October 2020 CMS Quarterly OASIS Q&As

Temporary Guidance: COVID-19 Public Health Emergency (PHE)

The following Q&As in this category are in effect, with a retroactive effective date of March 1, 2020 through the end of the emergency declaration.

Question 1: The *Home Health Agencies: CMS Flexibilities to Fight COVID-19* resource that was last updated May 15, 2020 provided an exemption through June 30, 2020 for submission of OASIS. Is that exemption being extended beyond June 30th? If it was not extended, then are the original assessment completion and submission timelines back in effect starting July 1st? And if so, is this change determined by the M0090 date?

Answer 1: Starting with Quarter 3 that begins July 1, 2020, CMS expects providers to report their quality data.

Until an end to the public health emergency is declared, the waivers and flexibilities outlined in the Interim Final Rules [CMS-5531-IFC and CMS-1744-IFC] (https://www.federalregister.gov/documents/2020/05/08/2020-09608/medicare-and-medicaid-programs-basic-health-program-and-exchanges-additional-policy-and-regulatory) and this CMS waiver (https://www.cms.gov/files/document/covid-home-health-agencies.pdf and https://www.federalregister.gov/documents/2020/04/06/2020-06990/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public) remain in effect. This includes the waiver extending the 5-day assessment completion requirement to 30-days for the comprehensive assessment.

Assessment Completion:
For example, an episode with a Start of Care (SOC) date of July 25, 2020 would be expected to have a date of no later than August 24, 2020 entered in M0090 – Date Assessment Completed.

Assessment Submission:
For all assessment timepoints with a M0090 date of July 1, 2020 or later, CMS expects the assessments to be submitted following the Quality Reporting Program (QRP) Requirements.

This document is intended to provide guidance on OASIS questions that were received by CMS help desks. Responses contained in this document may be time-limited and may be superseded by guidance published by CMS at a later date.

Question 2: Due to the COVID-19 pandemic, we have begun to make Telehealth visits to some of our patients. Are Telehealth visits considered an actual visit when determining who the last qualified clinician is that needs to complete a Discharge OASIS? In other words, can a Discharge OASIS comprehensive assessment be completed by a clinician who performed a Telehealth visit or would only a clinician that made an in-home visit be a qualified clinician?

Answer 2: Based on the CMS Interim Final Rule [CMS-5531-IFC] announced on April 30, 2020, in the situation of an unplanned discharge, the last qualified clinician that performed the last in-person visit or Telehealth encounter could complete the discharge comprehensive assessment with OASIS using information collected at the visit/encounter. That assessing clinician may use additional information available from other staff, from the date of the last patient visit/encounter plus the four preceding days.

CMS defines a qualified clinician for the purpose of collecting and documenting accurate OASIS data as a Registered Nurse, Physical Therapist, Speech-Language Pathologist, or Occupational Therapist.

Question 3: Is it acceptable for a physical therapist to perform their discipline-specific evaluation and have the RN visit the patient after the PT to complete the Start of Care (SOC) OASIS data set and comprehensive assessment?

Answer 3: It is assumed that in your scenario, orders for both nursing and physical therapy were present at the SOC.   Based on your question, there are two possible scenarios depending on the timing and availability of COVID-19-related waivers and flexibilities.

- For evaluations where the initial assessment, SOC visit, and/or SOC comprehensive assessment took place before March 1, 2020:

    The Condition of Participation, 484.55, Comprehensive Assessment of Patients (found at https://www.federalregister.gov/documents/2017/01/13/2017-00283/medicare-and-medicaid-program-conditions-of-participation-for-home-health-agencies) stipulates that a registered nurse (RN) must conduct the initial assessment unless it is a therapy only case. Since "initial" means first, when nursing orders exist at Start of Care, the RN must be the first person to see the patient and complete the initial assessment requirements.

The Conditions also require that if nursing orders exist at SOC, the RN must complete the SOC comprehensive assessment including the OASIS. This does not necessarily mean that the SOC comprehensive assessment must be completed by the RN on the SOC date or that the initiation of therapy must be delayed until the RN completes the comprehensive assessment. Federal guidelines state the SOC comprehensive assessment including the OASIS must be completed within 5-days after the SOC date. (See the OASIS Assessment Reference Sheet, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/Downloads/OASISRefSheet.pdf). Of course, if your agency policies are more restrictive (e.g., require earlier completion), you must follow your policy.

- Temporary Guidance related to COVID-19 Public Health Emergency (PHE): <u>As of March 1, 2020</u>, CMS has waived the requirements in 42 CFR § 484.55(a)(2) and § 484.55(b)(3) that rehabilitation skilled professionals may only perform the initial and comprehensive assessment when only therapy services are ordered. This temporary blanket modification allows any rehabilitation professional (OT, PT, or SLP) to perform the initial and comprehensive assessment for all patients receiving therapy services as part of the plan of care, to the extent permitted under state law, regardless of whether or not the service establishes eligibility for the patient to be receiving home care. More information on this waiver can be found at: https://www.cms.gov/files/document/covid-home-health-agencies.pdf.

  Under this waiver, if the initial assessment, SOC visit and SOC comprehensive assessment all take place **on or after March 1, 2020 until the end of the Public Health Emergency (PHE)**, the physical therapist could evaluate the patient prior to the nurse completing the SOC comprehensive assessment with OASIS as long as the initial assessment is completed on or before the physical therapy evaluation. The nurse or the physical therapist could complete the initial assessment.

Category 2

Question 4: With the CARES Act, physician assistants, nurse practitioners, and other advanced practice nurses are now allowed to certify a patient's need and eligibility for home health services. Is this update permanent? Even after the PHE ends will these practitioners be allowed to order home care services?

Answer 4: Yes, per the Coronavirus Aid, Relief, and Economic Security Act or the CARES Act (Public Law 116-136), this update is intended to be permanent. Even after the COVID-19 PHE ends, nurse practitioners, physician assistants and other advanced practice nurses that are identified in the CARES Act will continue to be allowed to certify their patient's need and eligibility and provide orders for home health services.

Category 4b

<u>M0102, M0104</u>
Question 5: For OASIS items where coding is affected by physician orders, would orders received from physician assistants, nurse practitioners or other advanced practice nurses have the same coding impact? For example, can new referrals/order information received from physician assistants, nurse practitioners, and other advanced practice nurses be used to code M0102 and M0104?

Answer 5: Yes, when coding OASIS items where the presence of a physician's order affects the item coding, orders from a physician assistant, nurse practitioner, or other advanced practice nurse would satisfy the condition of having a physician's order.

GG0130E

Question 6: Does the bathing/shower have to be an actual wet shower or bath, or can coding of GG0130E be based on a simulated performance?

Answer 6: The intent of GG0130E – Shower/Bathe self is to assess the patient's ability to wash, rinse and dry self (excludes washing of back and hair). It does not include transferring in/out of a tub/shower, or onto or off of a tub bench.

Coding of an activity may be based on observation, patient/caregiver report, collaboration with other agency staff, or assessment of similar activities.

Use clinical judgment to determine if the situation of simulating the shower/bath allows the clinician to adequately assess the patient's ability to complete the activity of shower/bathe self (GG0130E). If the clinician determines that this observation is adequate, code based on the type and amount of assistance required to complete the shower/bathing activity.

GG0170

Question 7: We understand that if a patient initially refuses to attempt a GG activity during the assessment period, and later agrees to perform the activity, the code which represents the patient's actual performance will supersede the refusal code (07). If the clinical staff determine on day 1 or day 2 that the patient has a safety or medical issue which prevents them from attempting an activity, but on day 3 has progressed to the point where he/she can now perform the activity, would that code supersede the earlier code (88)? A patient may not be safe to attempt the activity on day 1 (their baseline prior to the benefit of therapeutic interventions), but after two days of therapy, may then be safe to perform the activity. Which code would be reported on the OASIS: code 88 or a Performance Code 06-01?

Answer 7: At Start of Care (SOC)/Resumption of Care (ROC), the self-care or mobility performance code is to reflect the patient's baseline ability to complete the activity, prior to the benefit of services provided by your agency staff.

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

"Prior to the benefit of services" means prior to provision of any care by your agency staff that would result in more independent coding.

In your scenario, if the patient's baseline status prior to the benefit of services was that the activity could not be completed due to a medical or safety concern and the performance code could not be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of a

similar activity, code 88 – Not attempted due to medical conditions or safety concerns, even if the patient's status changes and he is able to complete the activity on a later day during the assessment period.

GG0170E

Question 8:   We have a patient who required substantial to max assistance to perform a transfer during the assessment, so is coded 02 for this activity. This maximal assist transfer is not safe for the elderly family to complete, so two family members will be using a Hoyer lift to transfer the patient from bed to chair. Would the correct code for Chair/bed-to-chair transfer be 02, based on the maximal assist transfer required when the therapist transfers the patient; or would the correct code be 01, because the transfer will be carried out by 2 family members?

Answer 8: The intent of GG0170E – Chair/bed-to-chair transfer is to assess the patient's ability to transfer to and from a bed to a chair (or wheelchair).

When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as he/she is safe.

If the patient performed the activity during the assessment period, code based on that assessment. Use the 6-point scale codes to identify the patient's baseline performance on the assessment.

If when allowed to complete the activity as independently as possible, the patient was able to complete the transfer activity with substantial to max assist safely, code 02- Substantial/maximal assistance.

GG0170M

Question 9: A question has come up regarding when it is appropriate to use code 09 – Not applicable for functional tasks such as curb step and stairs. If a patient has a ramp that he uses to enter his home due to his past medical issues would we use the code 09? Or do we use code 88 – Not attempted due to medical conditions or safety concerns?

Answer 9: The intent of GG0170M – 1 step (curb) is to assess the patient's ability to go up and down a curb and/or up and down one step. If, at the time of the assessment, the patient is unable to complete the activity and the performance cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities use the appropriate activity not attempted code.

Code 88 - Not attempted due to medical conditions or safety concerns indicates the patient performed the activity prior to the current illness, exacerbation or injury, but does not perform the activity at the time of assessment due to a medical issue or safety concern.

Code 09 - Not applicable indicates that the patient did not perform the activity prior to the current illness, exacerbation or injury and the patient does not perform the activity at the time of assessment.