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CMS OASIS Updates

April and July 2023

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Locating Related CMS Documents

- Quarterly OASIS Q&A -
  - https://qtso.cms.gov/providers/home-health-agency-hha-providers/reference-manuals
- OASIS-E Static Q&A
  - https://qtso.cms.gov/providers/home-health-agency-hha-providers/reference-manuals
- Final OASIS-E Manual
  - OASIS User Manuals | CMS
- CY 2023 Home Health Final Rule
  - https://www.federalregister.gov/documents/2022/11/04/2022-23722/medicare-program-calendar-year-cy-2023-home-health-prospective-payment-system-rate-update-home
- Risk Adjustment Specifications 2023
  - https://www.cms.gov/files/document/risk-adjustment-technical-specificationsjanuary2023.pdf
- Home Health Agencies: CMS Flexibilities to Fight COVID-19
  - https://www.cms.gov/files/document/covid-home-health-agencies.pdf

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Updates

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Updates

- Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements
  - https://www.federalregister.gov/documents/2023/07/10/2023-14044/medicare-program-calendar-year-cy-2024-home-health-hh-prospective-payment-system-rate-update-hh
- WellSky Free Resource (on demand webinar)
  - https://info.wellsky.com/072623-CY2024-home-health-proposed-rule.html
- Expanded HHVBP information
  - https://innovation.cms.gov/innovation-models/expanded-home-health-value-based-purchasing-model
- Home Health Quality Measures
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Measures

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Quality Measure Questions

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Quality Measures

April 2023 Q&A #1

The Take-Away

M0090 on or after 1.1.23.

Question 1: When did the new risk models for 2023 take effect?

Answer 1: The new 2023 risk models are used for all quality episodes where M0090 – Date Assessment Completed for the start of care (SOC) or resumption of care (ROC) is January 1, 2023 or later

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Quality Measures

April 2023 Q&A #2

The Take-Away

CMS is currently collecting data on OASIS E items; the items will be considered in future risk models. Exception PHQ-2 to 9 information is currently being utilized as mapped with data collected on OASIS D-1 item M1730.

Question 2: Are the new items that were added to the OASIS-E instrument being used in the new risk models that took effect 1/1/2023?

Answer 2: To include new items in risk models, CMS first needs to analyze the data submitted for those items. As data collection for OASIS-E began January 1, 2023, the items new to OASIS-E are not used in these new risk models but will be evaluated and considered for use in future risk models. However, as CMS was able to map responses available from OASIS-E item D0150 - Patient Mood Interview (PHQ-2 to 9) to the responses available from OASIS-D1 item M1730 - Depression Screening, D0150 is used in the new risk models that took effect January 1, 2023.

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Quality Measures

April 2023 Q&A #3

The Take-Away

Advanced care planning is important- when referring to hospice when indicated, your outcomes won't be negatively affected by declining abilities.

Question 3: What assessment-based quality measures exclude patients who are transferred or discharged from home health to hospice?

Answer 3: Patients who were transferred to an inpatient hospice or discharged to a non-institutional hospice (on or after January 1, 2023) are excluded from the calculation of the following OASIS-based quality measures:

- Improvement in Ambulation/Locomotion
- Improvement in Toilet Transferring
- Improvement in Management of Oral Medications
- Improvement in Dyspnea
- Improvement in Bathing
- Improvement in Lower Body Dressing
- Improvement in Bowel Incontinence
- Discharged to Community
- Improvement in Bed Transferring
- Improvement in Upper Body Dressing
- Improvement in Confusion Frequency

These hospice exclusions apply to quality episodes with a M0906 Discharge/Transfer/Death Date of 1/1/2023 or later:

That end in a transfer to an inpatient hospice (M0100 Reason for assessment - RFA 6 or 7 Transferred), and M2410 - Inpatient Facility response is 4 - Hospice,

-OR-

That end in a discharge to a non-Institutional (home) hospice (M0100 Reason for assessment - RFA 9 Discharge from Agency), and M2420 - Discharge Disposition is response 3 - Patient transferred to a non-institutional hospice.

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Quality Measures

April 2023 Q&A #4

The Take-Away

Excluded from OASIS- based DTC measure: transfer to inpatient hospice, d/c to home hospice, DAH, or DC disposition is UK.

Question 4: What patients are excluded from the OASIS-based Discharged to Community measure?

Answer 4: For the Discharged to Community (OASIS-based) quality measure, patients who are transferred or discharged to hospice, patients who die, and patients whose discharge disposition is unknown, are excluded from the measure. These exclusions are specified as follows:

- Quality episodes that end in a transfer to an inpatient hospice (M0100 - Reason for assessment - RFA 6 or 7 Transferred), and M2410 - Inpatient Facility response is 4 - Hospice, and with a M0906 Discharge/Transfer/Death Date of 1/1/2023 or later), or
- Quality episodes that end in a discharge to a non-institutional/home hospice (M0100 Reason for assessment - RFA 9 Discharge from Agency), and M2420 - Discharge Disposition response is 3 non-institutional hospice, and with a M0906 Discharge/Transfer/Death Date of 1/1/2023 or later, or
- Quality episodes that end with death at home (M0100 - Reason for assessment - RFA 8 Death at Home), or
- Quality episodes that end with discharge from agency (M0100 - Reason for assessment - RFA 9 Discharge from Agency) for which the patient's discharge disposition is unknown (M2420 - Discharge Disposition response is unknown "UK").

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CMS OASIS Q&A

Category 2 - Comprehensive Assessment

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Single Visit Within A Quality Episode - DC Practices

July 2023 Q&A #1

The Take-Away

Whenever there is a single visit in a quality episode a discharge OASIS (RFA-9) should not be collected or submitted.

Question 1: We understand that OASIS is not required to be collected when a patient receives only one visit in a quality episode. If a SOC OASIS is completed (to facilitate billing for the single visit), should we also complete a discharge OASIS?

Answer 1: Based on CMS policy, OASIS data collection and submission is not required when only one visit is made in a single visit quality episode. In some single visit quality episodes, a SOC OASIS (RFA-1) may be required for billing. Whenever there is a single visit in a quality episode a discharge OASIS (RFA-9) should not be collected or submitted. This refined instruction supersedes previously published guidance in Chapter 3 of the OASIS-E Guidance Manual, eff. January 1st, 2023, and Q46 in Category 2 of the CMS OASIS Q&As last edited 05/22 that simply stated that the discharge OASIS is not required/mandated in the situation of a single visit quality episode.

* (page 46-47 of WellSky OASIS-E Field guide to data collection)

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OASIS Changes (Error v. Discrepancy) - Clinician Absence

July 2023 Q&A #2

The Take-Away

A true error is different than a discrepancy and must be validated and corrected based on agency policy if the assessing clinician is no longer available to correct.

Question 2: We have a situation where a clinician has left the agency and there are several OASIS assessments that our QA department had questions on, regarding the OASIS codes that were selected by the assessing clinician. Since the clinician is no longer available to provide their input how should the identified discrepancies be handled? Can the OASIS reviewer change the codes even if the assessing clinician cannot give their approval?

Answer 2: When a potential inconsistency is identified within the assessment timeframe and the assessing clinician is not available to approve the suggested edits then the original OASIS responses selected by the assessing clinician on the completed OASIS would be submitted. If an error is discovered upon review by a supervisor or other auditing staff and it can be validated that it is a true error and not just a discrepancy (a difference between two data items without knowledge of which data item is correct), that error should be corrected following the agency's correction policy and established professional medical record documentation standards. When the original assessing clinician is not available to correct the true error, the clinical supervisor or quality staff may make the correction of the validated error following the agency's correction policy. The supervisor may document why the original assessing clinician is not available to make the correction and how the error was identified and validated as an error.

Please note that the comprehensive assessment, including OASIS, is a legal document and when signed by a clinician, the signature is an attestation that all information contained in the document is truthful and accurate.

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CMS OASIS Q&A

Category 4b - OASIS Data Items

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C1310 - CAM - Comatose Baseline and At Time of Assessment

July 2023 Q&A #4

The Take-Away

C1310A. 0. No

C1310B. Inattention - 1. Present does not fluctuate

C1310C. Disorganized thinking - 0. Not present

C1310D. Altered level of consciousness - 1. Present does not fluctuate

Question 4: How should C1310 - Signs and Symptoms of Delirium (from CAM ©) be coded when a patient is comatose at baseline and at the time of assessment?

Answer 4: If the patient was comatose at baseline and at the time of assessment, code the items as follows: C1310A - Acute Onset of Mental Status Changes as Code 0 - No C1310B - Inattention as Code 1 - Behavior continuously present, does not fluctuate. C1310C - Disorganized Thinking as Code 0 - Behavior not present. C1310D - Altered level of consciousness as Code 1 - Behavior continuously present, does not fluctuate. C1310 - Signs and Symptoms of Delirium (from CAM ©) identifies any signs or symptoms of acute mental status changes as compared to the patient's baseline status and if there are any signs or symptoms of delirium present at the time of assessment.

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D0150 - Patient Mood Interview

April 2023 Q&A #5

The Take-Away

If both D0150A1 and D0150B1 are coded 9, OR, both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise continue. For all other scenarios proceed to ask the remaining seven questions (D0150C to D0150I) of the PHQ-9 and complete D0160, Total Severity Score.

Question 5: Please clarify when the entire Patient Mood Interview should be completed for D0150 - Patient Mood Interview (PHQ-2 to 9). The instruction in the OASIS-E Guidance Manual appears to conflict with the language in the D0150 item.

Answer 5: At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases, use the most recent guidance.

Related to the Patient Mood Interview, please disregard the statement in the OASIS item that states "If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview".

This statement is outdated due to refinements in OASIS guidance. Please use the instruction found in the Response-Specific Instructions for D0150 in the OASIS-E Guidance Manual, which reflects the most recent guidance.

As stated in the manual, whether or not further evaluation of a patient's mood is needed depends on the patient's responses to the PHQ-2 (D0150A and D0150B). If both D0150A1 and D0150B1 are coded 9, OR, both D0150A2 and D0150B2 are coded 0 or 1, END the PHQ interview; otherwise continue. For all other scenarios proceed to ask the remaining seven questions (D0150C to D0150I) of the PHQ-9 and complete D0160, Total Severity Score.

*(page 314 of WellSky OASIS-E Field guide to data collection/page 47 Simplified Clinician Resource)

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K0520B. - Nutritional Approaches; Feeding Tube

April 2023 Q&A #6

The Take-Away

Feeding tubes are selected if used to provide nutrition / hydration; not is used only for medication delivery.

* Identified need for additional hydration/ nutrition must be documented.

Question 6: Should K0520B - Nutritional Approaches; Feeding Tube be checked if there is a feeding tube present, but it is not being utilized for nutritional/hydration purposes? Can K0520B be coded if it is just used to deliver medications?

Answer 6: The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge. If a feeding tube is in place but there are no scheduled or prn orders to provide nutrition or hydration via the feeding tube on the current care/treatment plan, do not code K0520B - Feeding Tube. At Start of Care/Resumption of Care (SOC/ROC) and discharge check all of the nutritional approaches that are part of the patient's current care/treatment plan at the time of assessment for SOC/ROC (or discharge), even if not used at the time of assessment for SOC/ROC (or discharge).

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K0520 - Nutritional Approaches

July 2023 Q&A #5

The Take-Away

NPO related to surgery / procedures is NOT considered here.

Question 5: If a patient has an order to be NPO in anticipation of a procedure/surgery is this considered either a mechanically altered diet or a therapeutic diet when coding K0520 - Nutritional Approaches?

Answer 5: No. The intent of K0520 - Nutritional Approaches is to assess and report which of the listed nutritional approaches apply to the patient on admission and/or discharge. NPO related to a procedure/surgery is not considered a nutritional approach for the purposes of coding K0520C - Nutritional Approaches; Mechanically altered diet and/or K0520D - Nutritional Approaches; Therapeutic diet.

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K0520, N0415, O0110

April 2023 Q&A #7

The Take-Away

Any check or dash in K0520; N0415; O0110 would eliminate the "Z-none of the above" response from being checked or dashed: it should be left blank.

Question 7: Please provide guidance as to the accurate response for K0520Z - Nutritional Approaches; None of the Above in the following scenario: K0520A - Parenteral/IV Feeding = checked K0520B - Feeding Tube = not checked K0520C - Mechanically altered diet = Dash to indicate there was no available information K0520D - Therapeutic diet = not checked Should K0520Z - None be unchecked because K0520A is checked, or dashed because K0520C is dashed?

Answer 7: When one or more items for K0520A - K0520D is checked, to indicate that the specified nutritional approach applies to the patient, then K0520Z should be left unchecked. This is true even if one of the other items K0520A - K0520D is dashed. This same concept applies to N0415 - High Risk Drug Classes: Use and Indication and O0110 - Special Treatments, Procedures, and Programs.

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K0520, N0415, O0110

April 2023 Q&A #8

The Take-Away

"Day of Assessment" does NOT apply; must be CURRENT to be coded- If it is on the reconciled drug regimen or care/ treatment plan it is included.

Question 8: What is the look back or time period under consideration for the new OASIS items K0520 - Nutritional Approaches, N0415 - High-Risk Drug Classes: Use and Indication, and O0110 - Special Treatments, Procedures, and Programs? Is it the day of assessment, which may include medications, nutritional approaches, and/or treatments, procedures, or programs the patient may have taken/received in an inpatient facility before they were discharged home, or is coding just based on what is part of the current reconciled drug regimen and/or current care/treatment plan at the time of the assessment?

Answer 8: The general OASIS convention "Day of Assessment" which is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home does not apply to K0520 - Nutritional Approaches, N0415 - High-Risk Drug Classes: Use and Indication, and O0110 - Special Treatments, Procedures, Programs. These items are coded based on what is part of the patient's current reconciled drug regimen and/or care/treatment plan during the SOC/ROC (or discharge) assessment.

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M1000 - Inpatient Facility

July 2023 Q&A #6

The Take-Away

Hospital at home DC within past 14 days = response 3 IPPS.

Question 6: If a patient has been receiving care in their home under a Hospital at Home program, and is then referred to Home Health within 14 days of discharge from the program, how should M1000 - Inpatient Facility be coded?

Answer 6: The intent of M1000 - Inpatient Facilities is to identify whether the patient has been discharged from an inpatient facility within the 14 days immediately preceding the Start of Care/Resumption of Care date. In an instance where a patient is receiving care in their home under a Hospital at Home program, they are considered to be in an inpatient facility. This is because the services being provided are being delivered under the coordination of an acute care hospital. If the patient's discharge from the Hospital at Home program is within the past 14 days, then for M1000, response 3 - Short-stay acute hospital (IPPS) should be checked.

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M1021/M1023. Primary/Secondary Diagnosis

April 2023 Q&A #9

The Take-Away

Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code.

Question 9: Should a symptom control rating be assigned for a code beginning in V, W, X, Y and Z reported in M1021 - Primary Diagnosis or M1023 - Other Diagnoses? The OASIS-D manual guidance specifically stated no, but that statement is no longer in the OASIS-E guidance manual.

Answer 9: The guidance for coding symptom control ratings has not changed. Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code.

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M1600 - UTI Past 14 Days

July 2023 Q&A #7

The Take-Away

OASIS rules and Coding guidelines are separate and distinct. M1600 response 1 identifies treatment of a suspected or confirmed UTI during the past 14 days. Coding guidelines require that the condition (UTI) is present or treated and supported by MD documentation at the time of admission. Agency and Vendor scrubbers may provide warnings to remind the clinician to score and code appropriately.

Question 7: When coding M1600 - Has this patient been treated for a Urinary Tract Infection in the past 14 days? as 1 - Yes, does there also need to be a specific ICD-10 code added to the OASIS? The EMR that our agency uses provides a warning when we code 1 - Yes but there isn't a specific code identifying the UTI entered into the software system.

Answer 7: M1600 - Has this patient been treated for a Urinary Tract Infection in the past 14 days?, identifies treatment of a suspected or confirmed urinary tract infection during the past 14 days. The OASIS guidance does not speak to requiring a specific, or any, ICD-10-CM diagnosis code(s) that would reflect the presence of or treatment for a UTI. Questions related to vendor products or services should be addressed directly with your vendor.

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M1400, O0110 - Dyspnea/Special Treatment, Procedures, Programs - Oxygen Therapy

April 2023 Q&A #10

The Take-Away

Intermittent and continuous oxygen use guidance varies for O0110 and M1400. O0110 is defined as continuous if used >14 hours and intermittent if < 14 hours. To determine M1400 response, assess with oxygen ON if the patient always uses oxygen continuously (during the day of assessment, with only brief interruptions) and OFF is the patient wears the oxygen inconsistently (physician orders are not considered).

Question 10: Is there a definition for continuous oxygen use for M1400 - Dyspnea? Does the definition for intermittent and continuous oxygen, used in O0110 - Special Treatments, Procedures, and Programs, apply to M1400 as well?

Answer 10: Each OASIS item should be considered individually and coded based on guidance specific to that item. The definitions for intermittent and continuous oxygen use provided in the guidance for O0110 - Special Treatments, Procedures, and Programs are intended to be specifically used to support coding for O0110C1 - Oxygen Therapy, O0110C2 - Continuous, and O0110C3 - Intermittent. M1400 - When is the patient dyspneic or noticeably Short of Breath? identifies the level of exertion/activity that results in a patient's dyspnea or shortness of breath, regardless of any underlying condition. For M1400, if the patient uses oxygen continuously (at all times during the day of assessment, with only brief interruptions) , enter the response based on assessment of the patient's shortness of breath while using oxygen. If the patient uses oxygen intermittently, enter the response based on the patient's shortness of breath WITHOUT the use of oxygen. Responses are based on the patient's actual use of oxygen in the home, not on the physician's oxygen order.

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N0415 - High Risk Drug Classes - Use and Indication

April 2023 Q&A #11

The Take-Away

Do not include flushes to keep an IV access port patent.

Question 11: If an anticoagulant is used to flush a PICC line that has become blocked with clotted blood, should that anticoagulant be considered when coding N0415 - High-Risk Drug Classes: Use and Indication?

Answer 11: The intent of N0415 - High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any prescribed medications in specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

Do not include flushes to keep an IV access port patent.

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N0415 - High Risk Drug Classes - Use and Indication

April 2023 Q&A #12

The Take-Away

Code any medication that is used by any route in any setting (e.g., at home, in a hospital emergency room, at physician office or clinic) while a patient of the home health agency that is also part of a patient's current reconciled drug regimen, even if it was not taken at the time of assessment.

Question 12: Please provide guidance on the following scenario. A patient is admitted to a home health agency and then, during the assessment timeframe, goes to the Emergency Department (ED) and receives a one-time dose of a medication that is classified as a medication in the list of high-risk medication for N0415 - High-Risk Drug Classes: Use and Indication. If the Start of Care assessment was not completed until after the patient returned from the ED should the medication that was received in the ED be considered when coding N0415?

Answer 12: The intent of N0415 - High-Risk Drug Classes: Use and Indication is to record whether the patient is taking any prescribed medications in the specified drug classes and whether the patient specific indication was noted for all medications in the drug class. Code any medication that is used by any route in any setting (e.g., at home, in a hospital emergency room, at physician office or clinic) while a patient of the home health agency that is also part of a patient's current reconciled drug regimen, even if it was not taken at the time of assessment.

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O0110H1 - IV medications

April 2023 Q&A #13

The Take-Away

"Code any medication or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item." Specifically, for O0110H1 do include IV fluids with medications added, unless otherwise excluded in guidance.

Question 13: The guidance for O0110H1 - IV Medications includes an exclusion for Dextrose 50% and Lactated Ringers, stating that these are not considered medications. There are references that have both Dextrose 50% and Lactated Ringers listed as medications. Should these be excluded from consideration when coding O0110H1? Should any solution that includes dextrose be excluded from consideration?

Answer 13: At times CMS provides new or refined instruction that supersedes previously published guidance. In such cases use the most recent guidance. This Q&A represents the most recent guidance. Please disregard the statement from the Guidance Manual that states: "Dextrose 50% and/or Lactated Ringers given IV are not considered medications and should not be included here." As stated in the Coding Instructions for O0110H1 - IV medications "Code any medication or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item." Specifically, for O0110H1 do include IV fluids with medications added, unless otherwise excluded in guidance.

Please note the following exclusions:

- Do not include flushes provided to keep an IV access port patent
- Do not include IV fluids without medication
- Do not include medication delivered via subcutaneous pump
- Do not include IV medications of any kind that were administered during dialysis or chemotherapy.

*(page 579 of WellSky OASIS-E Field guide to data collection/ page 98 Simplified Clinician Resource)

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O0110 - Special Treatments, Procedures, and Programs

April 2023 Q&A #14

The Take-Away

Include a PICC line that is being discontinued at the time of the assessment.

Question 14: We know that we code O0110 - Special Treatments, Procedures, and Programs based on what is part of the current care/treatment plan at the time of the assessment. Can CMS provide further clarification on how to code O0110O1 - IV Access and O0110O4 - IV Access; Central if a PICC line is being pulled during the discharge assessment?

Answer 14: The intent of O0110 - Special Treatments, Procedures, and Programs is to identify any special treatments, procedures, and programs that apply to the patient. Check all treatments, programs and procedures that are part of the patient's current care/treatment plan at the time of assessment, even if not used during the time of assessment for SOC/ROC (or discharge). This includes a PICC line that is being discontinued at the time of the assessment.

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Thank you

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