



# OASIS & RN GUIDELINES

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# OASIS C-1

- Outcome and Assessment Information Set
- Part of the comprehensive assessment done by RN to determine eligibility/payment for home health under Medicare
- SOC, Recertification, ROC and Discharge
- Must be filled out completely and in a timely manner

# COMPREHENSIVE ASSESSMENT

- OASIS items required
- Drug Regimen Review
- Head-to-toe assessment
- Agency's core comprehensive assessment items
- Agency's discipline specific assessment items

# SOC - Start of Care

- Done within 48 hours of referral or on physician ordered date
- Multiple forms needed to establish patient's care
- RN must explain what home health is, assess patient and their needs, and discuss plan of care on initial visit.
- Opens a 60 day certification period

# Recertification / Discharge

- Done in the last 5 days of the certification period
- RN reassesses the patient to determine if patient will continue home health services for another 60 days (recertification) or is stable enough to be discharged

# ROC-Resumption of Care

- Must be done within 48 hours of return home from an inpatient facility admission of 24 hrs or > for reasons other than diagnostic tests
- Proper medication reconciliation is very important at this time
- Proper assessment of patient's needs to avoid re-hospitalizations

# OASIS Guidelines

- Please fill out the OASIS completely, especially the first page and the patient name and MR# on each page. Fill out all items, not just the M items in blue.
- Most items are self-explanatory. Make sure to read each question carefully, taking note of exclusions, skip questions and time frame of each question

# Time Frame

- Most questions pertain to the day of assessment - 24 hrs preceding and including assessment visit, unless otherwise specified
- Examples of other time periods
  - Within the last 14 days- anxiety, confusion
  - Day of assessment and recent pertinent past - pain
  - Prior to current illness, exacerbation or injury - M1018, M1900, M2040
  - This payment episode - 60 day paymenty episode
  - Since the previous OASIS assessment - at or since



# OASIS CONVENTIONS

- Patient's status may change from day to day or during a given time
  - Consider what patient's status is >50% of the time
- **Never** use NA, unknown or no assessment done
- Direct observation is needed, especially for ADLs
- Combine observation, interview (both pt and PCG) and other strategies to complete assessment
- **Assistance** means hands-on, standby, verbal cues or reminders
- Base on patient's ability, not performance

# Vaccinations

- On every RN assessment, ask the patient if they received the flu shot (flu season is Oct 1-Mar 31), PNA shot and Tetanus
- Document on OASIS if patient received it
  - when and where
- If patient wants the flu shot, we offer it during flu season
  - Assess if they qualify for the flu shot
  - Have them sign the consent for flu shot and submit with your packet

# Let's break down the OASIS

- Q5001: Hospice or Home Health Care provided in patient's home/residence
- Q5002: Hospice or Home Health Care provided in Assisted Living Facility
- Q5009: Hospice or Home Health Care provided in place not otherwise specified

## COMPREHENSIVE ADULT NURSING ASSESSMENT INCLUDING SOC/ROC OASIS ELEMENTS WITH CMS 485 INFORMATION

Follow M numbers in sequence unless otherwise directed.

REASON FOR ASSI

Start of Care  Resumption of Care

DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
TIME IN \_\_\_\_ TIME OUT \_\_\_\_

# MD Information

**(M0010) CMS Certification Number:** (Locator #5) \_ \_ \_ \_ \_

**Branch Identification** (M0014) **Branch State:** \_ \_

**(M0016) Branch ID Number:** \_ \_ \_ \_ \_

**(M0018) National Provider Identifier (NPI)** for the attending physician who has signed the plan of care:

\_\_\_\_\_  
 **UK - Unknown or Not Available**

Phone: (Locator #24) \_ \_ \_ - \_ - \_

Name: (Locator #24) \_\_\_\_\_  
(First) (MI)

\_\_\_\_\_  
(Last) (Suffix)

Address: (Street/Apt. No.) (Locator #24)

\_\_\_\_\_  
City: (Locator #24)

\_\_\_\_\_  
State: (Locator #24) ZIP Code: (Locator #24)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CMS # : 059602

Branch State: CA

Branch ID #: NA

# Patient's info

All this information will be on your patient profile for SOC or 485 for all other OASIS

Please fill out completely

**(M0020) Patient ID Number:** (Locator #4)

-----  
Medical Record Number if different than M0020  
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**(M0030) Start of Care Date:** (Locator #2) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
month / day / year

**(M0032) Resumption of Care Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 NA - Not Applicable month / day / year

**(M0040) Patient Name:** (Locator #6)

----- (First) ----- (MI) -----  
----- (Last) ----- (Suffix)

Patient Phone: -----

Patient Address: (Locator #6)

-----  
(Street/Apt. No.)

-----  
(City)

**(M0050) Patient State of Residence:** (Locator #6) \_\_\_\_

**(M0060) Patient ZIP Code:** (Locator #6) -----

**(M0063) Medicare Number:**  NA - No Medicare

-----  
(including suffix)

**(M0064) Social Security Number:**  UK - Unknown or Not Available

-----  
**(M0065) Medicaid Number:**  NA - No Medicaid

-----  
**(M0066) Birth Date:** (Locator #8) \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
month / day / year

Patient's HI Claim No.: (Locator #1)

1 - Same as **M0063**  2 - Same as **M0065**  
 3 - Other -----

**(M0069) Gender:** (Locator #9)  1-Male  2-Female

Emergency Triage Code: \_\_\_\_\_

DNR Order:  Obtained  Requested

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## (M0140) Race/Ethnicity: (Mark all that apply.)

- 1 - American Indian or Alaska Native
- 2 - Asian
- 3 - Black or African-American
- 4 - Hispanic or Latino
- 5 - Native Hawaiian or Pacific Islander
- 6 - White



## (M0150) Current Payment Sources for Home Care: (Mark all that apply.)

- 0 - None; no charge for current services
- 1 - Medicare (traditional fee-for-service)
- 2 - Medicare (HMO/managed care/Advantage plan)
- 3 - Medicaid (traditional fee-for-service)
- 4 - Medicaid (HMO/managed care)
- 5 - Workers' compensation
- 6 - Title programs (for example, Title III, V, or XX)
- 7 - Other government (for example, TriCare, VA)
- 8 - Private insurance
- 9 - Private HMO/managed care
- 10 - Self-pay
- 11 - Other (specify) \_\_\_\_\_
- UK - Unknown

Certification Period: (Locator #3)

From \_\_\_/\_\_\_/\_\_\_ To \_\_\_/\_\_\_/\_\_\_



# Diagnosis

- M1010, M1016, M1020 and M1022
- Please put your suggested diagnosis on a post it and attached to specified area
- The office has a coder that looks at the H&P, MD progress note, RN OASIS/assessment and medications to come up with a comprehensive list of diagnosis to submit to Medicare

# Living arrangement/Supportive assistance

## LIVING ARRANGEMENTS/SUPPORTIVE ASSISTANCE

**(M1100) Patient Living Situation:** Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)**

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional/short-term assistance	No assistance available
a. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input checked="" type="checkbox"/> 04	<input type="checkbox"/> 05
b. Patient lives with other person(s) in the home	<input type="checkbox"/> 06	<input checked="" type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15

Name of facility \_\_\_\_\_ Phone \_\_\_\_\_



# Caregiver

**Primary Caregiver:**  Patient  
 Caregiver (name) \_\_\_\_\_

Phone Number (if different from patient) \_\_\_\_\_

Relationship \_\_\_\_\_

List name/relationship of other caregiver(s) (other than home health staff) and the specific assistance they give with medical cares, ADLs, and/or IADLs:

\_\_\_\_\_  
\_\_\_\_\_

Able to safely care for patient?  Yes  No

Comments: \_\_\_\_\_

Community resources (for example; Meals on Wheels; adult daycare):

\_\_\_\_\_  
\_\_\_\_\_

# Vision and Hearing

## EYES

## EARS

**(M1210) Ability to Hear** (with hearing aid or hearing appliance if normally used):

- 0 - Adequate: hears normal conversation without difficulty.
- 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- 2 - Severely Impaired: absence of useful hearing.
- UK - Unable to assess hearing.

# Speech/Oral (Verbal) expression

## **SPEECH/ORAL (VERBAL) EXPRESSION**

**(M1220) Understanding of Verbal Content** in patient's own language (with hearing aid or device if used):

- 0 - Understands: clear comprehension without cues or repetitions.
- 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- 3 - Rarely/Never Understands.
- UK - Unable to assess understanding.

**(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):**

- 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible).
- 5 - Patient nonresponsive or unable to speak.

# Pressure Ulcers

**(M1300) Pressure Ulcer Assessment:** Was this patient assessed for **Risk of Developing Pressure Ulcers?**

0 - No assessment conducted [**Go to M1306**]

1 - Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool

2 - Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)

**(M1302) Does this patient have a Risk of Developing Pressure Ulcers?**

0 - No     1 - Yes

**(M1306) Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher** or designated as Unstageable? (Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

0 - No [**Go to M1322**]     1 - Yes

**Complete Braden Scale form per organizational guideline (Briggs #3166). WOCN Staging Guidelines (see page 8 of 20).**

# Pressure Ulcers

- Review your definition of pressure ulcer stages
- If slough/eschar makes it hard to see the wound bed, then it is unstageable
- Stage I and II can heal
- Stage III and IV close but they do NOT heal
  - They can also turn into a surgical wound if amputated or muscle flap procedure is performed
- Reverse staging is not appropriate
- Debridement does not change the classification of a wound

# Skin Lesions



## M1350 – SKIN LESION OR OPEN WOUNDS

C+O

### MANY DIFFERENT TYPES OF SKIN LESIONS EXIST

Primary lesions  
Pustules, vesicles, wheals

Secondary lesions  
Crusts, scars, ulcers

Breaks in the skin surface  
Abrasion, excoriation, fissure, incisions

Vascular lesions  
Petechiae, ecchymosis

Change in shape of skin surface  
Cysts, nodules, edema

Changes in color or texture  
Maceration, scale, lichenification

✓ WHEN IN DOUBT; CHECK AN ASSESSMENT TEXTBOOK

- (CMS Q&As Cat. 4b Q112.7)

# Integumentary Status

**INTEGUMENTARY STATUS (Cont'd.)**

WOUND/LESION (specify)	#1	#2	#3	#4	#5
Location					
Type: Pressure ulcer Venous stasis ulcer Arterial Mechanical Malignancy Diabetic foot ulcer					
Size (cm) (LxWxD)					
Tunneling / Sinus Tract	length _____ cm @ _____ o'clock	length _____ cm @ _____ o'clock	length _____ cm @ _____ o'clock	length _____ cm @ _____ o'clock	length _____ cm @ _____ o'clock
Undermining (cm)	_____ cm, from _____ to _____ o'clock	_____ cm, from _____ to _____ o'clock	_____ cm, from _____ to _____ o'clock	_____ cm, from _____ to _____ o'clock	_____ cm, from _____ to _____ o'clock
Stage (pressure ulcers only)					
Odor					
Surrounding Skin					
Edema					
Stoma					
Appearance of the Wound Bed					
Drainage/Amount	<input type="checkbox"/> None <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large	<input type="checkbox"/> None <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large	<input type="checkbox"/> None <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large	<input type="checkbox"/> None <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large	<input type="checkbox"/> None <input type="checkbox"/> Small <input type="checkbox"/> Moderate <input type="checkbox"/> Large
Color	<input type="checkbox"/> Clear <input type="checkbox"/> Tan <input type="checkbox"/> Serosanguineous <input type="checkbox"/> Other	<input type="checkbox"/> Clear <input type="checkbox"/> Tan <input type="checkbox"/> Serosanguineous <input type="checkbox"/> Other	<input type="checkbox"/> Clear <input type="checkbox"/> Tan <input type="checkbox"/> Serosanguineous <input type="checkbox"/> Other	<input type="checkbox"/> Clear <input type="checkbox"/> Tan <input type="checkbox"/> Serosanguineous <input type="checkbox"/> Other	<input type="checkbox"/> Clear <input type="checkbox"/> Tan <input type="checkbox"/> Serosanguineous <input type="checkbox"/> Other
Consistency	<input type="checkbox"/> Thin <input type="checkbox"/> Thick	<input type="checkbox"/> Thin <input type="checkbox"/> Thick	<input type="checkbox"/> Thin <input type="checkbox"/> Thick	<input type="checkbox"/> Thin <input type="checkbox"/> Thick	<input type="checkbox"/> Thin <input type="checkbox"/> Thick

# Head to Toe Assessment

- Vital signs, BS, Ht and Weight
- Pain
- System by system
  - Endocrine
  - Integumentary
  - Cardiopulmonary
  - Respiratory
  - Nutritional/GI
  - Elimination
  - Abdomen
  - Neuro/Emotional/behavioral



# Depression Screening - a must!

**(M1730) Depression Screening:** Has the patient been screened for depression, using a standardized, validated depression screening tool?

0 - No

1 - Yes, patient was screened using the PHQ-2<sup>®</sup> scale.

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2 <sup>®</sup>	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 - 11 days	Nearly every day 12 - 14 days	NA Unable to respond
a) Little interest or pleasure in doing things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA

2 - Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.

3 - Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

- Never answer "NO"
- If patient has s/s or medication for depression, M2250 d. should always be a "YES"

# ADLS

## SCORING CONSIDERATIONS:



Ability, Not Performance

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Ability Infers Safety

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Majority/Frequency of the Tasks

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Understand Item Exclusions

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Caregiver Doesn't Impact Ability

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# More on ADLs



## NON-COMPLIANCE VERSUS INABILITY

### Non-compliant due to impairment

**Example:** Patient demonstrates she can walk safely with walker, but FORGETS to use walker #3 needs supervision

**IMPAIRMENT** impacts ability

### Non-compliant due to choice

**Example:** Patient demonstrates she can walk safely with walker, but CHOOSES not to use walker, even though she is aware of the potential related risk #2 needs a 2 handed device

**MATTER OF CHOICE** does not impact ability

# ADLs

- If your answers on SOC, ROC or recert are all 0 (independent) for the ADLs, then call the office because that means that patient does not meet qualifications for home health.
- Remember, independent means 100% independent with hands on assistance, stand by assistance or even verbal cues or reminders needed.
- Patient can be independent on discharge assessment.

# M1900 Prior Functioning ADL/IADL

- This is their level of function before the current illness, exacerbation or injury
- Medicare wants to see a change or decline in their level of functioning, prompting the need for home health
- Thus, it is ok to answer 0 or 1 here and then show the current decline in ADLs in M1800-M1890

# ACTIVITIES PERMITTED

- Usual answers are 3-Up as tolerated and 5-Exercises prescribed, especially if patient has PT
- Do not answer 7-Independent in home because this means patient does not need home health

# ALLERGIES

- Important to ask the patient for any allergies to medications, food or latex
- Note the allergies on the OASIS, Med profile and home health folder (white/green folder)

# MEDICATIONS

- Follow skip pattern of questions
- If a problem is found during SOC/ROC the MD needs to be contacted within 1 day with a response to fix the issue
- If patient takes meds via G-tube, M2020 is NA
- Answer should always be what is safe for the patient and not what patient does



# INFUSIONS

- If patient has infusions, please fill out infusion section in detail and indicate medication to be infused and flushing instructions
- If no infusion, then check N/A

# M2102: CARE MANAGEMENT

- If patient was referred to PT, answer 2 for ADL assistance (a), Medical treatments (d) and Safety (f) because PT will instruct patient/PCG on ambulation, transfers, HEP and safety/fall precautions.
- If patient has nursing visits planned, answer 2 for Medication administration (c) because nurse will instruct on medications on visits.
- Do not answer 0 or 1 on all types of assistance because that means patient does not need home health
- If 3 and 4 are answered, then refer the patient to MSW since there is no caregiver available to help the patient.

# M2250 Plan of Care Synopsis

- Never answer No, either Yes or NA only
- Answers should match the other answers in the OASIS
- Ex: c. Fall prevention should match M1910
  - f. Intervention to prevent pressure ulcer should match M1302 and Braden scale

# Narrative

- Please fill up all narrative portions of the OASIS with a description of all skilled care/interventions done during the assessment.
- For the recert and discharge OASIS, please fill up the 60 day or discharge summary with a summary of what happened to the patient during the certification period.

# SUMMARY

- Please fill out the OASIS entirely, not just the blue M items. The office uses all the information on the OASIS to generate the 485/POC and diagnosis for billing.
- Your answers determine the payment for the episode.
- Incomplete or wrong documentation by the RN adversely affects the patient's chart, plan of care, coding and billing.
- Fill out the rest of the paperwork included in the packet, such as wound assessments, consents, etc.

- If you are not sure which one to answer, especially in ADLs, choose the lower one.
  - Ex: patient has both a walker and a cane, choose the walker
  - We do not want the patient declining under our care. Thus, if the RN assessed the patient as needing a cane, and then in later assessments needs to use a walker, that is considered a decline in function.
  - Ex: Stage 1 vs. Stage 2 pressure ulcer
  - Choose the Stage 2 because patient can easily progress to a stage 2 in a few days.

- If you have any questions, please feel free to talk to any of the case managers in the office and we will be happy to assist you with your paperwork
- All packets are due within 48 hrs/2 days of your assessment
- If we need to change any of your answers on your assessment after auditing it, we will inform you and get an approval