HOME HEALTH (HH) QUALITY REPORTING PROGRAM (QRP) PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM IN-PERSON TRAINING ON NOVEMBER 16–17, 2016

Current as of February 2017

#	Question Category	Question	Answer
General			
1	General	Does OASIS-C2 start on January 1, 2017, for the Start of Care (SOC) date or for the M0090 date?	OASIS-C2 should be used for all assessments dated January 1, 2017, or later in item M0090 Date Assessment Completed.
2	General	What happens when the patient was not taken under care because of immediate transfer back to the hospital due to clinical findings that require prompt medical intervention?	If during your initial assessment visit (evaluation of immediate care and support needs) you determine that the patient should be transferred back to the hospital and is not taken under the care of the home health agency, no comprehensive assessment or OASIS would be expected.
3	General	Will this 2-day presentation be recorded and available so that agencies can use this to train staff?	All training materials with answers have been posted on the Home Health Quality Reporting Program Training page on the Centers for Medicare & Medicaid Services (CMS): https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html. The recordings have been posted and are accessible on the CMS YouTube site at https://www.youtube.com/playlist?list=PLaV7m2-zFKpjEFSnyc1riwF5cXvhIP5o7.
4	General	Will web-based participants receive certificate of completion, and does that include continuing education credits (CEUs) for nursing?	Certificates of Completion will only be made available to those who attended in person. Certificates of Completion will not include CEUs.
5	General	I have been tasked with overseeing a home health program. Can you recommend reputable resources for educating myself on all things home health?	The focus of this training is on home health quality. It will be helpful to gain an understanding of the Home Health Quality Reporting Program, including OASIS data collection items and guidance and quality measure information. This information can be found at the CMS Home Health Quality Initiative website at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html. To receive updates from CMS related to the Home Health Quality Reporting Program, including Home Health Compare, please consider signing up for the Home Health Open Door Forum listserv, which will provide email updates to the Home Health, Hospice, and DME Open Door Forum as well as additional home health quality updates. This listserv signup is available at https://subscriptions.cms.hhs.gov/accounts/USCMS/subscriber/new?topic_id=USCMS_502.

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6	General	For questions and answers related to proper interpretation and completion of OASIS-C2, the source has always been OASIS Answers, which compiled all questions nationally. The proposal to send questions to each State's OASIS Educational Coordinator is concerning, as all States will likely receive different guidance. Also, this may be difficult for national agencies to follow or access. Is there a proposal for a central repository?	All questions related to the role and effectiveness of the OASIS Education Coordinators should be directed to Jeanine O'Malley at CMS (Jeanine.OMalley@cms.hhs.gov). Providers can access OASIS-C2 Quarterly Q&As at https://www.qtso.com/hhatrain.html.
7	General	The OASIS C2 still does not have a U.S. Office of Management and Budget (OMB) number. When will the OASIS C2 receive approval from OMB?	The OASIS-C2 data item set was approved by OMB on December 9, 2016, for implementation on January 1, 2017. The valid OMB control number for this information collection is 0938-1279 (expiration date is December 31, 2019).
8	General	When will the CMS web-based OASIS training on the CMS Survey and Certification Group – Surveyor Training website be updated to reflect OASIS-C2?	All questions related to the information provided to OASIS Education Coordinators should be directed to Jeanine O'Malley at CMS (Jeanine.OMalley@cms.hhs.gov).
9	General	HomeHealthQualityQuestions@cms.hhs.gov is listed as a resource. What types of questions may we submit to this site? May we ask questions about OASIS items?	Providers can email the Home Health Quality Help Desk with questions related to Home Health Quality Measures including (but not limited to) quality manuals (Outcome-Based Quality Improvement (OBQI), Outcome-Based Quality Monitoring (OBQM), Process-Based Quality Improvement (PBQI)), quality measures including measure calculation (OBQI, OBQM, PBQI, Quality of Patient Care Star Ratings, Home Health Compare), risk adjustment, public reporting, and Quality Assessment Only (QAO) Metric/Pay for Reporting (P4R).
Home Health (HH) Quality Reporting Program (QRP) Requirements, Definitions, and Assessments			
10	HH QRP Requirements, Definitions, & Assessments	How does CMS determine the total number of assessments that should be usable for quality measurement?	Information on the requirements for the Home Health Quality Reporting Program and the QAO Metric can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html In addition to information on this site, the "Pay for Reporting: Quality Assessments Only Methodology" can be found in the "downloads" section at the bottom of this web page.

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11	HH QRP Requirements, Definitions, & Assessments	The combinations of assessments and their relationships to the assessments are not in the downloads/slides. Could you please post them?	This information can be found on the Home Health Quality Program Reporting website (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html) under the Section titled "Determining Provider Compliance with Home Health Quality Reporting Program Requirements." All seven scenarios are posted.
12	HH QRP Requirements, Definitions, & Assessments	Where do we find our compliance percentage?	Information about how to determine your compliance rate is available via the QAO Report. The QAO Interim and Annual Performance Reports are available via the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQISpotlight.html.
13	HH QRP Requirements, Definitions, & Assessments	How will the removal of the potential avoidable events affect the survey process?	All questions related to Survey and Certification issues should be directed to Jeanine O'Malley at CMS (Jeanine.OMalley@cms.hhs.gov).
14	HH QRP Requirements, Definitions, & Assessments	In general, if a patient has a transfer and resumption of care (ROC) during an episode, for quality purposes, what happens to the data between the SOC and transfer when calculating the quality indicators at discharge if we are only looking at the timeframe ROC to Discharge?	A quality episode is calculated from SOC or ROC to end of care (transfer to an inpatient facility, discharge from the agency, or death). In your example, this patient would have two quality episodes: one from SOC to transfer and another from ROC to discharge.
15	HH QRP Requirements, Definitions, & Assessments	Are these new requirements to include the clients who are long term on Medicaid and require an admission and discharge OASIS?	Yes.
16	HH QRP Requirements, Definitions, & Assessments	What about the clients that you have on service prior to OASIS-C2 implementation? You would not have been following these regulations for clients discharged after January 2017.	OASIS-C1/ICD-10 (and related guidance) should be used for all assessments with a M0090 Date Assessment Completed prior to January 1, 2017. OASIS-C2 (and related OASIS-C2 guidance) should be used for all assessments with a M0090 Date Assessment Completed date of January 1, 2017, or later.

#	Question Category	Question	Answer
Percent of Patients With Pressure Ulcers That Are New or Worsened: M1311 and M1313			
17	M1311	Some experts are teaching that in M1311 row 2, you are to look to see if the current pressure ulcer was at the SAME STAGE as at SOC. If not, it would not be counted in row 2. Is there guidance to support that? The guidance says how many were present on admission—does that mean present as a wound, or present as a wound AT THIS STAGE? That is different from the old column 2 guidance.	The first question for each stage is how many pressure ulcers does the patient currently have? If any more than zero, the second question is how many of those pressure ulcers that the patient presently has were present at SOC (or ROC), at that same stage.
18	M1311	Does the instruction to code based on assessment as close to admission as possible, mean that if the ulcer is unstageable on Day 1 but debrided on Day 2, do we still report it as unstageable at SOC and leave it?	The initial clinical assessment that was conducted on the patient should be consistent with what is reported on the SOC. If the initial skin assessment completed on admission to home health services identifies a pressure ulcer, the stage of the pressure ulcer as identified on that initial clinical assessment is what should be reported on the SOC OASIS. Any subsequent changes in numerical staging would be reported on subsequent OASIS assessments. Therefore, if an unstageable pressure ulcer is identified as part of the initial skin assessment at SOC, this ulcer should be reported as unstageable on the SOC OASIS, regardless of whether it is subsequently debrided and stageable after the initial skin assessment (i.e., by Day 2).
19	M1311	If the Stage 3 pressure ulcer present at discharge was a Stage 2 pressure ulcer at admission, is the response to B2 a “0” or a “1”? Is it the “same stage” or the “same pressure ulcer”?	The response to Stage 3, B2 on discharge would be “0” because the Stage 3 pressure ulcer that is currently present on discharge was not present at this stage at the start of care.
20	M1311	If we are supposed to assess the condition of the ulcer on admission and it is now better than in a previous facility, why would we code it based on what it was instead of what we currently see?	We always consider the historical information of pressure ulcers when we perform skin assessment, and do not reverse stage. Reverse staging is clinically inappropriate because pressure ulcers do not heal in a reverse sequence. That is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development. For example, if a resident is admitted to the facility with a healing Stage 3 or Stage 4 pressure ulcer, the pressure ulcer would be documented as a Stage 3 or Stage 4 on admission and would remain a Stage 3 or Stage 4 pressure ulcer until it heals. Improvement/healing can be captured in M1320. Status of the Most Problematic Pressure Ulcer that is Observable, as well as narratively in the clinical record.

#	Question Category	Question	Answer
21	M1313	Historically, we've been told that we can't "watch the wounds heal" and that if the patient/caregiver is independent in wound care, the wound is significantly healed, and it appears that healing will continue without us "watching" it, we need to discharge the patient. However, in this scenario, since we can't down code, we would be discharging the patient with a healing Stage 2/3/4 ulcer, but it would still be present even though our documentation supports that it is very small and superficial as the final layer of skin is granulating over the wound. Are we now expected to continue to see the patient in the home until the ulcer is completely healed?	For OASIS scoring purposes, the stage of the pressure ulcer is reported at its highest stage unless it has healed. The question of whether or not agency staff are expected to continue to see the patient until the ulcer is completely healed is related to coverage criteria. The focus of this training is on OASIS scoring for the items used for calculation of the HH quality measures.
22	M1311	We have a patient with epidermolysis bullosa. I had been categorizing his blisters and open wounds as pressure ulcers. Is this correct? If not, what would I call them?	Pressure ulcers are defined as localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. If pressure is not the primary cause of an identified skin ulcer, it does not meet the definition of a pressure ulcer. epidermolysis bullosa is a disease that causes blistering of the skin. The etiology of these blisters is not as a result of pressure (as defined above) and therefore would not be reported as pressure ulcers. However, someone with epidermolysis bullosa can certainly develop pressure ulcers, and the clinician responsible for skin assessment should be skilled enough to know the difference in etiology. The blisters identified as part of the disease process of epidermolysis bullosa should be clearly identified as blisters associated with this disease process. Please consult with your agency related to documentation requirements.
23	M1311	For Practice Scenario 1 on M1311B2, please clarify why the answer would be 0; if it was a Stage 2 and now is Stage 3, it was still there at the start of care.	For this scenario, the patient had three Stage 2 pressure ulcers upon SOC. Two of the ulcers merged to become one, and the third ulcer increased in numeric stage. M1311B2 reports if the Stage 3 pressure ulcer identified on discharge and reported in M1311B1 was present at the most recent SOC/ROC at the same stage. Since that pressure ulcer was a Stage 2 at the SOC, it was NOT present on admission as a Stage 3. Therefore, M1311B2 would be reported as zero.

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24	M1311, M1313	The speaker refers to answering the OASIS items as “coding.” Please clarify that you are referring to “recorded as” or “response” and not whether or not you should use a diagnosis code (ICD-10 code) for a pressure ulcer?	For this presentation, the term “coding” refers to the encoding or scoring of the OASIS items, not ICD-10 coding.
25	M1311	What if we have a patient we know has a pressure ulcer, but it is not documented by the physician as a pressure ulcer (e.g., if it is only documented by the physician as a non-healing wound and coded that way in the clinical record from the physician’s office)?	If the clinician that completed the skin assessment identifies a pressure ulcer, the physician should be contacted to discuss and clarify that the ulcer meets the definition of a pressure ulcer and needs to be documented as such.
26	M1311, M1313	The patient had a Stage 4 right heel ulcer in the skilled nursing facility (SNF). The patient was admitted to home care with an unstageable right heel ulcer. During the home health episode the ulcer was debrided and is now a Stage 3; on discharge is it a Stage 3 or a Stage 4?	A pressure ulcer documented as a Stage 4 remains a Stage 4 until closed, unless it becomes unstageable due to slough/eschar or a non-removable dressing/device, or is treated with a graft or flap procedure. Reverse staging in not an acceptable clinical practice. A Stage 4 pressure ulcer would never become a Stage 3 pressure ulcer because pressure ulcers do not heal in a reverse sequence. That is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development.
27	M1311	If the pressure ulcer is identified as a Stage 3 in the SNF documentation but is under a dressing that cannot be removed at the SOC, for M1311 do I identify a Stage 3 or unstageable pressure ulcer due to non-removable dressing?	The only way you can report a pressure ulcer as unstageable due to non-removable dressing/device is by having documentation that there is indeed an ulcer underneath the dressing/device. In this case, since there is documentation of a Stage 3 pressure ulcer under the non-removable dressing/device, you would report the ulcer as unstageable due to non-removable dressing/device. Once the dressing is removed, the ulcer would need to be assessed and staged. The SOC M1311 response of unstageable due to non-removable dressing/device should not be changed to Stage 3, since that was the pressure ulcer’s status when first assessed upon admission.

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28	M1311	Is the second row in M1311 only coded at follow-up (recertification or other follow-up) and discharge? If a pressure ulcer is identified in the first row at follow-up or discharge, then I go to the second row and identify how many of the pressure ulcers in the first row were present at the same stage at SOC/ROC. For example, if I have one Stage 3 at follow-up, I look back to SOC/ROC and determine if there was a Stage 3 pressure ulcer present at that location. If yes, I code 1. If it was not present as a Stage 3, I code 0.	On the follow-up and discharge assessment, you are asked about the current number of pressure ulcers at each stage. The next question then asks how many of these ulcers (that is, the ones currently present on follow-up or discharge) were present on admission. For example, if on follow-up or discharge there are no pressure ulcers identified, and on the SOC/ROC there was one Stage 3 ulcer, then on follow-up or discharge M1311B1 would be coded as 0 since there are no pressure ulcers present. If, however, on follow-up or discharge, there is a Stage 3 pressure ulcer present, and on the SOC/ROC there was a Stage 3 pressure ulcer reported, the agency would need to determine if the ulcer identified on follow-up or discharge is the same ulcer that was present on admission at that stage as reported on the SOC/ROC. If yes, then M1311B1 would be coded as 1 and M1311B2 would be coded as 1. If not, then M1311B1 would be coded as 1 and M1311B2 would be coded as 0, as there is now a new Stage 3 ulcer identified on follow-up or discharge that was not present upon admission.
29	M1311	A patient has a Stage 3 on the right hip at SOC, it closes, and the patient develops a new Stage 3 on the left hip. At discharge, the patient has one current Stage 3 on the left hip (the one on the right hip is no longer reported since it is closed and considered “healed” by OASIS-C2 guidance), so row B1 is coded as “1.” For row B2, the patient still has just one Stage 3, but it is a NEW ulcer at a different location. Is B2 coded as “0” (the same total number of Stage 3 as at SOC), or is it coded as “1” (THIS Stage 3 on the left hip was not present at the SOC)?	In this scenario on the SOC/ROC assessment, you would code M1311B1 as 1, and at the follow-up or discharge you would code M1311B1 as 1 and M1311B2 as 0. The rationale is that the new Stage 3 ulcer was not present at SOC/ROC.
30	M1311	Please clarify the B item, “Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC.” If a pressure ulcer is observed at discharge as Stage 3 but at SOC it was a Stage 2, would the coding be B1=1, B2=2 because it is a different stage?	In this example, at discharge or follow-up assessment, you would report Stage 2 M1311A1=0, M1311A2=Skip; M1311B1=1 and M1311B2=0. The reason is that at discharge there are no Stage 2 pressure ulcers and one Stage 3 pressure ulcer. M1311B2 asks how many of these ulcers were present upon admission. The answer to that question would be 0, as there were no Stage 3 pressure ulcers on SOC/ROC.

#	Question Category	Question	Answer
31	M1311	Is M1311 completed ONLY at SOC/ROC, Follow-up and Discharge? Should it be completed at transfer, recertification, etc.?	At SOC/ROC, you are required to answer questions M1311A1–F1. At discharge and follow-up, you are required to answer M1311A-1–F1 and M1311A2–F2. Recertification is a type of Follow-up Assessment when M1311 is completed. Since completing M1311 relies on data from a patient assessment, it is not collected at data collection time points (like Transfer and Death at Home) that are not associated with a comprehensive assessment.
32	M1311, M1313	Can you do reverse staging for Stage 1 or Stage 2?	Reverse staging is not an acceptable clinical practice because pressure ulcers do not heal in a reverse sequence. That is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development. For example, if a patient is admitted with a healing Stage 3 or Stage 4 pressure ulcer, the pressure ulcer would be documented as a Stage 3 or Stage 4 on admission and would remain a Stage 3 or Stage 4 pressure ulcer until it heals.
Percent of Patients With Pressure Ulcers That Are New or Worsened Covariates: M1620, M1028, M1060			
33	M1028	How do you determine active diagnosis for recertification?	Time points for active diagnosis are SOC/ROC only, not follow-up or discharge.
34	M1028	For M1028, if the patient does not have any of the three listed diagnoses, is that patient excluded from the measure if none of the boxes are checked?	The patient is not excluded from the pressure ulcer measure if M1028, Active Diagnoses, is checked, unchecked or dashed. All are valid item responses, and are not considered missing data.
35	M1028	When a patient has diabetic peripheral vascular disease (PVD) or peripheral artery disease (PAD), should both items checked (as yes) even though these are combination codes (E-codes) and no I-code is included?	Yes. If a diabetic patient has either PAD or PVD, both the diabetes mellitus item (2) and the PAD/PVD (1) items are checked in item M1028, Active Diagnoses.
36	M1060	If a patient does not have a scale and we do not have a weight from the discharging facility, is it better that we estimate the weight or should we enter a dash?	The guidance for obtaining the weight indicates that the clinician must obtain the weight directly, following agency policies/procedures (not utilizing data from the referral source).

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37	M1060	Must we weigh the patient on SOC, or can the information be obtained from the MD or hospital? M1060b says you can record the most recent weight in the last 30 days. If my agency weighs the patient at SOC, then the patient is transferred and care resumed, on the ROC can the agency use the same weight from the SOC if taken within 30 days?	At SOC, the patient should be weighed. M1060b **should not** be obtained from the MD or hospital records. As per the OASIS-C2 Guidance Manual, Chapter 3: C-26, Steps for Assessment for M1060b, Weight, Item 3, "If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, enter a dash value (–) and document the rationale on the patient's medical record." At ROC, an attempt to weigh the patient should be made. If this is not possible and the previous agency-obtained weight in M1060b is within the 30-day window, the weight can be used at ROC.
Percent of Patients With Pressure Ulcers That Are New or Worsened Covariate: GG0170C			
38	GG0170C	If the patient is not allowed to lay in a bed due to shoulder surgery but instead sleeps in a recliner, would we use code 88 or assess them in the recliner?	If the patient's usual sleep surface is a recliner, the recliner can be considered the patient's "bed" for GG0170C. You would assess the patient's mobility in the recliner, treating the recliner as the "bed."
39	GG0170C	Do we consider "safety" when answering GG0170C?	Yes, safety is always a concern. GG00170C states "the ability to SAFELY move from lying on the back to sitting on the side of the bed, with feet flat on the floor, and with no back support."
40	GG0170C	Why is the scoring scale reversed with code 06 being independent and code 01 being dependent? This is the reverse of other OASIS scoring.	The scale was set up based on consensus among clinical therapy experts and tested across all care settings.
41	GG0170C	How would a patient with below-knee amputation (BKA) be coded to perform lying to sitting position with feet on the floor?	If any patient can perform the activity independently and safely, sitting on the side of the bed with no back support, and their feet do not touch the floor, they can be scored as a 06, Independent. 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.

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42	GG0170C	If a patient uses a Hoyer or other lift, would the response be 09 and then a "dash" for the discharge goal?	If prior to the current illness, exacerbation, or injury, the patient did not perform this activity with a Hoyer lift for transfers, the patient would be scored as Code 09 (Not applicable, if the activity was not applicable to the patient prior to the current illness, exacerbation, or injury). If the need for the Hoyer lift was new and/or temporary, the code would be Code 88, not attempted due to medical condition or safety concerns. If the patient is expected to gain function, then you would score the discharge goal accordingly using the scale of 01 to 06. If it is not expected that the patient will regain this function by discharge, the Discharge Goal for GG0170C2 would be a "dash" (–).
43	GG0170C	The agency admits a patient that was bedbound prior to this SOC/ROC. The nurse scores GG0170C1 ROC/SOC Performance score as 09–Not applicable. For discharge goal, GG0170C2, what is the appropriate score? If Code 09 is not an option for GG00170C2, would the correct code to use be a dash (–)?	Assuming the patient is expected to stay at his/her SOC/ROC functional level and will remain bedbound, enter a dash (–) for GG0170C2 indicating the assessing clinician is not establishing a Discharge Goal for the patient's mobility task. If the patient is expected to make functional progress allowing the activity to be performed, report the discharge goal using the six-point scale.
44	GG0170C	The patient can be assessed by report by the patient or caregiver/family. If the patient refuses to do the activity but verbally tells you what he/she is capable of doing, can you code 01 through 06 or do you have to code 07?	The patient's functional status requires a functional assessment by a clinician. Information to support functional status can be supplemented by patient or caregiver report. If the patient refuses to complete the activity to allow a clinical functional assessment, the score entered on the OASIS-C2 would be Code 07, Patient refused.
45	GG0170C	For GG0170C2, what is the discharge goal being used for? Does it impact/increase the risk adjustment as a covariate for Risk for Pressure Ulcer Quality Measure (QM)? Is it not included in the Discharge Assessment, because we are not measuring improvement in mobility?	The SOC/ROC Performance score and the Discharge Goal score for GG0170C are standardized in all post-acute assessment instruments. The SOC/ROC Performance Score will be available for use as a risk covariate for the quality measure, "Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened." The Discharge Goal is not expected to impact any of the home health quality measures in 2017 but may be used directly or indirectly in future quality measure calculation.
46	GG0170C	When the clinician chooses an answer for the goal on GG0170C2, is this just an opinion based on the assessment? Will it affect any outcomes if the goal chosen is not reached?	The Discharge Goal score for GG0170C2 is a standardized item that is included in all post-acute care patient/resident assessment instruments. It is determined by the assessing clinician based on findings from the comprehensive assessment. The Discharge Goal is not expected to impact any of the home health quality measures in 2017, but may be used directly or indirectly in future quality measure calculation.

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47	GG0170C	If a patient uses a belt to go from lying to sitting on the side of the bed, but someone had to hand the belt to the patient, would that still be considered independent?	For GG0170C, 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 usually requires a caregiver to hand them the assistive device to perform the activity, this would be scored as Code 5, Setup or clean-up assistance, because the patient requires setup assistance prior to performing the activity.
48	GG0170C	If you have a bedbound patient on Admission/SOC, you code them as 88, Not attempted due to medical condition or safety concerns. What do you code them at discharge if you cannot use codes 07, 09, or 88?	If prior to the current illness, exacerbation, or injury, the patient did not perform this activity because he/she was bedbound, the patient would be scored as Code 09, Not applicable. If the bedbound status was new and/or temporary, and the activity was not attempted, the not attempted response code for the activity would be Code 88, Not attempted due to medical condition or safety concerns. If the patient is expected to gain function, then you would score the discharge goal accordingly using the scale of 01 to 06. If it is not expected that the patient will regain this function by discharge, the Discharge Goal for GG0170C2 would be a dash (–).
49	GG0170C	Will GG0170C be used to calculate risk adjustment for other OASIS outcome measures (beside pressure ulcer)?	GG0170C is used as a risk covariate for the quality measure, “Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened.” It currently is not used to calculate risk adjustment for other OASIS outcome measures.
50	GG0170C	If the patient sleeps in an electric recliner (which we are assessing as the patient’s bed), and the patient pushes a button for the chair to return to a sitting position, is this considered assistance?	If patients are able to use an assistive device themselves, the response code entered on the OASIS would be coded as a 06, Independent.
51	GG0170C	If GG0170C for SOC/ROC was scored 07, 09, or 88, is dash the correct scoring for GG0170C2 discharge? If the patient refused, should we use clinical judgment to determine a discharge goal?	If the patient is expected to gain function, the assessor would score the discharge goal accordingly using the scale of 01 to 06. If it is not expected that the patient will regain this function by discharge, the Discharge Goal for GG0170C2 would be a dash (–).
Drug Regimen Review Conducted With Follow-Up for Identified Issues: M2001, M2003, M2005			
52	M2003, M2005	How does the 5-day rule for completion of the comprehensive assessment at SOC impact this item? If the assessing clinician identifies the clinically significant medication issue on Day 2, does this “reset” the clock for the midnight of the next calendar day?	M2003 and M2005 ask if a two-way communication and completion of any prescribed/recommended actions 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.

#	Question Category	Question	Answer
53	M2003, M2005	Does “midnight of the next calendar day” refer to the date of SOC or ROC or the date of completion as indicated in M0090?	The cited timeframe does not refer to either specifically, but rather to the time period from the identification of the medication issue to the notification of the physician and through the completion of the requested actions.
54	M2003, M2005	ROC OASIS must be completed within 48 hours of patient discharge from facility or the agency being aware of the patient being discharged from a facility. If the OASIS assessment is done on the second day (hours 25–48) and a medication issue is identified, does the clinician still have until midnight of the following day to resolve the issue, or does the issue need to be resolved before the 48th hour is complete?	M2003, Medication Follow-up must also be answered within the timeframe allowed at the SOC/ROC to ensure compliance with the Conditions of Participation regarding the completion of the comprehensive assessment. If a medication problem is identified at SOC or ROC, physician communication and completion of prescribed/recommended actions must occur by midnight of the next calendar day after identification and before the end of the allowed assessment timeframe.
55	M2001	When completing the drug regimen review, do we need to state every possible adverse effect (AE), side effect (SE), etc., with the patient or just observe in our clinical assessment if we note any of the possible AE, interactions, or SE?	There is no OASIS guidance that requires OASIS assessment data be duplicated elsewhere in the patient’s clinical record. It is expected that there would be documentation in the clinical record to support that a drug regimen review was conducted to identify potential clinically significant medication issues that may include (but are not limited to) adverse reactions to medications, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, and non-adherence.
56	M2005	M2005 states “since SOC/ROC.” Does that mean “at the time of or since SOC/ROC”? If the intent of the question was to go back to the SOC, why would “ROC” be in the question?	Quality episodes can be calculated from a start of care or a resumption of care to the end of the care episode (transfer to an inpatient facility, discharge from the agency, or death). In completing M2005 at Transfer, Death or Discharge, you must review the documentation from that time point back to the time of or at any time since the most recent Start of Care or Resumption of Care.

#	Question Category	Question	Answer
57	M2001	How do we answer this item for a compliant degenerative joint disease patient who was noted to have pain symptoms of 4/10 (per patient) on SOC, who already is on a new narcotic analgesic during the past week? With this symptom, can we answer "0 = No, no issues found during review" if we think this issue does not necessitate notifying the physician by midnight of the next business day?	A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). **Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue.**
58	M2005	Please, can you go over M2005 Scenario 1?	In M2005, Practice Scenario 1, item M2001 would be answered as "1, Yes, issues found during review" because the RN did identify a potential clinically significant medication issue. Item M2003 would be answered as "0, No," because the call to the physician was not returned within the required timeframe (before midnight of the next calendar day). Item M2005 would be answered as "0, No," because there was an issue on SOC but the two-way communication and actions were not completed within the timeframe.
59	M2001	Would you clarify if we have to call the physician for all food interactions?	Physician contact is expected for any "potential clinically significant medication issue." A potential clinically significant medication issue is an issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). **Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue.**

#	Question Category	Question	Answer
60	M2001	Is it required that an RN do the drug regimen review in cases of therapy-only home health episodes?	The RN is not required to do the drug regimen review in therapy-only home health episodes. The comprehensive assessment must include a review of all medications the patient is using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects and drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Each agency must determine the capabilities of current staff members to perform comprehensive assessments, taking into account professional standards or practice acts specific to your State. No specific discipline is identified as exclusively able to perform this assessment. According to Federal guidelines, only RNs, physical therapists (PTs), occupational therapists (OTs), and speech and language pathologists (SLPs) are qualified to perform comprehensive assessments and collect OASIS data. In cases of therapy-only services, where the scope of practice for the therapist is limited by State, agency, or other policies/restrictions, the agency may instruct that the therapist collaborate with nursing to complete the drug regimen review.
61	M2001, M2003, M2005	On the SOC or ROC assessment, if the patient is missing a prescribed medication and unable to obtain it from the pharmacy (for example, due to the pharmacy being closed or a transportation issue), do you still notify the doctor of a potential issue? Is a follow-up phone call to the patient sufficient enough to ask if they did indeed obtain the medicine, or would a visit need to be made?	Depending on the situation, the assessing clinician might determine that absence of a medication is a “clinically significant” issue appropriate for timely physician contact. A potential clinically significant medication issue is an issue that in the care provider’s clinical judgment requires physician/physician-designee notification by midnight of the next calendar day (at the latest). Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue. If a medication-related problem is identified and resolved by the agency staff (not requiring physician/physician-designee contact by midnight of the next calendar day), the problem does not need to be reported as an existing clinically significant problem in M2001. The manner in which the agency validates the resolution is a clinical practice question for the agency to determine.
62	M2001	Where can we find a comprehensive tool to help us with reconciliation of medication?	It is the responsibility of the agency to determine what validated resource tool it will use for this purpose.

#	Question Category	Question	Answer
63	M2003, M2005	There may be times because of an agency process that the drug regimen review is not completed within the assessment timeframe. Would that be an instance when a dash is used?	A dash is expected to be a rare occurrence and indicates that no information is available and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged, or dies before assessment of the item could be completed. Agencies must ensure that their processes are not a barrier to complete a drug regimen review within the given timeframe and should adjust their processes to ensure that a drug regimen review is completed as required.
64	M2001	Please clarify the difference between the national and State--level requirements regarding whether therapists are qualified to conduct medication reviews.	The requirements presented in the OASIS and OASIS Guidance are Federal requirements. The comprehensive assessment must include a review of all medications the patient is using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects and drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Each agency must determine the capabilities of current staff members to perform comprehensive assessments, taking into account professional standards or practice acts specific to your State. States may have more stringent guidance, and State-specific queries should be addressed to the appropriate State agency. No specific discipline is identified as exclusively able to perform this assessment. According to Federal guidelines, only RNs, PTs, OTs, and SLPs are qualified to perform comprehensive assessments and collect OASIS Data.
65	M2001	Upon discharge from the hospital, on the discharge summary the medication list is frequently documented. They are listed in sections under “start taking these medications,” “continue taking these medications,” and “stop taking these medications.” They have been reviewed by a physician. If the patient is taking any medications that have the potential to cause a significant issue, such as two different blood pressure medicines or pain medications, do we still notify the physician, even though the specific medications are documented on the discharge summary, and that has been reviewed already by a physician?	As part of the OASIS assessment, it is the responsibility of the clinician to conduct the review on SOC/ROC and notify the responsible physician of any “potential clinically significant issues.”

#	Question Category	Question	Answer
66	M2001	The speaker said that if the patient has a diagnosis but does not have a corresponding medication in the medication list, that would always be a potential clinically significant medication issue. Requiring a direct match between patient diagnoses and current meds is a pretty outdated philosophy. Has something changed to require this based on impact, or could this just be the speaker's opinion?	The statement was that medications listed without a diagnosis should always be confirmed via physician contact to confirm both the medication and its rationale or purpose for this patient.
67	M2001, M2003, M2005	We do a two-step admission process where the initial assessment is completed within 24 hours of discharge/referral. The initial visit does include the medication review to identify immediate medication reconciliation needs and establishes the SOC date. The comprehensive assessment is conducted within 5 days of the SOC. If the potential clinically significant medication issues identified during the initial assessment are resolved by the time the comprehensive assessment (OASIS) is scored, how do we respond to M2001 on SOC OASIS and M2005 at discharge?	Completion of the Drug Regimen Review is part of the SOC Comprehensive Assessment. In the scenario you describe, it sounds like you start the comprehensive assessment on the SOC date, then complete it within 5 days of the SOC date. If the clinician identifies a potential clinically significant medication issue at the SOC visit or at the subsequent visit when the comprehensive assessment is completed, M2001 would be coded as "1, Yes – Issue found during review." M2003 would also be scored as "1, Yes" if the issue was not only identified but also reported via two-way communication to the physician/physician designee, with prescribed/recommended actions completed by midnight of the next calendar day, and within the assessment timeframe.
68	M2003, M2005	To improve accuracy of clinical documentation, we instruct our clinicians to perform their charting at the time of the visit or at least the day of the visit. This is also a Medicare guideline. With the wording of the medication reconciliation questions, how is this possible for the documentation to be completed if the clinician has to wait until midnight of the following day to complete the documentation on the OASIS?	The clinician does not have to wait until midnight of the next calendar day to complete the comprehensive assessment or OASIS data collection. If the communication and completion of recommended actions occur earlier, the clinician may complete the assessment earlier. The agency may take up to 5 days after the SOC and 2 days after the ROC to complete the comprehensive assessment.

#	Question Category	Question	Answer
69	M2001, M2003, M2005	How do we respond to M2005 in 2017 if the SOC started in 2016, at which time M2001 and M2003 were completed?	M2005 reports if the agency contacted and completed physician prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC. The transition from OASIS-C1 in 2016 to OASIS-C2 in 2017 does not impact the look-back timeframe or scoring guidance. In your example, your look-back may include documentation for visits that occurred in 2016.
70	M2001, M2003, M2005	Is "collaboration" allowed for this item (i.e., another clinician performs the "look-back" to determine if each potential clinically significant medication issue was identified, communicated, and completed within the timeframe)?	Yes, another individual with the qualifications necessary to gather the information (e.g., RN, PT, OT, SLP) may perform a record review for M2005 and communicate the findings to the assessing clinician, who would be responsible for confirming and validating that non-assessment information is accurate.
71	M2001, M2003, M2005	If we are unable to resolve a medication issue before midnight of the next calendar day due to no physician reply, how is that reflected within the reporting structure for M2003 and M2005? How does it differentiate a no physician reply vs. no agency action? Moreover, what are the implications, if any, for the agency and/or the physician for a pattern of non-adherence to this best practice?	M2001 does not offer the option of "Drug regimen review not done." To answer M2003 and M2005, the review must be done. M2003 asks if the physician was contacted and the actions completed. If no issues were identified, there is no need to contact the physician; if issues were found, the communication and response are both needed. Selecting "No" for M2003 and M2005 indicates that the best practice of identifying a medication issue, reporting it to the physician, and completing the recommended/prescribed actions possible by midnight of the next calendar day was not accomplished. The item response choices for M2003 and M2005 do not identify the reason why the best practice was not met.
Data Submission and Reporting			
72	Data Submission & Reporting	Where is the best place to learn about reports to run, to understand what each report is composed of and what it is showing you?	The OASIS Submission User's Guide and CASPER Reporting User's Manual available on the OASIS User Guides & Training page of the QIES Technical Support Office (https://www.qtso.com/hhatrain.html) are useful resources to support providers in accessing, understanding and using their provider reports. Additionally, information regarding the QAO Reports is available in the Downloads section of the following web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html, and information regarding the Home Health Star Ratings, including regarding the Preview Reports, is available on the following website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIHomeHealthStarRatings.html.

#	Question Category	Question	Answer
73	Data Submission & Reporting	Regarding the top 10 errors returned for OASIS records, does the Warning or Fatal Error message you receive following erroneous record submission specify exactly what the error was? For example, in Error #2, Patient Info Mismatch, would the message pinpoint exactly which information is conflicting with previous record submission?	The Final Validation Report provides a detailed account of the errors found during the validation of the records in the submitted HIS file. Chapter Five of the OASIS Submission User's Guide (available at https://www.qtso.com/download/Guides/hospice/Users_Sec5.pdf) includes detailed information about each error message. This information is catalogued according to the Error ID and includes notation of the severity of the error and potential causes, tips, and provider actions related to each message. Home health providers may also find the Quick Reference to Final Validation Reports in Appendix A of the CASPER Reporting HHA Provider User's Guide (available at https://www.qtso.com/download/Guides/hha/cspr_appA_hha_prvdr.pdf) helpful to them as they work to interpret the information included in the Final Validation Report.
74	Data Submission & Reporting	Can you elaborate on what data are permitted to be corrected during the 4.5-month preview period?	For information about making corrections to OASIS data, refer to Survey and Certification Memo # 15-18-HHA, Outcome and Assessment Information Set (OASIS) transition to the Automated Submission and Processing System (ASAP) and OASIS Correction policy (available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-15-18.html) and the OASIS Submission User's Guide (available at https://www.qtso.com/hhatrain.html).
Case Study			
75	M2001	The patient in the case study was also on Coreg (a beta blocker), which should have been questioned with the MD due to the patient also taking Metoprolol (also a beta blocker). If this isn't addressed by either the nurse or the MD, I assume there's no need to include it in the responses? Just curious as to why it wasn't identified as a potential duplicate drug therapy.	Identification of potential duplicate drug therapy is a required component of the Drug Regimen Review. Therapeutic duplication is the use of more than one medicine from the same drug category or therapeutic class to treat the same condition. This can be intentional in cases where drugs with similar actions are used together for demonstrated therapeutic benefit. Depending on the situation, the assessing clinician may determine that the duplicate drug therapy is a potential or actual clinically significant medication issue that, in the care provider's clinical judgment, requires physician/physician-designee notification by midnight of the next calendar day (at the latest). **Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue.**

#	Question Category	Question	Answer
Overview of the IMPACT Act			
76	IMPACT Act	Does the 80-percent quality reporting compliance standard only include traditional Medicare patients, or does it also include managed care Medicare patients as well, as their OASIS information also gets transmitted?	The percent requirement on the QAO metric of pay-for-reporting performance is calculated based upon OASIS submission requirements and includes Medicare fee-for-service, Medicare Advantage (aka Medicare managed care), and Medicaid. HHAs do not need to submit OASIS data for those patients who are excluded from the OASIS submission requirements. As described in the December 23, 2005, Medicare and Medicaid Programs: Reporting Outcome and Assessment Information Set Data as Part of the Conditions of Participation for Home Health Agencies final rule (70 FR 76202), and excludes those patients: • Receiving only non-skilled services; • For whom neither Medicare nor Medicaid is paying for home health care (patients receiving care under a Medicare or Medicaid Managed Care Plan are not excluded from the OASIS reporting requirement); • Receiving pre- or post-partum services; or • Under the age of 18 years.