge if it's not clear the patient will be discharged from the home health agency. When a Transfer without Agency Discharge was initially submitted but the agency now wishes to discharge the patient and complete a new SOC there isn't a need to 'change the OASIS' to a Transfer with Agency Discharge (unless required by your EMR software). This information supersedes earlier CMS OASIS Q&A guidance.

QUESTION 3: 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?

1.13 M0100: Pt. 2

M0100: Transfer With or Without Agency Discharge April 2020 Q&A #3 and #5

ANSWER 3: 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 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 hospital stay, you would complete RFA 7- Transfer to an inpatient facility- patient discharged from agency.

However, if the patient requires post-acute care in a SNF, IRF, LTCH or IPF during the 30-day period of home health care, CMS expects and recommends (but does not require) the home health agency to discharge the patient by completing the RFA-7 (Transfer to an inpatient facility- patient discharged from agency) and then to readmit the patient with a new Start of Care upon return to home care. **If the home health agency decides to complete an RFA-6 (Transfer to an inpatient facility- patient not discharged from agency), the home health agency will need to complete an RFA-3 (Resumption of Care) upon return to home care. <see Q&A #5 for clearer guidance>**

1.14 M0100: Pt. 3

M0100: Transfer With or Without Agency Discharge April 2020 Q&A #3 and #5

QUESTION 5: When a patient transfers to a short stay acute care hospital and we do a transfer without discharge (RFA 6), then we later discover that the patient has subsequently transferred to a SNF or IRF, etc., and we now discharge the patient, do we correct the transfer OASIS previously submitted to indicate it was a transfer with discharge (RFA 7).

ANSWER 5: There is **no need to update or change the RFA 6 transfer OASIS to an RFA 7 transfer OASIS to reflect this discharge.**

1.15 IRF and IPF Definitions in PDGM

April 2020 Q&A #4

IRF and IPF Definitions in PDGM April 2020 Q&A #4

THE TAKE-AWAY:

Post-acute care includes Inpatient Rehabilitation Facilities (IRF) which are free-standing or part of another facility, and Inpatient Psychiatric Facilities (IPF) which are free-standing or part of another facility. Remember, selecting these facilities in M1000 does not impact reimbursement as CMS looks at the Medicare Claims Processing System to determine the referral source for reimbursement purposes under PDGM.

QUESTION 4: For PDGM, if a patient requires post-acute care, does inpatient rehabilitation facility (IRF) include an inpatient rehabilitation hospital or designated rehab unit? Does inpatient psychiatric facility (IPF) include a psychiatric hospital or unit?

ANSWER 4: An inpatient rehabilitation facility or unit (IRF) means a freestanding rehab hospital or a rehabilitation bed in a rehabilitation distinct part unit of a general acute care hospital. An inpatient psychiatric facility (IPF) means a psychiatric hospital or unit.

1.16 M0104: Referral Dates and Approved PDGM Diagnoses

January 2020 Q&A #3

M0104: Referral Dates and Approved PDGM Diagnoses January 2020 Q&A #3

THE TAKE-AWAY:

The referral date does not change simply because a more specific primary diagnosis is required for PDGM billing purposes.

QUESTION 4: A complete referral is received from a physician at an inpatient facility on 01/01/2020 and has a diagnosis that does not fall into a PDGM clinical grouping; patient is discharged to home health on 01/01/2020. Intake staff calls physician requesting a more specific diagnosis. The more specific diagnosis is received on 01/04/2019 and care is started on 01/05/2020. Will M0104 be changed to 01/04/2020 based on the update to the specificity of the diagnosis?

ANSWER 4: M0104 specifies the referral date, which is the most recent date that verbal, written, or electronic authorization to begin or resume home care was received by the home health agency. A valid referral is considered to have been received when the agency has received adequate information about a patient (name, address/contact info, and diagnosis and/or general home care needs) and the agency has ensured that the referring physician, or another physician, will provide the plan of care and ongoing orders. In the scenario described, if your agency received adequate information as outlined above (including a relevant diagnosis) a valid referral is present on 1/1/2020 to allow the home health admission to be initiated and the M0104 date would be based on the date the referral was received. The assessment process, along with collaboration with the physician, may lead to identification of additional diagnoses for care planning and/or reimbursement purposes.

1.17 M0110 Early or Later Calculation in PDGM

January 2020 Q&A #4

M0110 Early or Later Calculation in PDGM January 2020 Q&A #4

THE TAKE-AWAY:

M0110 is not used to determine whether a PDGM period is Early or Later. CMS uses the Medicare Claims Processing System to determine episode timing. CMS allows a response of NA for M0110 for traditional Medicare records and for any payer that does not require a response other than NA. Note some EMR software is designed to 'pull' this information into a calculation screen for payment calculation within the software only. Other EMR software will not allow a response of NA in M0110.

QUESTION 4: For PDGM, should the response for M0110 be based upon the OASIS-D Guidance Manual instructions (PPS definition), or should the response be based upon what is considered Early or Late for episode timing under PDGM?

ANSWER 4: While CMS will no longer use M0110 to influence payment under PDGM, other payers, including Medicare Advantage, may be using this data in their PPS-like payment model. In such cases, agencies should follow instructions from individual payors directing data collection. 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). Otherwise, the coding instructions for M0110 are not changing from what is in the OASIS-D Guidance Manual.

1.18 M1840: Toilet Transfer – January 2020 Q&A #7

M1840: Toilet Transfer – January 2020 Q&A #7

THE TAKE-AWAY:

Female patients who only use a bedpan and not a urinal can be coded 03-Unable to get to and from the toilet or bedside commode but able to use a bedpan/urinal independently. Use of both a bedpan and a urinal is not a requirement for this response selection with female patients. (A male patient must be independent in use of both the urinal and bedpan when both are used)

QUESTION 7:

If a female patient, who only uses a bed pan and does not use a urinal, can transfer on and off the bed pan independently should she be scored as a code 03 - unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently?

ANSWER 7: If the patient is unable to get to and from the toilet or bedside commode and uses only a bed pan (i.e. voiding and bowel movements for a female patient), then for M1840, response code 3 would apply if she/he is independent in safely getting on and off a bed pan.

1.19 M2001/M2003/M2005: Medication Review

January 2020 Q&A #8

M2001/M2003/M2005: Medication Review January 2020 Q&A #8

THE TAKE-AWAY:

An RN, not an LPN, must review the patient medication list for home health rehabilitation therapy only cases.

QUESTION 8: The new CoPs indicate it is mandatory that an office nurse does the medication review. Our agency is letting the LPNs do this. Is this compliant with OASIS guidelines and the COPs?

ANSWER 8: While the new CoPs continue to allow an RN, PT, OT, or SLP to complete a comprehensive assessment and collect OASIS, [the new Interpretive Guidelines §484.55\(c\)\(5\) do state that in rehabilitation therapy only cases, the therapist must submit a list of patient medications to an HHA nurse for review. According to the Home Health Survey Mailbox Team, in therapy only cases, an agency RN should review the medication list.](#)

Further questions related to the Interpretive Guidelines may be directed to the home health regulations and compliance team via the Home Health Survey Mailbox at hasurveyprotocols@cms.hhs.gov.

1.20 M2200: Therapy Need– January 2020 Q&A #5

M2200: Therapy Need– January 2020 Q&A #5

THE TAKE-AWAY:

A response of NA may be entered in M2200 unless a payer requires a numeric response. M2200 is used for risk adjustment, therefore an agency can choose to enter a numeric response.

QUESTION 5: I understand that for Medicare payment episodes that began before January 1, 2020, CMS would automatically adjust claims up or down to correct for episode timing (early or later, from M0110) and for therapy need (M2200) when submitted information was found to be incorrect. With PDGM, will CMS continue to make corrections if values submitted by HHA for M0110 and M2200 are not correct?

ANSWER 5: CMS will no longer use M2200 to influence payment under PDGM and [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. Because CMS is no longer using the data from M2200 for payment, this information will not be on the Medicare FFS claims and therefore will no longer be corrected by the Medicare Claims Processing System. This is effective for processing claims related to a payment period with a M0090 date on or after January 1, 2020.

1.21 M2420: Discharge Disposition

January 2020 Q&A #9

M2420: Discharge Disposition January 2020 Q&A #9

THE TAKE-AWAY:

Code '2-Patient remained in the community (with formal assistive services)' when a patient will receive skilled home health services from another agency following discharge.

QUESTION 9: For the new quality measure, Transfer of Health Information to Provider, how are we to identify if the patient was discharged to the care of another home health agency? There is no OASIS item that identifies this information.

ANSWER 9: You are correct that currently, there is no way to determine if a patient was discharged to a home health agency, however, the guidance for M2420 Discharge Disposition is being revised to collect this information.

(continued...)

1.22 M2420: Pt. 2

M2420: Discharge Disposition January 2020 Q&A #9

THE TAKE-AWAY:

Code '2-Patient remained in the community (with formal assistive services)' when a patient will receive skilled home health services from another agency following discharge.

ANSWER 9: (continued...)

Effective immediately, agencies should begin using the following guidance for M2420:

Code 1, Patient remained in the community (without formal assistive services), if, after discharge from your agency the patient remained in a non-inpatient setting, either with no assistive services, or with any assistive services EXCEPT:

1. Skilled services from another Medicare certified home health agency, and/or
2. Hospice care from a non-institutional ("home") hospice provider

Code 2, Patient remained in the community (with formal assistive services), if, after discharge from your agency the patient remained a non-inpatient setting, receiving skilled services from another Medicare certified home health agency, (with or without other assistive services).

There are no changes in guidance to M2420 response options 3, 4, or UK.

1.23 GG0130/GG0170 Functional Items – April 2020 Q&A #9

GG0130/GG0170 Functional Items – April 2020 Q&A #9

THE TAKE-AWAY:

Code 03-Partial/moderate assistance when patients provide exactly half the effort to complete a task (as opposed to contributing more than half or less than half of the effort).

QUESTION 9: The OASIS Guidance Manual for section GG clarifies that Code 03- Partial/moderate assistance indicates the helper is providing less than half the effort and Code 02 – Substantial/maximal assistance indicates the helper is providing more than half the effort. If a helper provides exactly half the effort, how would the item be coded?

ANSWER 9: In the situation you describe, the helper and patient each are providing exactly half of the effort to complete a GG activity. If the patient performs exactly half of the effort, code the item 03 - Partial/moderate assistance.

1.24 GG0100c: Prior Functioning/Stairs

January 2020 Q&A #10

GG0100c: Prior Functioning/Stairs January 2020 Q&A #10

THE TAKE-AWAY:

GG0100c reports ability to go up and down stairs prior to the current illness, exacerbation, or injury without requiring a certain number of steps or internal vs. external stairs.

QUESTION 10: Prior to injury, the patient was able to climb and descend 3 stairs to enter her home independently. She was unable to manage the full flight of stairs to the 2nd floor of her home, therefore stayed on the first floor. She reports that she did not use stairs in the community. Could you please advise as to the appropriate response for item GG0100C. Prior level of function on Stairs?

ANSWER 10: GG0100c identifies the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury. **CMS guidance includes "internal or external stairs," and does not further define the number of steps for GG0100C Stairs.**

In the scenario you describe, the patient does go and up down 3 stairs to get into and out of her home independently. Code GG0100C Prior Functioning - Stairs 3 – Independent.

1.25 GG0110: Prior Device Use

January 2020 Q&A #11

GG0110: Prior Device Use January 2020 Q&A #11

THE TAKE-AWAY:

A gait belt is not a mechanical lift for the purposes of GG0110.

QUESTION 11: Since GG0110C - Mechanical lift includes “any device a patient or caregiver requires for lifting or supporting the patient’s body weight,” does this mean a gait belt is included since it is a device that a caregiver could require for lifting or supporting a patient’s body weight?

ANSWER 11: No – this item is intended to refer to mechanical devices or equipment such as a Hoyer lift/ stair lift that involve some type of machine required for lifting or supporting the patient’s body weight.

1.26 M1800s/GG0130/GG0170: Functional Items and Fall Risk

January 2020 Q&A #6

M1800s/GG0130/GG0170: Functional Items and Fall Risk January 2020 Q&A #6

THE TAKE-AWAY:

Identifying a patient is ‘at risk for falls’ does not necessarily imply the patient must have supervision or assistance to complete functional tasks identified in M1800s or GG0130/GG0170.

QUESTION 6: Can you please provide clarification for the following situation? Many of my patients are identified by the MAHC-10 as “at risk for falls”. An outsource coding company our agency uses has directed us that any patient that is scored as a fall risk on the MAHC-10 must be coded as requiring at least supervision for the function items (M1800s and GG). This instruction doesn’t always seem to be consistent with general assessment observations, and if also used at discharge, limits the ability to show improvement my patients have made. Is there some specific instruction that has been provided that requires this directed coding?

ANSWER 6: Identifying that a patient is at risk for falls is only one criterion to consider when determining the type and amount of assistance needed for a patient to safely complete functional activities. **There is no CMS guidance that requires that a patient scored as "at risk" for falls must be coded as needing supervision (or greater assistance) for any or all of the function OASIS items.**

(continued...)

1.27 M1800s/GG0130/GG0170: Pt. 2

M1800s/GG0130/GG0170: Functional Items and Fall Risk January 2020 Q&A #6

THE TAKE-AWAY:

Identifying a patient is 'at risk for falls' does not necessarily imply the patient must have supervision or assistance to complete functional tasks identified in M1800s or GG0130/GG0170.

ANSWER 6: (continued...)

Although a patient may meet the MAHC-10's "at risk for falls" threshold, (e.g., due to age, 3+ diagnoses, age-related vision impairment, and poly-pharmacy), additional assessment findings (like the patient wears glasses to correct vision impairment, and sits while completing dressing activities) may allow the patient to safely complete some activities without supervision or assistance.

Even if a patient is determined to be at risk for falls, each OASIS item should be considered individually and coded based on the item specific guidance and OASIS conventions that apply to each item.

1.28 GG0130/GG0170 Functional Items

April 2020 Q&A #10

GG0130/GG0170 Functional Items April 2020 Q&A #10

THE TAKE-AWAY:

Code 05-Setup or Clean Up Assistance if verbal cueing is required only before or after and activity and not during the activity.

QUESTION 10: For the GG functional items, I understand that verbal cueing during an activity would be coded a 04 – Supervision or touching assistance. Can a verbal cue provided prior to the initiation of the task be considered as 05 – Setup or clean-up assistance, as long as no further cues were provided during the actual activity? For example, prior to the "Picking up an item from the floor" activity, the therapist needed to cue the patient on where to place their hand for stability; then the patient completed all of the activity safely and without any assistance or additional cues. Would this be 05 - Setup or 04 - Supervision? Additionally, the OASIS Guidance Manual indicates via an example for bed to chair transfers, that "locking chair brakes" prior to the transfer is 05 – Setup, as long as no further assistance was required during the activity. Could a verbal cue reminding a patient to lock wheelchair brakes prior to the initiation of the transfer be considered 05 - Setup as well, as long as no further cueing or touching was provided during the activity?

ANSWER 10: When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as he/she is safe.

(continued...)

1.29 GG0130/GG0170 Pt. 2

GG0130/GG0170 Functional Items

April 2020 Q&A #10

THE TAKE-AWAY:

Code 05-Setup or Clean Up Assistance if verbal cueing is required only before or after and activity and not during the activity.

ANSWER 10: At admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity prior to benefit of services provided by your agency staff. This may be achieved by having the patient attempt the activity prior to providing any instruction that could result in a more independent code, and then coding based on the type and amount of assistance that was required prior to the benefit of services provided by your agency staff.

Communicating the activity request (e.g., "Can you stand up from the toilet?") **would not be considered verbal cueing.** If additional prompts are required in order for the patient to safely complete the activity (e.g., "Push down on the grab bar", etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree found at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual>

In the scenarios described, assuming the verbal cues were only required prior to the activity, were provided prior to the benefit of services, and no other assistance was needed in order for the patient to complete the activity safely, then the verbal cues fit the definition for 05 – Setup or clean-up assistance.

1.30 GG0130/GG0170 Pt. 3

GG0130/GG0170 Functional Items

April 2020 Q&A #11

THE TAKE-AWAY:

Goals in GG0130/GG0170 do not need to be updated once the OASIS completion timeframe has ended.

QUESTION 11: Can goals be changed for the GG Self-Care (GG0130) and Mobility (GG0170) items after the admission assessment timeframe?

ANSWER 11: The GG Self-Care and Mobility Discharge Goals are used in the calculation of the Process measure – Percentage of Patients with an Admission and Discharge Function Assessment and a Care Plan that Addresses Function. The measure reports, in part, that discharge goals were established, and does not take into consideration whether or not the goals were met.

Once a goal is established, there is no need to update it on OASIS if circumstances change or additional information becomes available either within or after the SOC/ROC assessment timeframe.

1.31 GG0130A: Eating

January 2020 Q&A #12

GG0130A: Eating January 2020 Q&A #12

THE TAKE-AWAY:

GG0130A reports the level of independence with eating regardless of whether eating with the dominant or non-dominant hand. Respond based on the amount of assistance needed to safely eat in any manner.

QUESTION 12: A patient has had a stroke which has impacted their dominant hand. Upon admission to home health, the patient is noted to use their unaffected, non-dominant hand to feed themselves, and only requires setup/cleanup assistance. However, when asked by the OT to perform eating with the affected, dominant hand, the patient required substantial/maximal assist. These two attempts both occurred before therapeutic intervention was initiated. Which should be recorded as the patient's baseline status for admission?

ANSWER 12: The intent of GG0130A - Eating is to assess the patient's ability to use suitable utensils to bring food and/or liquids to the mouth and swallow food and/or liquid once the meal is placed before the patient. **When assessing GG0130A - Eating, allow the patient to complete the activity of eating as independently as possible as long as they are safe.**

1.32 GG0130E: Bathing

April 2020 Q&A #6

GG0130E: Bathing April 2020 Q&A #6

THE TAKE-AWAY:

Select an activity attempted code of 01-06 if sufficient judgment can be made about a patient's ability to bathe based on partial activities observed and other assessment means. If unable to determine a response, use an 'activity not attempted' code.

QUESTION 6: A patient agreed to shower during an OT visit within the SOC assessment timeframe but would not let the OT provide any needed assistance during the bathing process. The only tasks the patient completed were wetting her body and washing her abdomen. She declined to have the therapist assist to complete the remaining bathing tasks. How would GG0130E – Shower/bathe self be coded?

ANSWER 6: The intent of GG0130E - Shower/bathe self, is to assess the patient's ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair) and does not include transferring in/out of tub/shower.

If the patient only performs a partial bath and does not have a complete bath during the entire assessment timeframe, use clinical judgment to determine if the situation allows the clinician to adequately assess the patient's ability to complete the activity of bathing self (GG0130E). If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires.

1.33 GG0130F/G/H: Dressing

January 2020 Q&A #13

GG0130F/G/H: Dressing January 2020 Q&A #13

THE TAKE-AWAY:

GG0130 dressing items are answered based on the ability to put on/take off all relevant items regardless of the timing of when individual items are put on/taken off.

QUESTION 13: Does the donning and doffing of devices and/or prosthetics have to occur at the same time of dressing to be counted as dressing items?

ANSWER 13: Coding of the dressing activities should consider relevant dressing items regardless of the timing of when each item is put on/taken off. For example, if a patient dresses himself except for donning an elastic support bandage because it is to be put on later in the day, or because the patient needed assistance to put on the support, code GG0130G – Lower body dressing based on the type and amount of assistance needed to put on/take off all items relevant to the patient, including the elastic support bandage.

1.34 GG0130F/G/H: Dressing

January 2020 Q&A #14

GG0130F/G/H: Dressing January 2020 Q&A #14

THE TAKE-AWAY:

The response to GG0130 dressing items is determined based on when assistance is needed (before, during, and/or after the activity) rather than the type of assistance (i.e. set-up or supervision).

QUESTION 14: If a patient is independent with dressing but requires supervision to gather her clothes from the closet and take them to the bed before she can get dressed, is she “independent” for dressing, “supervision” for dressing” or “set-up” for dressing?

ANSWER 14: The intent of the items GG0130F and GG0130G is the patient’s ability to dress and undress above the waist (GG0130F) and below the waist (GG0130G); including fasteners, if applicable.

It is not the type of assistance that is provided that determines the O5 Setup/Clean-up code but rather when (related to the completion of the activity) the needed assistance is provided.

If the assistance provided is necessary only before or after the activity is completed, and no assistance is needed during the completion of the activity, select Code O5 Setup/Clean-up.

1.35 GG0130G: Lower Body Dressing

April 2020 Q&A #7

GG0130G: Lower Body Dressing April 2020 Q&A #7

THE TAKE-AWAY:

Code GG0130G based on the ability to put on/take off all routinely worn lower body clothing. When a correct response can be determined through observation of a portion of the task select 06-01. Otherwise, consider observing when more of the task is completed at a future visit or respond through other means of assessment such as interview or observing other similar tasks.

QUESTION 7: If For GG0130G - Lower body dressing, if a patient is wearing a dressing gown and underwear during the first assessment, is this scenario acceptable to code lower body dressing? Or, at a visit the following day within the assessment timeframe, if the patient is wearing more items including underwear and shorts/pants, should we use this later scenario instead as a true baseline of their lower body dressing ability?

ANSWER 7: The intent of GG0130G - Lower body dressing is to assess the patient's ability to dress and undress below the waist, including fasteners, if applicable, in clothing routinely worn by the patient. At admission, the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your agency staff.

Clinicians should use clinical judgment to determine if observing the patient dress and undress in the lower body clothing (i.e. underwear) worn during the first assessment allows the clinician to adequately determine the patient's ability to complete the activity of lower body dressing (GG0130G) in clothing routinely worn by the patient. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires.

1.36 GG0130H: Footwear

April 2020 Q&A #8

GG0130H: Footwear April 2020 Q&A #8

THE TAKE-AWAY:

Code GG0130H based on whatever footwear is routinely worn that allows for safe mobility. Both socks and shoes are not required if the footwear allows for safe mobility. Use an 'activity not attempted' code if safe footwear isn't available to assess the patient's ability.

QUESTION 8: As the definition of "footwear" states that it "includes the ability to put on and take off socks and shoes", how should GG0130H - Putting on/taking off footwear be coded when only one of these items is present?

ANSWER 8: The intent of GG0130H - Putting on/taking off footwear is to assess a patient's ability to put on and take off socks and shoes or other footwear.

GG0130H - Putting on/taking off footwear is assessed with 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 GG0130H - Putting on/taking off footwear, may be coded. If the patient's socks are not considered safe for mobility, and the patient does not have shoes available, and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities, then code using the appropriate "activity not attempted" code.

If the patient wears shoes that are safe for mobility, but does not wear socks, then GG0170H - Putting on/taking off footwear, may be coded.

1.37 GG0170G: Car Transfer

April 2020 Q&A #12

GG0170G: Car Transfer April 2020 Q&A #12

THE TAKE-AWAY:

Coding of GG0170G can be based on observation, patient/caregiver report, collaboration, and/or assessment of similar items. The correct response can be entered if observing only the transfer into a vehicle gives sufficient information to accurately respond for both entering and exiting the vehicle.

QUESTION 12: At discharge, if I assess my patient getting into their car to go to a doctor's appointment, can I code GG0170G - Car Transfer, OR do I have to observe the patient getting both into and out of a car to code this item?

ANSWER 12: The intent of GG0170G - Car Transfer is to assess the patient's ability to transfer in and out of a car seat on the passenger side.

Code the patient's functional status based on a functional assessment that occurs at discharge. At discharge, the self-care and mobility function scores are to reflect the patient's discharge status, and are to be based on observation of activities, to the extent possible. The assessing clinician may **combine general observation, assessment of similar activities, patient/caregiver(s) report, collaboration with other agency staff, and other relevant strategies to complete any and all GG items**, as needed. Clinicians should **use clinical judgment to determine if the situation (getting in the car) allows the clinician to adequately assess the patient's ability to complete the entire GG0170G - Car Transfer activity (transferring in and out of a car)**. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires.

1.38 GG0170G: Pt. 2

GG0170G: Car Transfer April 2020 Q&A #13

THE TAKE-AWAY:

Coding of GG0170G can be reported for a car, van, sports utility vehicle, or similar vehicle where the patient enters/exits a passenger side seat.

QUESTION 13: For GG0170G - Car Transfer, can the patient be assessed transferring in and out of a Sport Utility Vehicle (SUV)?

ANSWER 13: The intent of the GG0170G - Car Transfer is to assess the patient's ability to transfer in and out of a car or van seat on the passenger side.

Any vehicle model available may be used for the assessment. In the scenario presented, if in the clinician's professional judgment, the patient can transfer in/out of an SUV safely, code based on the type and amount of assistance required to complete the activity.

1.39 GG0170 I/J/K/L: Ambulation

January 2020 Q&A #15

GG0170 I/J/K/L: Ambulation January 2020 Q&A #15

THE TAKE-AWAY:

The GG0170 ambulation distances must be walked in their entirety by the patient in order to code 06-Independent through 01-Two Helpers Required – otherwise, use a 'not assessed' response of 07, 09, 10, or 88.

QUESTION 15: If the patient requires two helpers to carry him 10 feet from the bed to the chair, would this be coded 01- Dependent for GG0170I Walk 10 feet?

ANSWER 15: The walking activities cannot be completed without some level of patient participation. A helper cannot entirely complete a walking activity for a patient.

1.40 GG0170 I: Ambulating 10 Feet

April 2020 Q&A #14

GG0170 I: Ambulating 10 Feet April 2020 Q&A #14

THE TAKE-AWAY:

Further confirmation of January Q&A indicating a patient must walk the entire distance indicated to use an 'activity attempted' code.

QUESTION 14: I have a question regarding the guidance in Q15 of the January 2020 OASIS Quarterly Q&As. In the answer, it states "The walking activities cannot be completed without some level of patient participation. A helper cannot entirely complete a walking activity for a patient". The example given was someone carrying a patient 10 feet. How would you code a situation where the patient walks part of the distance, possibly 4 feet, and then the helper carries them the remaining distance to get to the 10-feet needed for GG0170I - Walk 10 feet? Would this be coded "02 - Substantial / maximal assistance" because the helper is carrying the patient the majority of the distance? I know with the GG wheelchair items that a helper can complete the distance needed by pushing the patient in the wheelchair, but I am seeking clarification for the walking items.

ANSWER 14: The intent of the walking item GG0170I - Walk 10 feet is to assess the type and amount of assistance a patient requires to ambulate 10 feet once in a standing position. **Since a helper cannot complete a walking activity for a patient, the walking activities cannot be considered completed without some level of patient participation that allows the patient to ambulate for the entire stated distance.** In your scenario where the patient participates in walking 4 feet and then requires the helper to carry them for further distances, the activity GG0170I - Walk 10 feet is not considered completed. **If the stated distance of 10 feet is not able to be walked by the patient, with or without some level of assistance, GG0170I would be coded with one of the "activity not attempted" codes.** Each OASIS item should be considered individually and coded based on the guidance provided for that item.

1.41 GG0170 I/J/K/L: Ambulation

January 2020 Q&A #16

GG0170 I/J/K/L: Ambulation January 2020 Q&A #16

THE TAKE-AWAY:

The GG0170 Ambulation is coded 01-Dependent when two helpers are required to assist a patient, even if one is only managing equipment.

QUESTION 16: When the therapist must provide contact guard assist to the patient during ambulation and there is a second person helping to manage an Oxygen tank (or IV pump tubing), how are the GG walking items scored?

ANSWER 16: If two helpers are required to assist the patient to safely walk, (one to provide support to the patient and a second to manage necessary equipment to allow the safe walk), code 01 – Dependent, as two helpers are required for the patient to safely complete the activity.

1.42 GG0170 I/J/K/L: Pt. 2

GG0170 I/J/K/L: Ambulation January 2020 Q&A #17

THE TAKE-AWAY:

Assistance solely to manage equipment during a walking item is coded to 04-Supervision/touching assistance.

QUESTION 17: Have some questions about coding GG0170K – walk 150 feet:

- a) Patient ambulates 155 feet with the use of oxygen. The oxygen tank is needed to be pushed throughout the entire walking distance by a therapist. The therapist does not cue or physically assist the patient. Truly, only there to push the tank. What would the code be for this scenario? It is not only as set-up, but throughout the entire walking episode.
- b) Patient ambulates 155 feet with the use of oxygen. The therapist obtains a longer nasal cannula tubing and only sets up/ removes the tank and tubing. The patient ambulates the distance without any assistance of others except for the tank set up/ "clean up". What is the code for such mobility?
- c) Patient is educated on the ability for themselves to modify the tank to allow for longer tubing during ambulation. The patient ambulates the distance of 155 feet and is able to set up and "clean up" the tubing and tank independently. Would this allow for a code of 06 - Independent?

1.43 GG0170 I/J/K/L: Pt. 3

GG0170 I/J/K/L: Ambulation January 2020 Q&A #17

THE TAKE-AWAY:

Assistance to manage equipment only during a walking item is coded as 04-Supervision/touching assistance.

ANSWER 17: Intent of the GG0170 walking items is to collect information about the patient's ability to ambulate safely.

- a) If the helper is only required to manage the oxygen tank, pushing it to allow the patient to safely walk without additional assistance from the helper, code 04 – Supervision/touching assistance.
- b) If the patient can complete the walking activity safely only after a helper retrieves and/or sets up oxygen equipment necessary to perform the included tasks, code 05 – Setup or clean-up assistance.
- c) If the patient is able to set-up the oxygen and is able to safely complete the walking activity without requiring the assistance of a helper, the activity would be coded 06- Independent.

1.44 GG0170 I/J/K/L: Pt. 4

GG0170 I/J/K/L: Ambulation January 2020 Q&A #16

THE TAKE-AWAY:

At SOC, GG0170 stair items are answered based on patient ability prior to intervention by agency staff such as education by a therapist during their evaluation.

QUESTION 18: For GG0170M, 1 step (curb), on admission a patient was not able to go up and down steps secondary to safety deficits. The PT completed their evaluation 2 days later and after providing education regarding the safety deficits and how to correctly ascend/descend the stairs the patient was then able to ascend and descend some steps. Do we code 88 – not attempted due to medical conditions or safety concerns for GG0170M, 1 step (curb) since patient was unsafe on admission? Or do we code based on how the patient performed on steps at the PT evaluation even though the patient had received interventions by agency staff in order to complete the activity?

ANSWER 18: The intent of the GG0170 stair items is to determine the amount of assistance required by a patient to go up and down the stairs, by any safe means. **At Admission, the mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your agency staff. "Prior to the benefit of services" means prior to provision of any care by your agency staff that would result in more independent coding.**

In your scenario if the patient was not able to go up and down the stairs prior to the benefit of services provided by the agency, and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities, use the appropriate activity not attempted code.

1.45 GG0170 Q/R/S: Wheelchair/Scooter Use

January 2020 Q&A #19

GG0170 Q/R/S: Wheelchair/Scooter Use January 2020 Q&A #19

THE TAKE-AWAY:

Code GG0170Q '0-No' only if the patient doesn't use a wheelchair or scooter under any condition at the time of assessment. Take into consideration the use of a wheelchair or scooter outside of the standard assessment timeframe. Select one of the 'activity not attempted' codes for GG0170R and GG0170S if a wheelchair/scooter isn't available and a response can't be determined by other means.

QUESTION 19: On admission, my patient reported that he only uses a wheelchair when he visits his cardiologist because of the distance from the car to the office. He shared that because of hospital policies, they also had an aide push him in a wheelchair as he was being discharged from the hospital two days ago. Because GG0170Q reports if a patient uses a wheelchair or scooter at the time of the assessment, would the answer be 1- Yes? If so, then how do I answer GG0170R and GG0170S if he doesn't own a wheelchair?

ANSWER 19: 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. The code 0 - No would only be used if at the time of the assessment, the patient does not use a wheelchair or scooter under any condition.

Although it is under infrequent conditions, in your scenario, the patient uses a wheelchair, therefore, GG0170Q would be coded 1 -Yes. Regarding GG0170R and GG0170S, if a patient does not complete the wheelchair activities during home visit, determine the patient's abilities based on the patient's performance of similar activities during the assessment, or on patient and/or caregiver report. If you are unable to observe the activity, and usual status cannot be determined based on patient and/or caregiver report or on assessment of similar activities, then select the appropriate activity not attempted code.

1.46 GG0170Q: Wheelchair/Scooter Use

April 2020 Q&A #15

GG0170Q: Wheelchair/Scooter Use April 2020 Q&A #15

THE TAKE-AWAY:

Further clarification that 0-No is coded only if the patient doesn't use a wheelchair or scooter under any condition at the time of assessment as the January 2020 guidance supersedes older OASIS guidance.

QUESTION 15: According to the guidance manual, the intent of GG0170Q - Does the patient use wheelchair and/or scooter is to assess the ability of patients who SELF-mobilize with a wheelchair/scooter or those who are learning to SELF-mobilize. The answer from the January 2020 Quarterly Q&As makes it sound like the item's intent is to code based on whether or not the patient is using a wheelchair or scooter at all, regardless if they self-mobilize. Please clarify.

ANSWER 15: At times, CMS provides new or refined instruction that supersedes previously published guidance. In such cases, use the most recent guidance. The January 2020 Quarterly OASIS Q&As represent more recent OASIS guidance than the OASIS Guidance Manual dated January 2, 2019, therefore, utilize the more recent guidance presented in January 2020, Question #20. Only code GG0170Q - Does the patient use a wheelchair and/or scooter? as "0 - No" if at the time of the assessment the patient does not use a wheelchair or scooter under any condition.

1.47 GG0170Q: Pt. 2

GG0170Q: Wheelchair/Scooter Use January 2020 Q&A #20

THE TAKE-AWAY:

GG0170Q is answered 1-Yes if a patient is using a wheelchair or scooter at the time of assessment whether or not the patient also ambulates. At discharge, respond to the ambulation questions when a wheelchair is no longer in use and answer GG0170Q 0-No.

QUESTION 20: For GG0170Q, the patient was coded at admission as yes for wheelchair use but was also ambulating. In the instances where a patient is both ambulating and using a wheelchair should both the walking activities and the wheelchair activities be coded? At discharge, if the same patient is ambulating and no longer using a wheelchair, can GG0170Q be coded "no"?

ANSWER 20: 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. The responses for the gateway wheelchair item (GG0170Q1 and GG0170Q3) do not have to be the same on SOC/ROC and discharge assessments.

If at the time of the SOC assessment, the patient is using a wheelchair, GG0170Q would be coded 1 – Yes. If at SOC the patient is both walking and using a wheelchair, then code both the walking and the wheelchair activities based on the type and amount of assistance required for the patient to safely complete each activity.

If at discharge, the patient does not use a wheelchair, then GG0170Q would be coded 0 -No. If at discharge, the patient is both walking and using a wheelchair, then code both the walking and the wheelchair activities based on the type and amount of assistance required for the patient to safely complete each activity.

1.48 Additional OASIS Information

Additional OASIS Information

1.49 CMS Flexibilities to Fight COVID-19

CMS Flexibilities to Fight COVID-19

<https://www.cms.gov/files/document/covid-home-health-agencies.pdf>

THE TAKE-AWAYS:

- The initial assessment and determination of patients' homebound status can be completed remotely or by record review. <NOTE: this is the Initial assessment, not the Comprehensive assessment>
- The timeframe requirement for completion of the comprehensive assessment is extended from five to thirty days.
- The 30-day OASIS submission requirement is waived. The OASIS must be submitted prior to submitting the final claim.
- Home Health Quality Reporting Program data submission is not required for the period of October 1, 2019 through June 30, 2020, and the annual market basket adjustment will not be impacted if data is not submitted.
- <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>

Updated document 5/11/2020 (see page 19 of document)

- Any therapist (PT, OT, SLP) may perform the Initial and Comprehensive Assessment. This temporary blanket modification allows therapists to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether the service that establishes eligibility. The existing regulations continue to apply that therapists would not be permitted to perform assessments in nursing only cases. Therapists must act within their state scope of practice laws when performing initial and comprehensive assessments, and access a registered nurse or other professional to complete sections of the assessment that are beyond their scope of practice.

1.50 Interim Final Rule: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

Interim Final Rule: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

<https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf>

THE TAKE-AWAYS:

- The use of OASIS-E for Home Health data collection has been delayed and will not begin on January 1, 2021.
- HHAs will be required to use OASIS-E to begin collecting data on the two Transfer of Health Information Measures beginning with discharges and transfers on January 1st of the year that is at least one full calendar year after the end of the COVID-19 public health emergency.
- For example, if the COVID-19 public health emergency ends on September 20, 2020, home health agencies will be required to begin collecting data on those measures beginning with patients discharged or transferred on January 1, 2022.
- We will also require HHAs to begin collecting data on the SPADEs (standardized patient assessment data elements) beginning with the start of care, resumption of care, and discharges (except for the hearing, vision, race, and ethnicity SPADEs, which would be collected at the start of care only) on January 1st of the year that is at least one full calendar year after the end of the COVID-19 public health emergency.

1.51 Thank You

THANK YOU

Congratulations! You've completed the course! If you have any questions please contact us at learning@wellsky.com.

RESTART COURSE

EXIT COURSE
