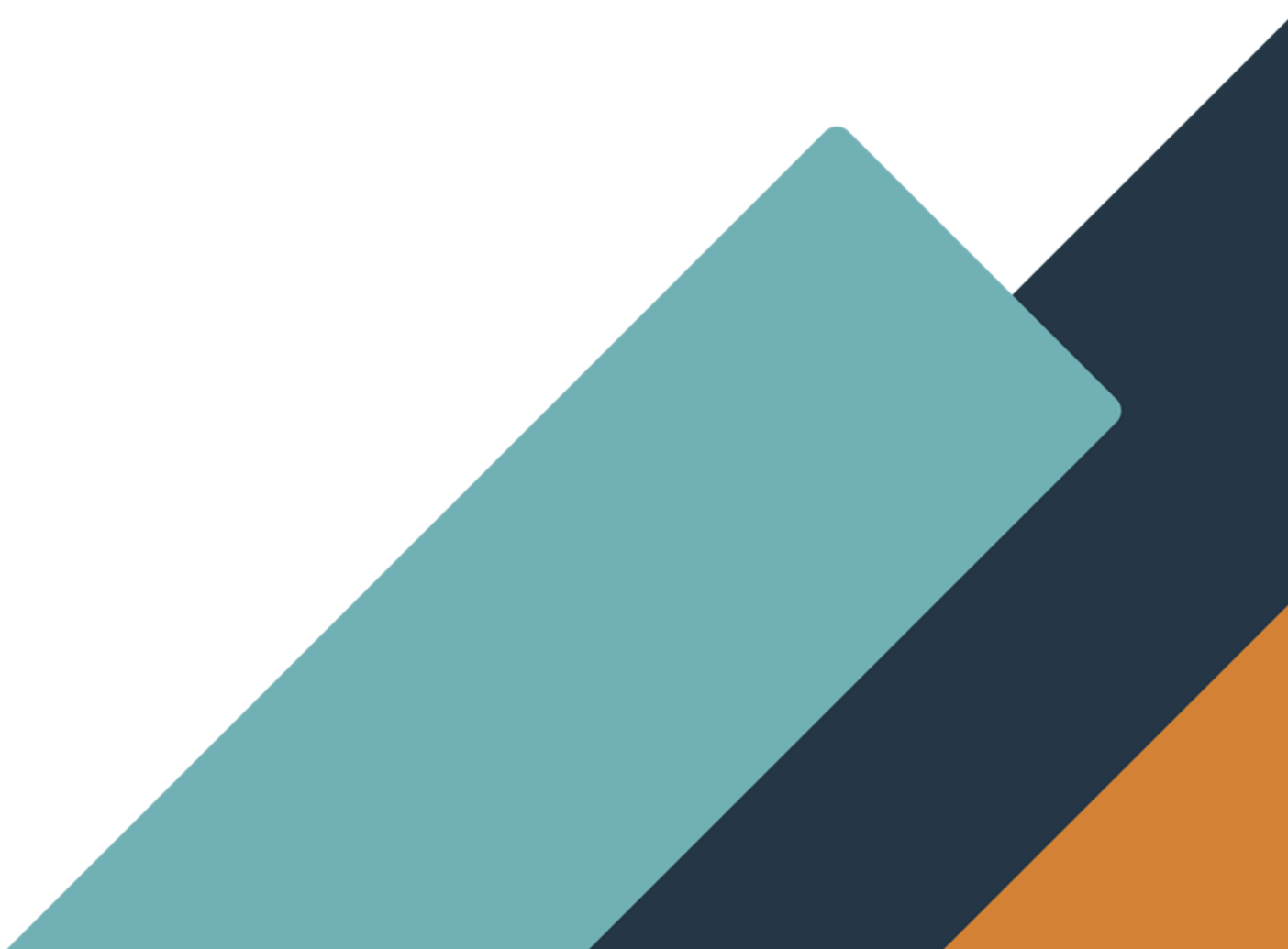




# CMS OASIS Updates:

April 2021







# CMS OASIS Updates April 2021

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5/5/2021



## Locating Related CMS Documents

- Quarterly OASIS Q&A -
  - <https://qtso.cms.gov/providers/home-health-agency-hha-providers/reference-manuals>
- Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update, Home Health Quality Reporting Program Requirements, and Home Infusion Therapy Services and Supplier Enrollment Requirements; and Home Health Value-Based Purchasing Model Data Submission Requirements
  - <https://www.federalregister.gov/documents/2020/11/04/2020-24146/medicare-and-medicaid-programs-cy-2021-home-health-prospective-payment-system-rate-update-home>
- Home Health Agencies: CMS Flexibilities to Fight COVID-19
  - <https://www.cms.gov/files/document/covid-home-health-agencies.pdf>
- Draft OASIS-E Instrument -
  - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-Data-Sets>

# COVID 19- CMS UPDATES

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# CMS COVID-19 Response - OASIS-E DELAYED

**Published May 8,2020**

- 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.
- 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

For example, if the COVID-19 public health emergency ends on July 17, 2021, home health agencies will be required to begin collecting data on those measures beginning with patients discharged or transferred on January 1, 2023.

# CMS Public Health Emergency Waivers - COVID-19

## **The Take-Aways**

- Home Health Agencies (HHAs) can provide more services to beneficiaries using telecommunications technology within the 30-day period of care, so long as it's part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care.
- The initial assessment and determination of patients' homebound status can be completed remotely or by record review.
- 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.
- The October 2020 refresh of the Home Health Compare/Care Compare Sites is the last scheduled refresh of this data until the January 2022 refresh.
- Any rehabilitation professional (OT, PT, or SLP) may 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 or not the service establishes eligibility for the patient to be receiving home care.
- The existing regulations continue to apply that OTs and other 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.

# Follow up



# GG0130A- Eating

January 2021 Q&A #5

**Email response from CMS:** ~~xli\$wt\$rwis\$w\$eggyvexi\$~~

So, in this situation, code the baseline ability seen with eating, even though the patient was ordered to be NPO during the assessment window.

Q5. How would the following scenario for GG0130A - Eating be coded? A patient was admitted and at Start of Care (SOC) required only set up assistance for eating. The following day, the patient went to the Emergency Department and returned within 24 hours with an overall decline in status and an order for no oral intake due to dysphagia. Would we code 05 - Setup or clean-up assistance based on initial ability or code 88 - Not attempted due to medical conditions or safety concerns because this is the new baseline following the decline?

A5. 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. At SOC/ROC, 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. In the scenario provided, use Code 05 -Setup or clean-up assistance for GG0130A - Eating if this represents the patient's baseline status. Use of an "activity not attempted" code should only be used if the patient was not able to complete the activity prior to the benefit of services and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities.

# CMS OASIS Q&A

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## Eligibility Certification - Who can order home care services?

### **The Take-Away**

Nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) can now certify eligibility for home health and establish a care plan permanently.

*(This serves as an updated reply to October 2020 CMS Quarterly OASIS Q&A Question 4)*

**Question 1: With the CARES Act, physician assistants, nurse practitioners, and clinical nurse specialists are now allowed to certify a patient's need and eligibility for home health services. Is this update permanent? Even after the Public Health Emergency (PHE) ends will these practitioners be allowed to order home care services?**

**Answer 1:** Yes, even after the COVID-19 PHE ends, per the Coronavirus Aid, Relief, and Economic Security Act or the CARES Act (Public Law 116-136), nurse practitioners, physician assistants and clinical nurse specialists are allowed, where not prohibited by State Law, to certify their patient's need and eligibility and provide orders for home health services.

# CMS OASIS Q&A

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# M1060: Patient Height and Weight

## **The Take-Away**

Documentation of height and weight must be obtained by the agency clinicians either within to 5 day assessment window OR documented within the past 30 days.

**Q2. If a patient's height was not measured within the Start of Care (SOC) assessment timeframe for M1060a - Height is it okay to use a height that was measured on day 6?**

**A2.** To be compliant the SOC/ROC assessment must be completed by the end of the assessment timeframe. **If a patient's height cannot be measured during the assessment timeframe, and no agency-obtained height from a documented visit conducted within the previous 30-day window is available, enter a dash (-) to indicate "no information" for M1060a - Height.** CMS expects dash use to be a rare occurrence.

# M1600: Treatment for Urinary Tract Infection

## The Take-Away

The key is treatment. 1-Yes is the correct response when the patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed OR suspected UTI.

**Q3. Is M1600 - Has this patient been treated for a Urinary Tract Infection in the past 14 days, only coded as “1-yes” when the patient is being treated for a confirmed Urinary Tract Infection (UTI)?**

**In the OASIS Guidance Manual, the Response Specific Instructions for M1600 state to “Enter Response 1 – Yes, when the patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed or suspected UTI.”**

**However, CMS OASIS Q&A Category 4b, Q116.6 states: “The physician must determine the diagnosis of a UTI, in order to select Response ‘1-Yes’. A UTI is not assumed to be present based on the presentation of a symptom(s).”**

**Should we be coding M1600 as response “1-Yes” for a confirmed or suspected UTI as stated in the guidance in the OASIS Guidance Manual, or just when the UTI diagnosis is confirmed per Q116.6?**

**A3. M1600 - Urinary Tract Infection reports if the patient has been treated for a urinary tract infection (UTI) in the past 14 days.**

**As instructed in the Guidance Manual, enter response “1 – Yes,” when the patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed or suspected UTI.**

At times, CMS provides new or refined instruction that supersedes previously published guidance.

## GG0130C- Toileting Hygiene

### The Take-Away

Toileting hygiene can be assessed and coded regardless of the patient's need to void at the time of assessment. Here is strengthened continued guidance to only use not attempted codes when a response cannot be determined based on direct observation, report, collaboration, or assessment of similar activities

**Q4. If a patient does not need to void and/or have a bowel movement during the day of assessment, should an “activity not attempted” code be used for GG0130C - Toileting Hygiene?**

**A4.** The intent of GG0130C - Toileting Hygiene is to assess and code the level of assistance required to complete perineal hygiene and clothing management (including undergarments and incontinence briefs) before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening of the ostomy or colostomy bag but not managing equipment.

The toileting hygiene activity can be assessed and coded regardless of the patient's need to void or have a bowel movement at the time of the assessment.

If the patient does not void or have a bowel movement on the day of assessment, assess the patient's toileting hygiene performance based on direct observation of patient function, assessment of ability to complete similar activities, patient/caregiver report or collaboration with other agency staff.

Use clinical judgment to determine if the information gathered allows the clinician to adequately assess the patient's ability to complete the activity of toileting hygiene. If the clinician determines that the information from observation and report is adequate, code based on the type and amount of assistance the patient required to complete the activity.

Use of an “activity not attempted” code should occur only after determining that the activity is not completed, and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities.

## GG0170G- Car Transfer

### The Take-Away

Clinical judgement on intent of item! The car transfer could still be completed while accommodating medical restrictions, such as long sitting.

**Q5. Can you code GG0170G - Car Transfer with a performance code if the patient transfers into the back seat or into a long sitting position because of medical restrictions?**

**A5.** The intent of GG0170G - Car Transfer is to assess the patient's ability to transfer in and out of a car or van on the passenger side.

Clinical judgment may be used to determine if a transfer in and out of the back seat is an acceptable alternative to meet the intention of this activity. The car transfer could still be completed while accommodating medical restrictions, such as long sitting.



## GG0170I,J,K,L- walking assessment

### **The Take-Away**

The assistance provided with CGA/ steadying the oxygen tank and throughout the activity. The support of the oxygen tank throughout the activity is considered supervision/ touching assistance.

**Q6. If we have a patient that requires a therapist to provide steadying assistance/contact guard assist and manage an oxygen tank while the patient is ambulating how would the GG0170 walking activities be coded?**

**A6.** The intent of the GG0170 walking items is to assess the patient's ability, once standing, to safely walk the stated distances and circumstances in each item.

If the helper is required to manage the oxygen tank and/or oxygen tubing and/or provide steadying assistance/contact guard, to allow the patient to complete an activity safely, code 04 - Supervision or touching assistance.

## GG0170I- Walk 10 feet

### The Take-Away

Continue to score based on patient ability PRIOR to any intervention that would make the patient more independent in the response. Simply giving a patient a walker to use would not automatically be considered a provision of services. Clinical judgement is required to differentiate between requests, cueing and therapeutic intervention.

**Q7. During the SOC, the PT initiates treatment by providing a new walker, instructing in its use, and offering cues for proper technique. The patient then walked 10 feet with moderate assistance. How should GG0170I - Walking 10 feet be coded? Would it be with an “activity not attempted code” or would it be coded based on the patient’s ability after the PT provided the walker and instruction?**

**A7.** At SOC/ROC, the GG0130 and GG0170 Self-Care and Mobility performance codes are to reflect the patient’s baseline ability to complete the activity, prior to the benefit of services provided by your agency staff.

The patient may be assessed based on the first use of an assistive device or equipment that has not been previously used. The clinician would provide assistance, as needed, in order for the patient to complete the activity safely, and code based on the type and amount of assistance required, 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.

Introducing a new device should not automatically be considered as “providing a service.”

Whether a device used during the clinical assessment is new to the patient or not, code based on the type and amount of assistance that is required for the patient to complete the activity prior to the benefit of services provided by your agency staff.

Communicating an activity request (“Can you walk to the door?”) would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity (“Stay closer to your walker,” etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree



# Thank you

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