January 2023 CMS Quarterly OASIS Q&As

Category 2

Question 1: Can CMS please provide further guidance on the transition from OASIS-D to OASIS-E. For example, if we initiate an OASIS at the end of 2022 but completed the assessment in 2023 should we be completing OASIS-D or OASIS-E? Does this change if we are recertifying a patient at the end of 2022 and the first day of the new 60-day certification period is in 2023?

Answer 1: The effective date for OASIS-E is January 1, 2023. The version of OASIS that should be collected will be based on the M0090 - Date Assessment Completed. The M0090 date 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 responses was completed.

With this transition to OASIS-E, there is no need for the use of artificial M0090 dates. All assessments with a M0090 - Date Assessment Completed on or before December 31, 2022 including the last 5 days of 2022 must be completed with OASIS-D1. This is true even when the first day of the new certification period is on or after January 1, 2023.

All assessments with a M0090 - Date Assessment Completed on or after January 1, 2023 must be completed with OASIS-E. This is true even when the assessment was initiated in 2022.

Category 4a

Question 2: While configuring the new OASIS-E items in our EMR system, would it be compliant if additional prompts were added to clarify the reason for coding a 0 response for one or more BIMS Interview Items (C0200 - C0400)? The 0 can have different meanings and the reason for coding the 0 may influence the scoring of C0500 - BIMS Summary Score.

Answer 2: The intent of C0200-C0500 - Brief Interview for Mental Status (BIMS) is to determine the patient's attention, orientation, and ability to register and recall information.

As stated in the coding tips for C0200-C0500, the assessing clinician should track the reason for coding answers as zero because this information will be used later for the coding of the summary score in C0500.

HHAs are required to incorporate the OASIS data items exactly as written into the agency's comprehensive assessment.

In addition to any required OASIS items, an agency may determine what other assessment items will be included in the agency's comprehensive assessment(s) to meet regulatory, coverage and clinical needs.

In the development and maintenance of the OASIS assessment user tools, vendors are advised to reference the Data Specifications (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/DataSpecifications).

While the Data Specifications dictate the assessment instrument items, their applicable time point(s) in the assessment instrument, the exact language of the Items, and each Items allowable response options, the Data Specifications do not dictate the format of the graphical user interface (GUI) software presentation of the Items in the assessment instrument. While the item language and response options may not be modified, reformatting of the presentation of the item is left to the user's discretion, as long as such modification does not impact the accuracy of the item scoring and is presented in a way that makes it clear which items (assessment questions and response options) are part of the OASIS, and which are not.

Category 4b

A1005, A1010, A1110, A1250

Question 3: A number of new items (A1005 - Ethnicity, A1010 - Race, A1110 - Language, A1250 - Transportation) state that a proxy can be used. Who would be considered a proxy? Can it be a caregiver, family member, friend or can it only be the Power of Attorney (POA), or health care representative?

Answer 3: For the items in Section A that reference a proxy, the assessing clinician determines who the appropriate proxy is based on the item specific guidance and the patient's unique circumstances. This can include but is not limited to family, caregiver, friend, Power of Attorney (POA) or health care representative.

A1110

Question 4: For A1110 - Language is it permissible to use a Spanish-speaking clinician as an interpreter?

Answer 4: A1110 - Language identifies the patient's self-reported preferred language and need for an interpreter. This item does not report who the interpreter will be.

C1310

Question 5: How is "baseline" defined at discharge for C1310A - Acute Onset Mental Status Change?

Answer 5: The intent of C1310 - Signs and Symptoms of Delirium is to identify any signs or symptoms of acute mental status changes as compared to the patient's baseline status.

As stated in the Coding Instructions for C1310A - Acute Mental Status Change, Code 1, Yes, if patient has an alteration in mental status observed or reported or identified that represents an acute change from baseline.

Examples of acute mental status changes:

- a patient who is usually noisy or belligerent becomes quiet, lethargic, or inattentive
- a patient who is normally quiet and content suddenly becomes restless or noisy
- a patient who is usually able to find their way around their living environment begins to get lost.

At discharge, compare the patient's current mental status to their baseline mental status (prior to the discharge assessment time period under consideration).

D0150, D0160

Question 6: Can you provide additional information on the rationale for having to use multipliers in D0160 - Total Severity Score? When reviewing the Pfizer version of the PHQ-9 scoring, Pfizer does not indicate a process computing scores for missed questions.

Answer 6: D0160 - Total Severity Score identifies the severity score calculated from responses to the PHQ-2 to 9. The Total Severity Score is a summary of the frequency scores on the PHQ-2 to 9 that indicates the extent of potential depression symptoms.

Item D0160 is used to report the total severity score for the Patient Mood Interview. The score in item D0160 is based upon the sum of the values that are contained in the following nine items: D0150A2, D0150B2, D0150C2, D0150D2, D0150E2, D0150F2, D0150G2, D0150H2, and D0150I2.

The Scoring Rules explain how to compute the score that is placed in item D0160. These rules consider the "number of missing items in Column 2" which is the number of items in Column 2 that are skipped.

- If all of the items in Column 2 have a value of 0, 1, 2, or 3 (i.e., they all contain non-missing values), then item D0160 is equal to the simple sum of those values.
- If the number of missing items in Column 2 is equal to one, multiply the sum of the 8 items in Column 2 by 9/8 (1.125).
- If the number of missing items in Column 2 is equal to two, multiply the sum of the 7 items in Column 2 by 9/7 (1.286).
- If items D0150A through D0150I were asked and if the number of missing items in Column 2 is equal to three or more, the interview is deemed NOT complete. Total Severity Score should be coded as "99".

CMS obtained permission from Pfizer to modify the PHQ-2 to 9 for use in CMS's data collection instruments.

J0510, J0520, J0530

Question 7: For the pain interview items, how do we define the term "over the past 5 days"? Does the day of assessment count as day 0 and then you count back, or is the day of assessment considered day 1 and then you count back?

Answer 7: For the Pain Interview items (J0510, J0520, and J0530) the day of assessment is considered day 0. The time period under consideration or "look back" for the pain interview item includes the day of assessment in addition to looking back over the last 5 days.

K0520

Question 8: If a patient is placed on a full liquid diet for a bowel cleanse should this be considered a mechanically altered diet when coding K0520 - Nutritional Approaches?

Answer 8: 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. K0520C - Nutritional Approaches; Mechanically altered diet reports if the patient requires a mechanically altered diet.

Mechanically altered diet is defined as a diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids for patients having trouble chewing and/or swallowing foods or thin liquids.

If, in your scenario, the diet texture is altered for a reason other than to facilitate oral intake, it would not be considered a mechanically altered diet when coding K0520C.

M0069

Question 9: My question relates to a patient who self identifies as a gender different than that assigned at birth, but who has a disease that is inherent to the gender assigned at birth. Example: patient designated male at birth identifies as a female and has a diagnosis of benign prostatic hypertrophy (BPH). As the patient self-identifies as female, we report 2 - Female for M00069 - Gender. If we also list female as the gender on the claim, the claim is rejected because the diagnosis of BPH is not compatible with the female gender. How should we resolve this situation?

Answer 9: Regarding the accurate coding of the OASIS item M0069 - Gender, refer to the OASIS Guidance Manual and published Q&As, then use clinical judgment to complete required OASIS assessment items. The Guidance Manual states to interview the patient and/or caregiver. If the patient does not self-identify, referral information (including hospital or physician office clinical data), or observation and physical assessment may be used. Based on these resources, enter a response for patient's gender in M0069.

CMS has no additional guidance on how to complete this OASIS item.

OASIS is not intended to represent a comprehensive assessment in and of itself. HHAs are expected to incorporate OASIS items into their comprehensive assessment documentation and follow their own

assessment policies and procedures regarding other items to include in their comprehensive assessments. This may include adding non-OASIS assessment items.

At the CMS level, M0069 is not used in performing any gender specific procedure editing, and is not used for OASIS and claims matching functions

There are no instructions at the CMS level requiring the gender of the patient submitted on the claim to be populated from the gender response reported in M0069 of the OASIS. More specific questions related to reporting gender codes on claims may be sent to the Home Health Medicare Administrative Contractor (MAC). Information on MAC's can be found at https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html#ABandHH+H.

N0415

Question 10: For N0415 - High-Risk Drug Classes: Use and Indication can you provide an example of a combination drug that would be in more than one of the listed high-risk drug classes?

Answer 10: 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.

Combination medications should be coded in all categories/pharmacologic classes that constitute the combination, regardless of why the medication is being used. For example, Percodan is a combination medication (oxycodone and aspirin) classified as both an opioid and antiplatelet. Therefore, for both N0415H - Opioid and N0415I - Antiplatelet, *Column 1 - Is Taking* would be checked, regardless of why the medication is being used.

Question 11: Are the following scenarios acceptable approaches to determining that a patient-specific indication is documented for N0415 - High-Risk Drug Classes: Use and Indication?

- **A clinician finds the patient-specific indication noted on the discharge paperwork from the referring facility (e.g., coumadin for afib)**
- **There is no patient-specific indication noted for a medication, so the clinician calls the physician to verify why the patient is taking the med and adds the physician response to the HH medical record**
- **The patient or family member verbally tells the clinician why the medication is being used (e.g., "for my back pain", "for my infection") and the clinician documents this reason in the HH medical record**
- **A clinician sees a diagnosis documented in discharge or referral paperwork (e.g., diabetes, schizophrenia) and the patient is taking related medications (e.g., hypoglycemic, antipsychotic) so considers the documented diagnosis as the patient-specific 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 the specified drug classes and whether the patient-specific indication was noted for all medications in the drug class.

When coding N0415, determine whether the patient is taking any prescribed medications in any of the drug classes (Column 1). If Column 1 is checked (patient is taking a medication in drug classification), review patient documentation to determine if there is a documented patient-specific indication for all medications in the drug class (Column 2).

Sources include medical records received from facilities where the patient received health care, the patient's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.

Discussions (including with the acute care hospital, other staff and clinicians, the patient, and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.

CMS does not provide an exhaustive list of examples for determining the source for the documented patient-specific indication. Use available resources along with clinical judgment to determine if the scenarios you suggest meet the criteria for a patient specific indication for the purposes of N0415.

O0110

Question 12: Would an AV fistula be reported in O0110O1 - IV Access?

Answer 12: An AV fistula does not meet the definition of IV Access for O0110O1.

If there is not a current IV access in place at the time of assessment, and no other treatments, programs, or procedures listed in O0110 apply to the patient then code O0110Z - None of the above.

Question 13: A patient's current care/treatment plan includes an order for PRN IV Lasix. At the time of the assessment and during the assessment timeframe the patient did not meet the parameters established by the physician to administer the Lasix. We understand that we would check O0110H1 - IV Medications, since the PRN IV Lasix is part of the patient's current care/treatment plan, even though it is not being received during the assessment timeframe. Would we also report O0110O1 - IV Access, even though the IV Access is not in place or needed during the assessment timeframe?

Answer 13: The intent of O0110 - Special Treatments, Procedures, and Programs is to identify any special treatments, procedures, and programs that apply to the patient.

If there is not a current IV access in place at the time of assessment do not code IV access for O0110O1, even if a treatment which would require an IV access is part of the patient's current care/treatment plan.