Fazzi
BE INVINCIBLE

OASIS-C2 - Get the Facts Webinar Q&A

Q: Overall, which OASIS are affected with the changes? Obviously SOC/ROC, but which additional are affected?

A: All of the OASIS time points are affected by the OASIS-C2 changes. Here is a chart summarizing Items that are new along with those OASIS-C1 Items having new guidance or look-back periods (versus clarification or minor expansion of guidance), and at which OASIS time points the Item is answered. For a complete list of the types of changes please see Appendix G of the OASIS-C2 Guidance Manual:

Item #	Item Description	SOC	ROC	FU/RC	TRF	DC	DAH
M1017	Diagnoses with Treatment Change	X	X				
M1046	Influenza Vaccine Received				X	X	
M1051	Pneumococcal Vaccine Received				X	X	
M1060	Height and Weight	X	X				
M1306	Unhealed Stage2 or Higher or Unstageable Pressure Ulcer	X	X	X		X	
M1307	Oldest Non-epithelialized Stage 2 Pressure Ulcer					X	
M1311	Current # of Unhealed Pressure Ulcers at Each Stage	X	X	X		X	
M1313	Worsening in Pressure Ulcer Status Since SOC/ROC					X	
M1320	Status of Most Problematic Observable Pressure Ulcer	X	X			X	
M1324	Stage of Most Problematic Observable Pressure Ulcer	X	X	X		X	
M1340	Does Patient Have a Surgical Wound	X	X	X		X	
M1501	Symptoms in Heart Failure Patients				X	X	
M1511	Heart Failure Follow-up				X	X	
M1600	Treatment for UTI in Past 14 Days	X	X			X	
M1710	When Confused	X	X			X	
M1720	When Anxious	X	X			X	
GG0170C	Mobility - Lying to Sitting on the Side of the Bed	X	X				
M2001	Drug Regimen Review	X	X				
M2003	Medication Follow-up	X	X				

M2005	**Medication Interventions**				**X**	**X**	**X**
M2016	**Patient/Caregiver Drug Education Intervention**				**X**	**X**	
M2301	**Emergent Care**				**X**	**X**	
M2400	**Intervention Synopsis**				**X**	**X**	

Q: I have a question related to M2003. The guidance states we should answer this question 1-Yes if the physician's direction takes longer than the time frame, but to answer 2-No if all prescribed actions weren't completed. Can you please explain how these differ?

A: You're right that first glance this does seem to be contradictory, but here's the difference:

> -The response of 1-Yes is correct when a physician is contacted and responds back with orders that will take longer than the "end of the next calendar day" to complete.
>
> The rationale is the agency identified a significant issue, contacted the physician, and has begun to implement the orders. In doing so, the clinician has taken all the steps to meet best practice recommendations, and CMS doesn't want to require a "no" response that would penalize the agency for completing all of the correct steps.
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> -The response of 0-No is used if the physician prescribed more than one action and the agency didn't complete all actions, even though they could have.
>
> For example, consider a scenario where a patient was taking and anti-hypertensive medication before hospitalization but was prescribed a new anti-hypertensive drug to take in place of the initial medication. The clinician learns during medication reconciliation that the patient misunderstood instructions, took both anti-hypertensive medications, and had a low blood pressure reading with dizziness at the SOC visit. The doctor instructs the clinician, "Make a visit to recheck the blood pressure again this evening, and then do another visit in the morning and call me with both the evening and morning blood pressure readings."
>
> The agency was unable to send a nurse back to the home that evening and instead made a follow-up call to check on the patient. The clinician did revisit the patient in the morning, checked a blood pressure reading, and called this reading to the physician.
>
> Because only one portion of the physician's order was completed, the answer of "no" must be selected, even though the morning recheck was done. The clinician was unable to complete all steps dictated by best practice standards.

Q: Are we to consider looking at the 60-day certification period only when setting a goal for GG0170C?

A: GG0170C consistently refers to "discharge" goal throughout its guidance, so if an agency anticipates the patient may require more than one certification period to meet his/her care needs the Discharge Goal for this item may be looking forward more than 60 days. This question was added to the OASIS as

a means to provide risk adjustment in less mobile patients who are more likely to develop pressure ulcers or have difficulty in healing existent ulcers. Risk adjustment is calculated based upon the quality episode which begins at SOC (or ROC if patient is hospitalized) and ends at discharge. Since outcomes aren't calculated at recertification it would be important to capture the patient's anticipated status at discharge rather than at the end of 60 days.

Q: If there are diagnoses listed in the OASIS that correspond to the new PVD/DM question, will EMR vendors be able to auto-populate these responses?

A: Although Fazzi can't speak for EMR vendors, it's likely an answer to M1028 would not be set up to pre-populate from diagnoses codes entered. The reason for this would be the need to ensure documentation is in the record to support the condition is 'active' as defined in the OASIS-C2 Guidance Manual. The EMR would not be able to determine if this documentation is present in the agency medical record.

Q: In M2003 if we mark "0" for No due to MD not getting back with us are we still 'dinged' on outcomes?

A: Yes, at this time even though this is not within the control of the agency it does impact calculations related to the agency providing best practice follow-up of medication issues. The measure is not publically reported on Home Health Compare, though.   The measure was evaluated as a part of the 2015-2016 Home Health Quality Measure Review. A technical advisory panel has recommend the related quality measure no longer be included in the Home Health Measures, and this is a part of the 2017 proposed Home Health PPS Rule This was the recommendation from the expert panel related to medication issues: "P28- *Potential Medication Issues Identified and Timely Physician Contact at Start of Episode*, P29- *Potential Medication Issues Identified and Timely Physician Contact during All Episodes of Care"* should be revised to either expand the timeframe within which physician response must be elicited or revise the responses in the OASIS items to indicate that the home health agency reached out to the physician and received their response within the allotted timeframe."

Q: Regarding M1028 Active Diagnoses, what about the code we use for PVD ulcers which is I87.2 followed by the ulcer code?

A: The diagnosis code I87.2 is used for venous insufficiency, followed by a code(s) for stasis ulcers when present. M1028 is only capturing arterial conditions. Any ulcers related to PVD would need to be arterial in origin rather than venous.

Q: On the new M2001 for medication, does the guidance still require the physician to respond within 24 hours?

A: M2001 indicates whether the drug regimen review identified any potential clinically significant medication issues. M2003 asks if the physician was contacted by midnight of the next calendar day with all prescribed/recommended actions completed. In order to mark 1-Yes the physician must have responded to the issue within that time frame and the agency must have completed the orders given. If

the orders involved a span of time past the end of the next calendar day, the agency must have begun any part of those orders that could be initiated.

Q: It appears that OASIS-C2 has removed the recert OASIS from the timeline to review back for process measures. Would this mean that we no longer need to carry process measures over on the recert POC because they were on the SOC 485?

A: The look-back period for M2401 is the most recent SOC or ROC assessment. This would mean if physician approved interventions appear on the SOC 485 (or ROC orders) and those interventions were completed a clinician could mark 1-Yes. If orders were present on the SOC 485 but weren't still in effect at ROC, then 0-No would have to be marked. Some agencies resume all prior orders that are applicable while other agencies write a new set of orders. This would need to be considered when selecting a response.

Q: The guidance for M1340 refers to a pressure ulcer repaired with a skin graft? Not just a muscle graft or flap?

A: The guidance for M1340 states, "If a pressure ulcer is surgically closed with a flap or graft it is no longer reported as a pressure ulcer. It should be reported as a surgical wound until healed. If the flap or graft fails, it should continue to be considered a surgical wound until healed." The guidance in M1308 states, "A pressure ulcer treated with a skin graft (defined as transplantation of skin to another site) should not be reported as a pressure ulcer and until the graft edges completely heal, should be reported as a surgical wound on M1340."

Q: Regarding M1028, if the patient has code E11.51, E11.52, or E11.59 can box 1 for PVD be checked?

A: Interestingly, none of the codes for diabetes with peripheral vascular disease are included in the guidance manual listing of conditions qualifying for the PVD response in M1028. The question itself states, "See OASIS Guidance Manual for a complete list of relevant ICD-10 codes." Given this statement (using the work *complete*) and the lack of the diabetic PVD codes on the approved list, additional clarification from CMS would be required before diabetic PVD codes should be considered when responding to M1028. Fazzi will request clarification and share any responses.

Q: What M question will determine the prior function status? M1900?

A: M1900 indicates a patient's functional status for ADL and IADL activities prior to the most recent illness, exacerbation, or injury. For outcome purposes, prior functional status vs. status at discharge is measured by responses to ADL/IADL questions at the most recent SOC/ROC to the time of discharge (a quality episode).

Q: Will we be able to collaborate with other disciplines in terms of the mobility questions? For example, if patient refuses to perform the bed mobility question for RN but does it for OT, will the clinicians be able to collaborate and select the best answer that describes the patient's ability?

A: The example you've provided for GG0170C would not allow for the SN to capture the mobility performed with the OT unless the SN was present at the time of the OT's visit, and the visit occurred during the 5-day SOC window or the 48-hour ROC window. Otherwise, the rule that only one clinician can complete the OASIS would be violated. The clinician completing the OASIS must have performed the assessment required to answer the question. However, if the SN assesses the bed mobility, it would be acceptable to confer with the therapists to discuss a realistic discharge goal.

Q: If a previous Stage 3 or Stage 4 pressure ulcer heals and is no longer open but then the area reopens, what stage is it?

A: A closed Stage 3 or Stage 4 pressure ulcer is always staged at its former worst stage if it reopens. A reopened ulcer that had been a Stage 3 may need to be captured as unstageable if the clinician is unable to visualize the base of the wound, as it could have advanced to a Stage 4. If any Stage 4 structures are visible (bone, muscle, tendon, or joint capsules) then the wound should be captured as a Stage 4.

Q: Regarding M1028, does the active diagnosis need to be listed in the top 6 diagnoses in M1021 and M1023? Second related question: Do you think on M1028 it will matter if the diagnosis is in the top 6 spaces or not considering CMS has "active". It could be an active comorbidity that is not uncontrolled.

A: The guidance for M1028 does not indicate that the related diagnoses must appear on the OASIS. There may be six other conditions requiring a more intensive focus of care, and in this instance it would be appropriate for the related PVD/DM diagnoses to appear in sequencing at the seventh position or lower. It would be prudent to include the diagnosis on the plan of at some point in the sequencing, as a major medical comorbidity that is active likely would at least require monitoring by the agency.

Q: How will the discharge goal for GG0170C affect the agency? Will this be an outcome?

A: Both responses in GG0170C provide potential risk adjustment only. At this point in time no outcome data is being generated from the response.