OASIS UPDATES & HOT TOPICS

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OASIS Updates & Hot Topics

- 2017 Expansion of One Clinician Rule
- Timeliness of Care (ToC) quality measure
- Physician-Ordered Resumption of Care (ROC) date
- M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage
- GG items
- Drug Regimen Review (DRR)
- Section J: Health Conditions: J1800 & J1900
- HHQRP Web Page Resources
- OASIS-D1: 1/1/20

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2017 Expansion of One Clinician Rule

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2017 Expansion of One Clinician Rule

- Based on feedback from home health stakeholders, and to better align with assessment practices in other Post-Acute Care settings, **CMS has modified the current home care guidance related to the one clinician convention**
- As required by the Conditions of Participation, the Comprehensive Assessment will continue to be the **responsibility of one clinician**. However, **effective January 1, 2018**, *the assessing clinician will be allowed to elicit feedback from other agency staff, in order to complete any or all OASIS items integrated within the Comprehensive Assessment*
- For OASIS items that reflect **clinical/patient assessment** (e.g., height, weight, functional status, pressure ulcer status), HHA's should base OASIS responses on assessment by agency staff, and not directly on documentation from previous care settings
- **When collaboration is utilized**, the assessing clinician is responsible for considering available input from these other sources, and selecting the appropriate OASIS item response(s), within the appropriate timeframe and consistent with data collection guidance
- **M0090 (Date Assessment Completed**) will indicate the last day the assessing clinician gathered or received any input used to complete the comprehensive assessment document, which includes the OASIS items

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2017 Expansion of One Clinician Rule

- For OASIS items requiring a patient assessment, the collaborating healthcare providers (e.g., other agency clinical staff: LPN/LVN, PTA, COTA, MSW, HHA) should have had **direct in-person contact with the patient**, or have had some other means of gathering information to contribute to the OASIS data collection (health care monitoring devices, video streaming, review of photograph, phone call, etc.)
- In the case of an **unplanned or unexpected discharge** (an end of home care where no in-home visit can be made), 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 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 days**
- If desired, agencies **may continue to limit** the OASIS to only that data directly assessed and collected by the single assessing clinician
- Agencies should follow practices in accordance with **provider policies and procedures** related to staff communication and patient information to track and/or identify those staff members contributing to the patient assessment information and/or supported in the patient's clinical record

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Timeliness of Care Process Quality Measure

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Timeliness of Care Process Quality Measure

- **Title:** Timely Initiation of Care
- Percentage of home health quality episodes in which the start or resumption of care date was on the physician-ordered SOC/ROC date (if provided), otherwise was within 2 days of the referral date or inpatient discharge date, whichever is later
- **Process** measure
- **Numerator**: Number of home health quality episodes in which the start or resumption of care date was on the physician-ordered SOC/ROC date (if provided), otherwise was within 2 days of the referral date or inpatient discharge date
- **Denominator**: Number of home health quality episodes ending with discharge, death, or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions
  - No measure-specific exclusions
- **Not** risk adjusted
- **Publically reported** on HH Compare
- Part of Quality of Patient Care **Star Ratings**

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A Related topic: Physician-ordered Resumption of Care (ROC) date

- For example, if the patient is discharged from the hospital on **May 1**, and the physician orders home care to resume on **May 4**, the M0102 - Date of Physician-ordered Resumption of Care date is 05-04-XXXX, the M0032 Resumption of Care date is 05-04-XXXX, and the M0090 Date Assessment Completed can be anytime on or between 05-04-XXXX and 05-06-XXXX.
- When the physician specifies a date that home care services must resume (a physician-ordered Resumption of Care date), the agency is expected to conduct the ROC visit **on that date**.
- The agency has up to 2 calendar days from the ROC date (M0032) to complete the ROC assessment document (M0090).

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Timeliness of Care (ToC) quality measure

- Items Used:
  - (M0102) Date of Physician-ordered Start of Care
  - (M0104) Date of Referral
  - (M0030) Start of Care Date
  - (M0032) Resumption of Care Date
  - (M0100) Reason for Assessment
  - (M1000) Inpatient Facility discharge
  - (M1005) Inpatient Discharge Date
- A complex quality measure
- 2-way communication with physicians challenging nationwide
- Consistently asked about ToC and related topics like physician-ordered SOC/ROC date once/month
- Want to share a few of these excellent questions on the next few slides...

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ToC WA provider Q&A #1
Patient requests SOC later than physician-ordered SOC

Q: When we have a complete referral on 9/1/18, within that referral is a MD ordered start of care date of 9/4/18. When we complete our triage call with the patient, the patient requests a different day, 9/5/18, for start of care. When the patient requests a change in start of care date, are we required to obtain a new order or just notify the MD of this request and are we required to actually speak with someone from that MD office who acknowledges the change in date and document who we spoke to or is sending a fax with the requested change in start of care sufficient as long as we are notifying before the end of business on 9/4, the original start of care date?

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ToC WA provider Q&A #1: **Answer Part 1**
Patient requests SOC later than physician-ordered SOC

A: See the Interpretative Guidelines for revised HHA CoPs: §484.55(a) Standard: Initial assessment visit, copied below.

"§484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.
Interpretive Guidelines §484.55(a)(1)
For patients receiving only nursing services or both nursing and rehabilitation therapy services, a registered nurse must conduct the initial assessment visit. For patients receiving rehabilitation therapy services only, the initial assessment may be made by the applicable rehabilitation skilled professional rather than the registered nurse. See §484.55(a)(2). The initial assessment bridges the gap between when the first patient encounter occurs and when a plan of care can be implemented. "Immediate care and support needs" are those items and services that will maintain the patient's health and safety through this interim period, i.e., until the HHA can complete the comprehensive assessment and implement the plan of care. "Immediate care and support needs" may include medication, mobility aids for safety, skilled nursing treatments, and items to address fall risks and nutritional needs. The clinical record must demonstrate that homebound status/eligibility for the Medicare home health benefit was determined and documented during the initial visit. An HHA that is unable to complete the initial assessment within 48 hours of referral or the patient's return home, shall not request a different start of care date from the ordering physician to ensure compliance with the regulation or to accommodate the convenience of the agency.
In instances where the patient requests a delay in the start of care date, the HHA would need to contact the physician to request a change in the start of care date and such change would need to be documented in the medical record."

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ToC CMS Q&A #1 : **Answer Part 2**
Patient requests SOC later than 48 hour time frame

Q18. I understand that the initial assessment visit (or Resumption of Care) is to be done within 48 hours of the referral (or inpatient discharge). What do we do if the patient puts us off longer than that? For example, the patient says, "I have an appointment today (Friday); please come Monday." [Q&A EDITED 10/18; Q&A EDITED 06/14]

A18. The initial assessment visit at SOC (or the Resumption of Care visit) must be completed within 48 hours of the referral, within 48 hours of the patient's return home OR on the physician-ordered SOC/ROC date. In the absence of a physician-ordered SOC/ROC date, if the patient refuses a visit within this 48-hour period, the agency may contact the physician to determine whether a delay in visiting would be detrimental to the plan of care and request a change in the SOC/ROC date.

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ToC WA provider Q&A #2
Need for new order?

Q5WA: There has been some confusion on timeliness of care compliance when hospital discharge occurs after the referral is received. I have found some information which states timeliness of care compliance is based off of M1005 (Inpatient discharge date) date if this date is later than M0104 (Date of referral). However, the Guidance Manual states: 'if a SOC is delayed due to extended hospitalization then the date the agency receives the updated/revised referral for services to begin would be the referral date.' Can you clarify if the agency needs to call to obtain new updated orders/referral from the doctor or does the 48 hour clock start from the inpatient discharge date rather than the referral date automatically without obtaining/calling for an updated referral?

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ToC WA provider Q&A #2: **Answer Part 1**
Need for new order?

A5WA: See bullet #2 in the Response Specific Instructions (RSI) for M0104: Date of Referral:

> "If the Start of Care is delayed due to the patient's condition or physician request (e.g. extended hospitalization), then the date the agency received the **updated/revised** referral information for home care services to begin would be considered the date of referral. This does not refer to calls or documentation from others such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission."

- Key terms: "updated/revised referral information" and this should be defined in agency policy
- Because according to the Response Specific Instructions for M0104, an extended hospitalization is a "physician request", the guidance does not state an updated order is needed

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ToC WA provider Q&A #2: **Answer Part 2 with related CMS Q&A**

A5WA (con't): A **different situation** when an updated/revised physician order would be required is when a patient requests a delayed SOC/ROC outside the 48 time period. In this scenario, the change in schedule would need to be approved by the physician ordering the home health services and an updated order to begin services could be obtained; see guidance in below CMS Q&As.

> **Q23.11.5.M0102. We have a very large referral base send referrals via fax. The physician ordered SOC date indicated on the referral is often 2-3 days before the date we even receive the fax (time stamp on fax is January 6th for a physician ordered SOC date of January 4th). We have been completing M0102 Date of Physician Ordered SOC date with the date specified by the physician (January 4th), which has penalized our agency on the Timeliness of Care measure. We have attempted to obtain a verbal order to update the SOC date, however the physician group have become irritated with our calls. Please advise. [Q&A ADDED 04/15; Previously CMS Qtrly 01/15 Q&A #4]**
>
> A23.11.5. The agency should contact the physician to state that a patient referral was received after the physician ordered SOC date and to confirm that patient is still in need of home care services. If the need still exists, a valid SOC order, with updated referral or physician's ordered SOC date can be obtained.

- Related question: The patient requests a delayed ROC and the agency notifies the physician by fax of the patient's request but does not receive 2-way communication approving the change in schedule
- This would not be in compliance and it would be outside the RN scope of practice to change a physician order without physician approval

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Also related... Definition: Valid referral

"If a physician is willing to follow the patient, and provides adequate information (name, address/contact info, and diagnosis and/or general home care needs) regarding the patient, this is considered a valid referral. If the referral meets these requirements outlined in OASIS Guidance, it is to be considered a valid referral"

- HHAs cannot add [F2F] to CMS' definition to 'valid referral'
- Because M0104 is used to calculate the publically reported Timeliness of Care process measure, all HHAs need to use the same definition of 'valid referral' for the 'playing field to be level' with respect to the data

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ToC WA provider Q&A related CMS Q&A

Q23.11.6.M0104. As outlined in the Conditions of Participation, the initial assessment visit must be conducted "within 48 hours of referral", and the referral date should be reported in M0104 – Date of Referral. What constitutes a "valid referral" for the purposes of considering that we, in fact, have an actionable referral to initiate home care services? Sometimes we get a home care referral from a hospitalist who will NOT be giving orders or signing the plan of care. Sometimes we get a referral that contains only the patient's name without any contact information (no phone number or address). Sometimes we get a general order to "Evaluate for Home Health Services". If/when we try to follow up with the patient's primary care physician, or with the referral source to get patient contact information or clarify orders, we don't hear back the same day, and wonder how/if this impacts our M0104 - Date of Referral and initial assessment visit compliance? [Q&A ADDED 04/15; Previously CMS Qtrly 10/14 Q&A #2]

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ToC WA provider Q&A related CMS Q&A: **Answer**

A23.11.6. In order to be eligible for the Medicare Home Health benefit, a patient must be "Under the care of a physician". When an agency receives an initial "referral" or contact about a patient who needs service, the HHA must ensure this physician, or another physician will provide for the plan of care and ongoing orders. If a physician is willing to follow the patient, and provides adequate information (name, address/contact info, and diagnosis and/or general home care needs) regarding the patient, this is considered a valid referral. In cases where the referring physician is not going to provide orders and follow the patient, this is **not** a valid "referral" for M0104. In the example of a hospitalist who will not be providing an ongoing plan of care for the patient, the HHA must contact an alternate, or attending physician, and upon agreement from this following physician, for referral and/or further orders, the HHA will note this as the Referral date in M0104 (unless referral details are later updated or revised). If a general order to "Evaluate for Home Care services" (no discipline(s) specified) is received from a physician who will be following the patient, this constitutes a valid order, and per CoPs §**484.55** the RN must conduct the initial assessment visit to determine immediate care and support needs and eligibility for the Home Health benefit for Medicare patients.

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ToC WA provider Q&A #3

SOC *before* MD ordered SOC?

Q: Can we visit the patient before the MD ordered SOC date? Our OASIS software is not allowing us to do this.

A: Per CMS:

"The CoPs don't really address the issue of an assessment occurring before the SOC date. This is more of a payment policy issue. We looked into this area a lot when reviewing our SOC definition. Based on the payment policy and our discussions with other components here, it appears that an assessment before the SOC is permissible. "

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M1311

Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

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M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Revised data collection guidance for PU items

- The OASIS pressure ulcer items should be coded based on findings from the **first skin assessment** that is conducted on or after, and as **close to the SOC or ROC date as possible**
  - What do we have? What do we see?
  - Many CMS questions about this revised data collection guidance for PU items
  - Why can't assess skin and change response like before?
    - Because of the data **standardization** requirements of the IMPACT Act
    - HH unique b/c care is *in-home*, not delivered in a brick-and-mortar facility
- If the first time a skin assessment could be done is on the second home health visit, and a pressure ulcer is identified during that assessment, then it should be reported on OASIS, as that would represent the initial skin assessment
- If a skin assessment was conducted on the SOC visit and no pressure ulcer was identified, then a subsequent skin assessment was conducted on the second visit and a pressure ulcer was identified, the pressure ulcer would not be reported on the OASIS at that time point, since the pressure ulcer status should be based on the **first skin assessment** conducted at the SOC/ROC time points

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M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

M1311 Item Intent

- Number of Stage 2, 3 or 4 pressure ulcers/injuries and designated as Unstageable, that are observed on assessment
- At discharge, identifies if each pressure ulcers present on the Discharge Assessment was observed at the same stage at the most recent SOC/ROC
- Stage 1 pressure injuries and all healed pressure ulcers/injuries are **not** reported in this item

General Revisions

- Item retained but different version created for specific time points
- Language modified to align with other PAC instruments
- Adapted NPUAP definitions and terminology
- Modified skip patterns
- M1313 deleted

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M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Item text Revised

- Added ulcers/injuries where applicable
- Added the word "device" to the item title in D1. Unstageable: non-removable dressing/device
- Removed "suspected...in evolution" from F1. Unstageable Deep tissue injury

- Use of the **dash**
  - Valid response at Discharge time point only
- M1311: **A1-F1**
  - At **SOC/ROC and FU** enter the number of ulcers for each stage that are observed at the first skin assessment completed during the assessment time frame
- M1311: **A1-F1 and A2-F2**
  - At **Discharge**, enter a response for each row unless directed to skip
  - If no Stage 2 pressure ulcers are observed, enter 0 in A1 and skip A2
  - If at least one Stage 2 pressure ulcer is observed, and reported in A1, enter in A2 the number of these Stage 2 pressure ulcers that were observed at the same stage at the most recent SOC/ROC

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M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Determining "Present on Admission"

- For each pressure ulcer/injury observed and coded in items M1311A1- F1 on Discharge, determine whether that pressure ulcer/injury was observed at the same stage at the time of the most recent SOC/ROC, and **did not form** during this home health quality episode
- If the pressure ulcer/injury was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge Assessment, its "Present at the most recent SOC/ROC" stage should be considered the stage at which it first becomes numerically stageable
- If it subsequently **increases in numerical stage**, do not report the higher stage ulcer as being "present at the most recent SOC/ROC" when completing the Discharge Assessment

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M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

CMS Guidelines

- Stage 2 PUs are not characterized by slough; if slough present, then PU is Stage 3 or 4
- Contact previous care providers to determine wound stage at highest
- Do not reverse stage; report at highest stage
- If stageable at SOC/ROC, then covered with slough/eschar and unstageable at DC, then this PU was not present on admission
- On the DC asmt, if at discontinuation of a device a PU is found underneath it, then it is considered new because its presence was unknown and not coded as present a the most recent SOC/ROC
- "Healed" vs. "unhealed" can refer to whether the ulcer/injury is "closed" or "open"
  - Stage 1 pressure injuries and DTIs although closed (intact skin), would not be considered healed
- "Known" refers to when documentation is available that states a PU/injury exists under the non-removable dressing/device

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M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

CMS Guidelines

- A deep tissue injury with intact skin at SOC/ROC, that becomes stageable, is considered present at the most recent SOC/ROC at the stage at which it first becomes numerically stageable
  - "Declares itself"; evolves into what it's going to be

Surgical Interventions; subtle differences

- Any type of flap procedure performed to surgically replace a pressure ulcer is reported as a surgical wound, until healed. It should not be reported as a pressure ulcer/injury on M1311
- A pressure ulcer treated with any type of graft is no longer reported as a pressure ulcer/injury, and until healed, should be reported as a surgical wound on M1340.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer and should not be reported as a surgical wound on M1340

Mucosal Ulcers

- Mucosal pressure ulcers are not staged using the skin pressure ulcer/injury staging system because anatomical tissue comparisons cannot be made
- Therefore, mucosal ulcers (e.g., those related to nasogastric tubes, oxygen tubing, endotracheal tubes, urinary catheters, mucosal ulcers in the oral cavity) should not be coded on the OASIS

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M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage: Quality Measure

Title: "Changes in Skin Integrity Post-Acute Care: Ulcer/Injury"

- The percent of quality episodes with reports of Stage 2-4 pressure ulcers, or unstageable pressure ulcers/injuries due to slough/eschar, non-removable dressing/device, or deep tissue injury, that were not present or were at a lesser stage on admission

Numerator: The number of complete quality episodes for patients whose assessment at discharge indicates one or more new or worsened Stage 2-4 or unstageable pressure ulcers/injuries compared to the start or resumption of care assessment

Denominator: The number of quality episodes, except those that meet the exclusion criteria. HHH quality episodes are defined as pairing assessments completed at start or resumption of care with assessments completed as discharge

- Denominator Exclusions
  - Episodes that end with death at home or transfer to inpatient facility
  - No SOC/ROC asmt
  - Data missing from M1311a-f

Cross-setting quality measure implemented to meet IMPACT Act requirements

Risk Adjusted

- Functional mobility: GG0170C Lying to Sitting on side of bed
- Bowel incontinence: M1620
- DM, PVD/PAD: M1028
- Low body mass index: M1060a-b

Replaces the current pressure ulcer measure, "Percent of Residents or Patients with Pressure Ulcers that are New or Worsened (Short Stay) (NQF #0678)

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GG Items

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GG Items

Different from M-items
- GG and M Item guidance does **NOT** match!
  - Ex: M1850 Transferring guidance VERY different from GG0170E
  - Be sure to apply guidance to each item individually
  - Differences can be related to what is included and excluded in specific item
- Lengthier, combine assessment of several activities

January 2019 CMS quarterly OASIS Q&As
- 32 questions – a record!
- Reflects the complexity of these items
- A lot of guidance in this batch!

Use **GG Self-Care and Mobility Decision Tree**!
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/GG-Self-Care-and-Mobility-Activities-Decision-Tree.pdf
- Series of yes/no questions that guide you to the correct code

"**Understanding OASIS Function M and GG item Coding**" Fact Sheet on the HHQRP Training web page (April 2019)
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Understanding-OASIS-Function-M-GG-Item-Coding_Fact-Sheet.pdf
- 2 great examples to illustrate the differences

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GG Items

- **Coding scales different**!
  - Response Options: Independence increases with the coding number
  - 06 (GG0130 & GG0170) or 03 (GG0100) being independent and 01 being dependent
  - Code 08: Unknown
  - Code 09: Not Applicable
  - **Dash** is a valid response
    - Indicates no information; that you did not *even try* to get the info
    - **Better to use Code 08: Unknown**
      - If no information about the patient's ability is available after attempt to interview the patient/family and after reviewing the patient's clinical record
- Use of assistive device(s) to complete an activity should not affect coding of the activity

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GG Items

GGO130 and GG0170: Document Discharge Goal along with activity performance

- If the SOC/ROC performance of an activity is coded using one of the activity not attempted codes (07, 09, 10, 88), a DC goal may be submitted using the 6-point Likert scale if the patient is expected to perform the activity by DC
- DC goals can be based on:
  - Prior medical condition
  - SOC/ROC asmt
  - Self-care & mobility status
  - Discussions with patient/family
  - Professional judgement
  - Practice Standards
  - Expected treatments
  - Patient motivation
  - Anticipated length of services
  - DC plan

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GG Items

The discharge time period under consideration includes the **last 5 days of care**

- This includes the date of the visit and the 4 preceding calendar days
- Code the patient's functional status based on a functional assessment that occurred close to the time of DC

Not Attempted Codes

- 07: Patient refused
- 09: Not applicable (patient did *not* do it before)
- 10: Not attempted due to environmental limitations (patient *did* do it before)
- 88: Not attempted due to medical condition or safety concerns (patient *did* do it before)
  - Used most often due to new medical condition

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GG Items

- Used to calculate the cross-setting Process Measure:
- "Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function (NQF#2631)
- Reports the percent of patients with a SOC/ROC and a discharge functional assessment and a treatment goal that addresses function
- Should reflect the SOC/ROC baseline status and be based on a functional assessment that occurs at or soon after the SOC/ROC
- Gather data **early** before services are provided to capture improvement
- Record patient's usual activity/performance (greater than 50% of the time), not the best or worst performance

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GG Items

GG0100 Prior Functioning
- Involves historical data gathering
- Time period under consideration?
  - Assessing clinicians must consider each individual patient's unique circumstances and use *professional clinical judgement* to determine how prior functioning and prior use applies for each individual patient

GG0100, GG0130 Self Care, GG0170 Mobility
- Does the M1800 ADL/IADL "majority of tasks" convention apply to Section GG items?
  - No! The activities should be reported based on the patient's usual performance
- Patient refusal to perform activities?
  - Can use other assessment strategies such as general observation, interview of patient/caregiver(s), collaboration with other agency staff and other relevant strategies to complete any & all GG items
  - Use Code 07, Patient refused when assessment/discussion of the activity is attempted, the patient refuses and no other Performance or Activity not attempted code is applicable
  - In situations where a definitive answer to an assessing clinician's question is not contained in published CMS OASIS guidance (OASIS Guidance Manual, Q&As, etc.), the clinician may have to rely on *clinical judgment* to determine how to code the item, ensuring that the response coded does not conflict with current guidance

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GG items **WA provider Q&A**

Q: For GG0110 Prior Device Use, a patient has a device (for example, walker or wheelchair) and also uses a cane or crutches (a device not listed). Can both letters A thru E be selected and Z? The directions state "Select all that apply" so does this mean one could code GG0110: A, D and Z?

A:For GG0110, if immediately prior to the current illness, exacerbation or injury, the patient used a wheel chair, a walker and a cane, this item would be coded as A and D. Z would not be coded (selected) because the patient ***did*** use at least one of the listed devices (guidance says to select Z ***if the patient did not use any of the listed devices or aids).*** In other words, data collectors should select A thru E or Z.

Please see the OASIS D Data Submission Specifications: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/Downloads/OASIS-D-Data-Specs-V2301-FINAL-09-10-2018.zip

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GG items [Guidance from January 2019 Qtrly Q&As]

GG0130 Self Care: What is/is not included
- **GG0130C Toilet Hygiene:** "The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment."
  - Toileting hygiene includes managing undergarments, clothing and incontinence products, and performing perineal hygiene
- **GG0130E Shower/bathe self:** "Code the item based on the patient's ability to bathe herself, regardless of where the bathing takes place. "
  - 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 05 Set-up/Clean up**
  - For example, your patient bathes at the sink and only requires assistance for setting up and filling the plastic tub she uses for bathing. If no other assistance is required while the patient washes, rinses and dries off her body, select **Code 05 Set-up/Clean-up**
  - If the patient requires any assistance at any time during the bathing activities of washing, rinsing, drying (for instance needs someone to refresh the tub of water for rinsing), then Code 05 Set-up/Clean-up is **not** the appropriate code

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GG items [Guidance from January 2019 Qtrly Q&As]

GG0130F Upper Body Dressing: What is/is not included

- The item includes "The ability to dress and undress above the waist; including fasteners, if applicable."
- If donning and doffing an elastic bandage, or an orthosis or prosthesis occurs while the patient is dressing/undressing the upper body, *then count the elastic bandage/orthotic/prosthesis as a piece of clothing* when determining the amount of assistance the patient needs when coding the upper body dressing item
- Assess ability to put on whatever clothing is routinely worn
  - If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing
  - There is no specified timeframe at which the modified clothing style will become the routine clothing
  - The clinician will need to determine which clothes should be considered routine

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GG items [Guidance from January 2019 Qtrly Q&As]

GG0130G Lower Body Dressing: What is/is not included

- This item includes: "The ability to dress and undress below the waist, including fasteners; does not include footwear."
- If donning and doffing an elastic bandage, a stump/shrinker or an orthosis or prosthesis occurs while the patient is dressing/undressing the lower body, *then count the elastic bandage/shrinker/orthotic/prosthesis as a piece of clothing* when determining the amount of assistance the patient needs when coding the lower body dressing item
- Note that while some types of clothing, wraps or supportive devices may cover both the lower leg/lower body and the foot, the patient's ability to put them on/take them off should not be considered for both GG0130G Lower Body Dressing and GG0130H Footwear
- In order to assist in determining which activity the piece of clothing/wrap/orthotic/prosthetic should apply to, consider items that cover all or part of the foot (even if it extends up the leg, like a sock or ankle foot orthosis) as footwear. Consider items that go on the lower body (excluding items that cover all or part of the foot) as lower body dressing items

GG0130H Footwear

- If the patient can complete the tasks of putting on/taking off footwear, and only needs a helper to retrieve or set up footwear/devices necessary to perform the included tasks, **code 05 – Setup/Clean-up assistance**

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GG items [Guidance from January 2019 Qtrly Q&As]

GG0170C Lying to Sitting on side of bed

- For a **BKA patient**, the score would be based on the amount of assistance required to complete the activity
  - If the patient was able to safely complete the activity independently, moving from lying to sitting on the side of the bed with one foot touching the floor or not, with no back support, the patient would be scored as a **06, Independent**
  - Please be aware that a **BKA patient** can wear lower extremity prosthetic(s) with attached "foot" to complete this activity
- The use of an assistive device does not affect the scoring of the measure if the patient is able to perform the activity independently
- If the patient requires a caregiver to hand him the assistive device to perform the activity, this would be scored as Code 5, Setup/Clean-up assistance, because the patient requires setup assistance prior to performing the activity

GG0170E Chair/bed to chair transfer

- For GG0170E, the activity begins with the patient sitting (in a chair, wheelchair, or at the edge of the bed) and includes transferring to sitting in a chair, wheelchair, or at the edge of the bed
- The activity may be assessed using a chair-to-chair transfer, therefore an environmental limitation restricting placement of a chair at the bedside would not need to affect the assessment or coding of this GG activity
- While the need for assistance with ambulation *may impact the M1850 Transferring item* (which is specifically a transfer to and from the bed), the need for assistance with ambulation **would not impact** the code selected for GG0170E which simply reflects a transfer between any two sitting surfaces
  - ☛**Note**: Guidance for M1850 very different from guidance for GG0170E!

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GG items [Guidance from January 2019 Qtrly Q&As]

GG0170F Toilet transfer
- The toilet transfer activity involves the patient transfer on and off the toilet/commode and does **not** include getting to/from the toilet/commode

GG0170J Walk 50 ft. with 2 turns
- The turns do not have to be consecutive and can occur at any time during the 50-foot walk

GG0170K thru GG1070O: Walk 150 ft., Steps, Uneven surfaces
- When combining OASIS activities in the patient assessment, consider where one activity ends and another begins, then code based on the amount of assistance needed for each distance
- The activities are coded on OASIS separately
- The assessing clinician can use clinical judgement to determine how the actual patient assessment is conducted

Discharge Goal
- Even in situations where activity performance is coded with an "activity not performed" code or skipped, a discharge goal may still be reported.
- Use of a dash is permissible for any remaining self-care or mobility goals where a discharge goal was not established
- ASAP nat'l submission system will issue a fatal error if no DC goal documented as required by the process measure

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Drug Regimen Review (DRR)

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Drug Regimen Review (DRR)

- Not new for HHAs; New to other PAC settings in 2018
- Originally introduced 1/1/10; revised 1/1/17
- Key quality indicator
  - Medication issues are a common cause of emergent care and re-hospitalizations
- The 2 way communication with the physician/designee is a challenge **nation-wide!**
  - Telephone, voicemail, electronic messaging, fax
- Tough b/c 3 conditions must be met for a favorable measure result:
  1. Completion of DRR at SOC/ROC
  2. Physician contact and follow-up if medication issues are identified at SOC/ROC
  3. Physician contact and follow-up each time medication issues are identified throughout the episode of care

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Drug Regimen Review (DRR): Quality Measure

- **Title**: Drug regimen review conducted with follow-up for identified issues
- Data comes from **M2001, M2003 & M2005**
- **Numerator** = Number of episodes in the denominator where the medical record contains documentation of a drug regimen review conducted at SOC/ROC with all potentially clinically significant medication issues identified during the course of care and follow-up with a physician/designee
- **Denominator** = Number of patient care episodes with a DC, transfer or death at home assessment during the reporting period
- **No** denominator exclusions
- **Not** risk-adjusted
- **Publically** reported
- If **dash** entered for M2001, 2003 or 2005, the quality episode will not be included in the numerator but will be included in the denominator
  - A **less favorable** result

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Drug Regimen Review (DRR)

- DRR generally considered to include:
  1. Medication reconciliation
  2. A review of all medications a patient is currently using
  3. A review of the drug regimen (schedule/timing)
     a) Prescribed
     b) OTC
     c) Herbals/Supplements
     d) Includes TPN & oxygen

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Drug Regimen Review (DRR)

- **Clinically Significant Medication Issue** defined:
  - A potential or actual issue that, *in the clinician's professional judgement*, warrants physician/designee communication and completion of prescribed/recommended actions by midnight of the next calendar day (at the latest)
    - Adverse reactions
    - Ineffective drug therapy
    - Side effects
    - Interactions
      - Drug-drug
      - Food-drug
      - Drug-Disease
    - Duplicate therapy
    - Omissions
    - Dosage errors
    - Non-adherence
  - Medication issue must reach level of clinical significance that notification of physician/designee for orders/recommendations by midnight of the next calendar day is required

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Drug Regimen Review (DRR)

- More & more therapy-only patients
- Who can do what?

WA Provider Question:

Q7WA: I have a question regarding therapy patients only. With the new CoP changes that will be in effect very soon, we have started to provide patients with a copy of their medication reconciliation that we complete on admission with the patient. The Physical Therapists have raised concerns, stating that providing a medication reconciliation list is not in their scope of practice. Do you have any resources available that can help me find a solution?

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Drug Regimen Review (DRR)

- WA Provider Answer:

A: I have a few strategies to suggest:

1) Consider reminding your therapists that the drug regimen review (DRR) for HHA patients is a long standing patient safety requirement; it is not a new addition to the Medicare HHA CoPs, but rather the CoPs were reorganized and only the location of this requirement changed; your agency's processes may have changed around the new CoPs and that may be what your therapists are reacting to.

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Drug Regimen Review (DRR) & Collaboration

2. See the guidance in Medicare HHA Interpretive Guidelines to State Operations Manual (SOM)
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_b_hha.pdf]

§484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

Interpretive Guidelines §484.55(c)(5) The patient's clinical record should identify all medications that the patient is taking (both prescription and non-prescription) as well as times of medication administration and route. As part of the comprehensive assessment the HHA nurse should consider, and the clinical record should document, that the HHA nurse considered each medication the patient is currently taking for possible side effects and the list of medications in its entirety for possible drug interactions. The HHA should have policies that guide HHA clinical staff in the event there is a concern identified with a patient's medication that should be reported to the physician. In rehabilitation therapy only cases, the patient's therapist must submit a list of patient medications, which the therapist must collect during the comprehensive assessment, to an HHA nurse for review. The HHA should contact the physician if indicated.

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Drug Regimen Review (DRR) & Collaboration

- 3) **CMS Q&As for M2001**; copied below from: https://www.qtso.com/hhatrain.html
  - Note that each Q&A refers to "agency policy"
  - Q&As 160.3.2 & 160.3.3 address collaboration in therapy-only cases

Q160.3.2. M2001. On therapy only cases, can the therapist collaborate with a pharmacist when completing the Drug Regimen Review? [Q&A EDITED 10/16; Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 07/11 Q&A #16]

A160.3.2. In a therapy only case, it would be acceptable for the therapist to collaborate with a pharmacist when performing the drug regimen review. Agency policy and practice will determine how the pharmacist participates in the drug regimen review process and how it is documented.

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Drug Regimen Review (DRR) & Collaboration

Q160.3.3. M2001. For therapy only cases, can we have our therapist complete the entire comprehensive assessment, except the Drug Regimen Review (DRR), and then have our agency send a nurse out to complete the entire DRR, including providing responses to the medication related OASIS questions to the assessing clinician? [Q&A EDITED 10/18; EDITED 10/16; Q&A EDITED 04/15; ADDED 06/14; Previously CMS Qtrly 10/13 Q&A #9]

A160.3.3. Yes. The comprehensive assessment continues to be the responsibility of one clinician, the "assessing clinician". Collaboration, however, is allowed on any and all OASIS items, including the medication/DRR tasks and items. One example of collaboration allows the assessing clinician to visit the patient at home and conduct the actual patient assessment, compiling the medication list and evaluating the patient's status (e.g., presence of potential ineffective drug therapy, side effects or patient nonadherence). A "collaborating clinician" in the office might evaluate the medication list to assist with reconciling discrepancies between the facility discharge med list and meds available in the patient's home. In another example of collaboration, the "collaborating clinician" might contact the patient by phone, to discuss issues with the patient regarding side effects they may be experiencing, or effectiveness of the medication. In any case, it is the assessing clinician who is ultimately responsible for ensuring a complete DRR was performed and for reporting the appropriate responses for medication related OASIS items. Note that collaboration options also allow a second clinician to contribute to the drug regimen review by allowing the assessing clinician to utilize information gathered from a second clinician's in-home assessment, during the period in which collaboration is allowed. Agency policy and practice will determine the agency's processes and documentation expectations. The M0090 date reports the date the assessment is completed and should include any time the assessing clinician took to collaborate with others to gather all needed assessment data and determine all relevant OASIS responses. It should be noted that in situations where nursing is admitting for a therapy only patient, the nurse could not complete or even start the comprehensive assessment (including drug review tasks) prior to the SOC date.

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Drug Regimen Review (DRR) & Collaboration

- WA Provider Answer (con't):
  4) Also note the below links to an archived webinar: **HH Scope of Practice for Therapists from CMS HHQI:** http://www.homehealthquality.org/UP/UP-Event-Archives.aspx;
  - Scroll down a bit on the web page to the **January 28th, 2015** webinar; you will also find links to the presentation slides; content addresses not just medication review but mentions other interventions as well.
  - **See slide #13** text copied below: "APTA has a position statement adopted by its House of Delegates which states: *"Physical therapist patient/client management integrated an understanding of a patient's/client's prescription and nonprescription medication regimen with consideration of its impact upon health, impairments, functional limitations, and disabilities. The administration and storage of medications used for physical therapy interventions is also a component of patient/client management and thus within the scope of physical therapist practice."*
    - The Role of Physical Therapist in Home Health; APTA Official Statement
  - **Therapist Scope of Practice Webinar Q&As:** http://www.homehealthquality.org/getattachment/UP/UP-Event-Archives/Therapy-webinar-Q-A.pdf.aspx;

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Drug Regimen Review (DRR) & Collaboration

- January 2019, CMS Quarterly OASIS-D Q&As

QUESTION 6: When completing M2003 or M2005, does the midnight of the next calendar day "clock" start when the assessing clinician identifies the clinically significant medication issue, even if the issue is identified, for instance, on Day 2 of the episode?

ANSWER 6: M2003 and M2005 ask if **two-way communication** and **completion of any prescribed/recommended action**s occurred by midnight of the next calendar day when a clinically significant issue is identified. For **M2003**, the timeframe is "by midnight of the next calendar day" from the time the potential clinically significant medication issue was identified and within the SOC or ROC comprehensive assessment timeframe. For **M2005**, the timeframe is "by midnight of the next calendar day" each time a potential clinically significant medication issue was identified at the time of, or at any time since, the most recent SOC/ROC assessment.

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Section J: 1800 & 1900

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Section J: 1800 & 1900

- Used to report specific problems or symptoms that affect the patient's health status and to identify risk factors for illness, accident and functional decline
- M1800 Any Falls since SOC/ROC; Yes/No
  - Gateway item
  - Reports both witnessed and unwitnessed falls
  - **Fall definition**
    - "An unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (such as a bed or chair)"
    - Not a result of an overwhelming external force such as a person being pushed
    - **Intercepted fall** occurs when the patient would have fallen if they had not caught themselves or been intercepted by another person
    - Intercepted fall is considered a fall

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Section J: 1800 & 1900

- CMS understands that challenging a patient's balance and training him/her to recover their balance is an **intentional therapeutic intervention**, and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as *intercepted falls*
  - If assistance is provided during this activity, it is not considered a fall for OASIS
- But if the patient falls during the Timed Up and Go (TUG) assessment, then that would be reported on OASIS
- A patient stumbling while working with a therapist with therapist needing to intervene to prevent a fall, would be considered an intercepted fall and would be reported
- Be sure to interview patient and/or caregiver about occurrence of falls
  - Patient report not always be completely accurate
  - Not intentionally lying but not forthcoming; short term memory issues?
  - Human nature to minimize occurrence of injuries

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Section J: 1800 & 1900

- **M1900 Number of Falls since SOC/ROC - A "look-back" item**
  - No injury
  - Injury except major:
    - Skin tears, lacerations, superficial bruises, hematomas, sprains, and any fall-related injuries that causes the patient to complaint of pain
    - Not an exhaustive list; **use clinical judgement**
  - Major injury:
    - Joint dislocations, closed head injuries with altered consciousness, subdural hematomas
    - Not an exhaustive list; **use clinical judgement**
  - Record one level of injury for each fall
  - Code injury *not* the treatment
    - Staples, sutures, etc.
- Assessment Strategies
  - Review documentation
  - Interview patient and caregiver
  - Determine number of falls and code injury level

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Section J: 1800 & 1900

- Code falls as 1, Yes, *no matter where they occur*; inside or outside the home
  - CMS received many questions about fall location
- "No injury" definition:
  - No evidence of any injury noted on assessment
  - No complaints of pain or injury
  - No change in behavior
- No injury does not necessarily mean no fall
- J1800 and J1900 is completed at Transfer, Discharge, not to inpatient facility and Death at home
- J1800 and J1900 not completed at SOC/ROC

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Section J: 1800 & 1900 Quality Measure

- **Title:** Application of percent of residents experiencing one or more falls with major injury (National Quality Forum #06); adopted for HHQRP in 2020
- **Cross-setting** quality measure that meets requirements of IMPACT Act (2014)
- Not risk-adjusted
- **Numerator** = The number of quality episodes in which the patient experienced one ore more falls that resulted in **major injury** during the episode of care
- **Denominator** = All quality episodes that are eligible except those that are excluded
- The quality episode is **excluded** if:
  - The occurrence of falls was not assessed
  - The assessment indicates that a fall occurred and the number of falls with major injury were not assessed

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Home Health Quality Reporting Program (HHQRP) Web Page Resources

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Home Health Quality Reporting Program **(HHQRP) Web Site**

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html

- Spotlight & Announcements
- Reporting Requirements
- Quality Measures
- Start Ratings
- Data Sets
- JHAVEN
- Data Specifications
- Data submission deadlines
- User Manuals (Guidance Manual)
- Training
- Most pages have **Downloads section** at bottom of web page with valuable resources!

- Reconsideration and Exception and Extension
- How to Update HHA Demographic Info on HH Compare
- HHQRP Help Desks

HHQRP & OASIS related : Homehealthqualityquestions@cms.hhs.gov

CoP related: Hhasurveyprotocols@cms.hhs.gov

PPS policy related: Homehealthpolicy@cms.hhs.gov

- Technical Help: Help@QTSO.com; 800-339-9313

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OASIS-D2 Implementation 1/2020

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OASIS-D1: 1/1/2020 - Why and what added?

- CMS announced implementation of OASIS-D1 at 4/3/19 HH/HP/DME ODF
- Changes related to CY2019 Medicare HH PPS rates & wage index
- All Items Data Set posted (D1 data set) in April w/memorandum explaining changes (link) on HHQRP web pages
- No Guidance Manual revision
- OASIS-D1 implementation 1/1/2020
- Changes:
  - 2 existing items added at **Follow-Up** time period
    - M1033 Risk for Hospitalization
    - M1800 Grooming
- No changes to the other time point versions of the instrument are required (Start of Care, Resumption of Care, Transfer, Discharge, Death at Home)

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OASIS-D1: 1/1/2020– Items made Optional

- Changes con't:
  - **23 items made optional**
    - Start of Care/Resumption of Care (SOC/ROC)
      - M1910 Fall risk Assessment
    - Transfer (TRN) and Discharge (DC)
      - M2401a Intervention Synopsis: Diabetic Foot Care
      - M1051 Pneumococcal Vaccine
      - M1056 Reason Pneumococcal Vaccine not received Follow-Up (FU)
    - Follow-Up
      - M1021 Primary Diagnosis
      - M1023 Other Diagnoses
      - M1030 Therapies
      - M1200 Vision
      - M1242 Frequency of Pain Interfering with Activity
      - M1311 Current Number of Unhealed Pressure Ulcers at Each Stage
      - M1322 Current Number of Stage 1 Pressure Injuries
- Follow-Up con't
  - M1324 Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable
  - M1330 Does this patient have a Stasis Ulcer
  - M1332 Current Number of Stasis Ulcers that are Observable M1334 Status of Most Problematic Stasis Ulcer that is Observable
  - M1340 Does this patient have a Surgical Wound
  - M1342 Status of the Most Problematic Surgical Wound that is Observable
  - M1400 Short of Breath
  - M1610 Urinary Incontinence or Urinary Catheter Presence
  - M1620 Bowel Incontinence Frequency
  - M1630 Ostomy for Bowel Elimination
  - M2030 Management of Injectable Medications
  - M2200 Therapy Need

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OASIS-D1: 1/1/2020

- Data collection at certain time points for 23 existing OASIS items is optional
- For OASIS assessments with an M0090 Date Assessment Completed of January 1, 2020 or later, HHAs may enter an **equal sign (=)** for these items, at the specified time points only
- This is a new valid response for these items, at these time points; the items themselves are unchanged
- **Never a dull moment with OASIS ☺**

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That's all folks!

Washington State Department of Health

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