



Welcome to the Centers for Medicare & Medicaid Services OASIS-C Online Training. This module provides foundational education on the Clinical Record Items Domain of the OASIS data set. It covers items M0080 through M0110.

Introduction

This program provides an introduction to OASIS-C items found in the Clinical Record Items Domain.

Discussion includes relevant guidance found in Chapter 3 of the December 2011 OASIS-C Guidance Manual.

The following information is provided in this lesson:

- Specific OASIS conventions that apply to the domain
- Item intent for each specific item
- Time points for item completion
- Response-specific item instructions
- Data sources and resources



This program provides an introduction to OASIS-C items related to the Clinical Record Items Domain. This module includes relevant guidance found in the December 2011 version of the OASIS-C Guidance Manual, specifically from Chapter 3, which contains OASIS item-specific guidance. Topics covered in this module include specific OASIS conventions that apply to the Clinical Record Items Domain, item intent or clarification about what each item is intended to report, time points when each item should be completed, response-specific item instructions clarifying the differences between the various responses which could be selected for each item, and data sources and resources related to the Clinical Record Items Domain.

Module Objectives

- Identify four conventions that support accuracy in completing the Clinical Record Items Domain.
- Identify the intent of each item in the Clinical Record Items Domain.
- Specify the data collection time points for each item in the Clinical Record Items Domain.
- Identify response-specific guidelines for completing each item in the Clinical Record Items Domain.
- Identify data sources for each item in the Clinical Record Items Domain.



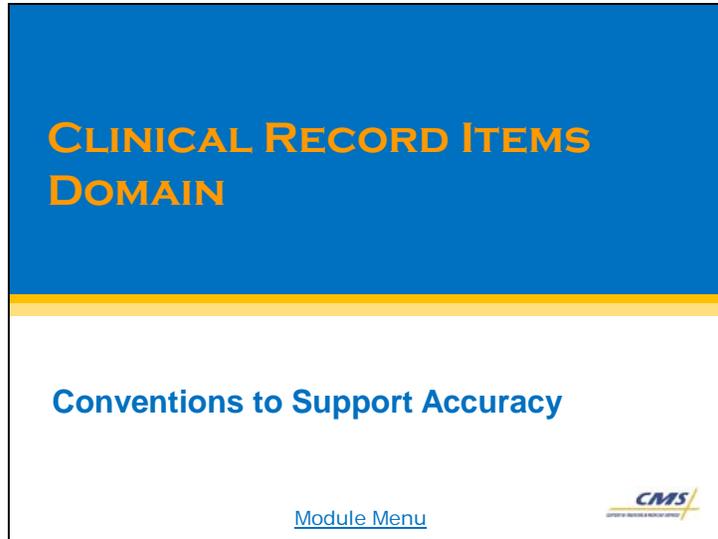
Following the presentation of this module on the Clinical Record Items Domain, you will be able to identify four conventions that support data collection accuracy in completing the Clinical Record Items Domain, identify the intent of each item in the Clinical Record Items Domain, specify the data collection time points for each item in the Clinical Record Items Domain, identify response-specific guidelines for completing each item in the Clinical Record Items Domain, and identify data sources for each item in the Clinical Records Domain.

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Select the Forward button to review the entire module, or you may select a topic from the Module Menu to review a specific topic of interest.



This topic addresses conventions to support OASIS-C accuracy.

OASIS Conventions to Support Accuracy

- Understand the time period under consideration.
- Understand definitions of words as used in the OASIS-C.
- Follow the rules included in the item-specific guidance.
- Only one clinician takes responsibility for completion of the comprehensive assessment.



There are specific conventions or general rules that should be followed when completing OASIS-C items. Although all the conventions are important to observe and apply when appropriate, four conventions are particularly important to remember when reporting OASIS-C items in the Clinical Record Items Domain. These conventions are understanding the time period under consideration for each item, understanding the definitions of words as used in the OASIS-C, following the rules included in the item-specific guidance, and knowing that only one clinician takes responsibility for completion of the Comprehensive Assessment.

Time Period Under Consideration

- Refers to how far back into the past you should consider when assessing the Clinical Record items.



The convention for “understanding the time period under consideration” refers to how far back into the past you should consider when assessing the Clinical Record Items. Each item in this OASIS domain sets a time period to consider when collecting data and selecting a response. Pay careful attention to the specific time period for each item to ensure the accuracy of data collection.

Time Period Under Consideration, cont.

- Report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance.
- The day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent for the home visit.



This convention guides the clinician to report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance. The day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home for the home visit. Items in this domain report facts regarding the patient known on the day of the assessment.

Understand OASIS Definitions

- Understand the definitions of words as used in the OASIS-C.
- Example: M0110 Episode Timing has several words that are specifically defined in OASIS:
 - Early Episode
 - Later Episode
 - Adjacent Episodes
- Definitions are found in the response-specific instructions in Chapter 3 of the OASIS-C Guidance Manual for this item.



The second convention states you must understand the definitions of words as used in the OASIS-C data set. M0110, Episode Timing, is a good example. “Early,” “Later,” and “Adjacent” are words with OASIS-specific definitions. These definitions, found in the response-specific instructions in Chapter 3 of the OASIS-C Guidance Manual, will be covered later in this module.

Follow the Rules

- Follow the rules in the response-specific instructions.

Response-Specific Instructions

If the originally ordered start of care is delayed due to the patient's condition or physician request (e.g., extended hospitalization), then the date specified on the updated/revised order to start home care services would be considered the date of physician-ordered start of care (resumption of care). For example, a patient discharged home on May 15 but for whom the physician orders home care to begin May 20 for a specified order (e.g., PT or administration of a subcutaneous drug), would have a physician-ordered start-of-care date of May 20.

If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.

Mark "NA" if the initial orders did not specify a SOC date.

In order to be considered a physician-ordered SOC date, the physician must give a specific date to initiate care, not a range of dates. If a single date to initiate services is not provided, the initial contact (via the initial assessment visit) must be conducted within 48 hours of the referral or within 48 hours of the patient's return home from the inpatient facility.



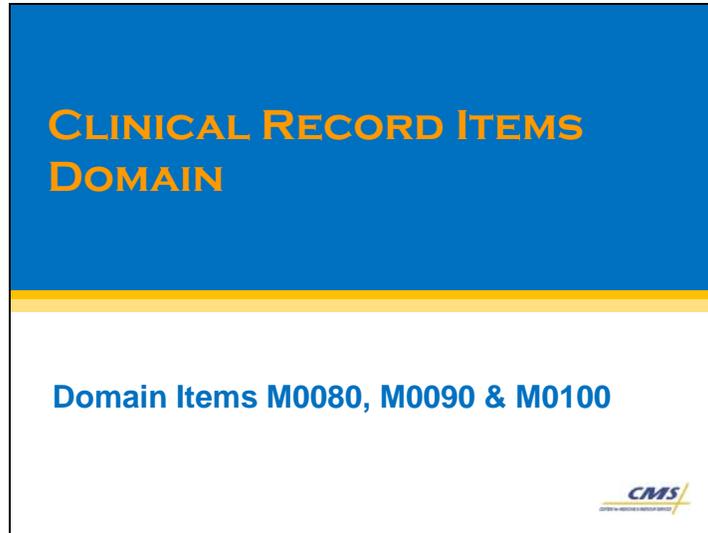
Be sure to follow the rules included in the response-specific instructions when completing the OASIS items. There are several instances in this domain where item-specific guidance will provide the direction required for accurate data collection.

Only One Clinician Is Responsible

- Only one clinician takes responsibility for accurately completing a comprehensive assessment.
- Collaboration is only appropriate for a few selected items.
- These exceptions are noted in the response-specific instructions for each item.
- Examples where collaboration is appropriate:
 - M2000 Drug Regimen Review
 - M2002 Medication Follow-up
 - M2004 Medication Intervention



The last convention that applies to the Clinical Record Items Domain states only one clinician can take responsibility for accurately completing a comprehensive assessment. Collaboration is only appropriate for a few selected items. These exceptions are noted in the item’s response-specific instructions. The Medication items, M2000 through M2004, are examples of items where collaboration is allowed. M0080 Discipline of Person Completing Assessment is an example of an item where the response-specific instructions remind us that only one clinician is responsible for completion of the assessment.



This topic addresses items M0080, M0090, and M0100.

JP1

Summary of M- Items

- M0080 Discipline of Person Completing Assessment
- M0090 Date Assessment Completed
- M0100 This Assessment is Currently Being Completed for the Following Reason
- M0102 Date of Physician-ordered Start of Care
- M0104 Date of Referral
- M0110 Episode Timing



The Clinical Record Items Domain consists of six items. This topic addresses three of these items: M0080 Discipline of Person Completing Assessment, M0090 Date Assessment Completed, and M0100 This Assessment is Currently Being Completed for the Following Reason.

M0080 Discipline of Person
Item Intent & Time Points

(M0080) Discipline of Person Completing Assessment:
 1 – RN 2 – PT 3 - SLP/ST 4 - OT

- Specifies the discipline of the clinician completing the comprehensive assessment:
 - During an actual visit at the specified OASIS time points
 - Reporting the transfer to an inpatient facility or death at home

Collected at All Time Points

Item Intent Time Points Response-Specific Instructions Data Sources/Resources 

The first item we'll discuss is M0080 Discipline of Person Completing Assessment. The intent of this item is to report the discipline of the clinician completing the comprehensive assessment. This may be a clinician conducting an actual visit to the patient's home at the specified OASIS time points, or the clinician reporting the Transfer to an inpatient facility or Death at Home. This item is collected at all OASIS time points.

**M0080 Discipline of Person
Response-Specific Instructions**

(M0080) Discipline of Person Completing Assessment:

1 – RN 2 – PT 3 - SLP/ST 4 - OT

- Only one individual completes the comprehensive assessment.



Item Intent Time Points **Response-Specific Instructions** Data Sources/
Resources



When selecting the correct response to M0080, consider these guidelines. Only one individual can complete a comprehensive assessment. Two disciplines may be seeing the patient at the time a comprehensive assessment is due, and care coordination and consultation are needed between these disciplines to select correct responses for applicable items. Only one individual, however, actually completes and records the assessment.

**M0080 Discipline of Person
Response-Specific Instructions, cont'd**

(M0080) Discipline of Person Completing Assessment:
 1 – RN 2 – PT 3 - SLP/ST 4 - OT

- When both an RN and PT/SLP are ordered on the initial referral, the RN must perform the SOC comprehensive assessment.



Item Intent Time Points **Response-Specific Instructions** Data Sources/
Resources



When multiple disciplines are ordered on an initial referral, such as a Registered Nurse and a Physical Therapist and/or Speech Language Pathologist, the Condition of Participation, §484.55, the Comprehensive Assessment of Patients, directs that the Registered Nurse must perform the SOC comprehensive assessment.

**M0080 Discipline of Person
Response-Specific Instructions, cont'd**

(M0080) Discipline of Person Completing Assessment:

1 – RN 2 – PT 3 - SLP/ST 4 - OT

- An RN, PT, OT, or SLP may perform subsequent assessments.

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/Resources _____



A Registered Nurse, Physical Therapist, Occupational Therapist, or Speech Language Pathologist may perform subsequent assessments. Licensed practical nurses, physical therapy assistants, certified occupational therapy assistants, medical social workers, and home health aides do not meet the requirements specified in the comprehensive assessment regulation for disciplines authorized to complete the comprehensive assessment or to collect OASIS data.

M0080 Discipline of Person Completing Response-Specific Instructions, cont'd

(M0080) Discipline of Person Completing Assessment:

1 – RN 2 – PT 3 - SLP/ST 4 - OT

- Only one individual completes the comprehensive assessment.
- When both an RN and PT/SLP are ordered on the initial referral, the RN must perform the SOC comprehensive assessment.
- An RN, PT, OT, or SLP may perform subsequent assessments.
- The last qualified clinician to see the patient completes the discharge comprehensive assessment.

Item Intent Time Points **Response-Specific Instructions** Data Sources/ Resources 

Additionally, the guidance states when both the Registered Nurse and a qualified therapist are scheduled to conduct Discharge visits on the same day, the last qualified clinician to see the patient is responsible for conducting the Discharge comprehensive assessment.

**M0080 Discipline of Person
Data Sources / Resources**

- Utilize resources:
 - Agency Policy
 - Condition of Participation, §484.55, the Comprehensive Assessment of Patients

§484.55 Condition of Participation: Comprehensive assessment of patients
Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary.

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/Resources _____



Your agency's policy related to the completion of comprehensive assessment and OASIS data items should be considered when answering this item. The Condition of Participation, §484.55, the Comprehensive Assessment of Patients, is another source for guidance.

M0080 Scenario

Your agency received a referral for Mr. Sable following a total right hip replacement.

Physical therapy has been ordered for strengthening and gait training.

Nursing has been ordered for one visit to remove staples in seven days.



Now let's apply what we just reviewed to this scenario. Your agency received a referral for Mr. Sable following a total right hip replacement. Physical therapy has been ordered for strengthening and gait training. Nursing has been ordered for one visit to remove staples in seven days.

M0080 Scenario Question

Which discipline should perform the Start of Care comprehensive assessment?

(M0080) Discipline of Person Completing Assessment:

1 - RN 2 - PT 3 - SLP/ST 4 - OT

Select the correct response for this scenario.

[Review Scenario](#) 

Which discipline should perform the Start of Care comprehensive assessment?

M0080 Scenario Answer

Which discipline should perform the Start of Care comprehensive assessment?

(M0080) Discipline of Person Completing Assessment:

1 - RN 2 - PT 3 - SLP/ST 4 - OT

That is correct! The RN is the discipline responsible for completing the assessment. According to the comprehensive assessment regulation, when both the registered nurse and physical therapist or speech language pathologist are ordered on the initial referral, the registered nurse must perform the Start of Care comprehensive assessment.



That is correct! The RN is the discipline responsible for completing the assessment. According to the comprehensive assessment regulation, when both a Registered Nurse and Physical Therapist or Speech Language Pathologist are ordered on the initial referral, the Registered Nurse must perform the Start of Care comprehensive assessment.

M0090 Date Assessment Completed
Item Intent & Time Points

(M0090) Date Assessment Completed: __ / __ / __ __ __
month/ day/ year

- Specifies the actual date the assessment is completed.



Collected at All Time Points

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/Resources _____



The next OASIS item in the Clinical Record Items Domain is M0090 Date Assessment Completed. The intent of M0090 is to specify the actual date the assessment is completed. This item is collected at all OASIS time points.

**M0090 Date Assessment Completed
Response-Specific Instructions**

(M0090) Date Assessment Completed: __ / __ / __ __
month/ day/ year

- If the date or month is only one digit, that digit is preceded by a "0".
- The date of assessment must not be before the Start of Care date (M0030).
- If the assessment is performed over more than one visit date, record the last date when final assessment data were collected.

Item Intent _____ Time Points _____ **Response-Specific Instructions** _____ Data Sources/ Resources _____ 

When completing this item, if the date or month is only one digit, precede the single digit with a zero. For example, May 4, 2012, would be reported as 05/04/2012. The date the assessment is completed must not be before the Start of Care date (M0030). If your agency allows for the assessment to be performed over more than one visit date, record the last date when final assessment data were collected in M0090.

M0090 Date Assessment Completed Response-Specific Instructions, cont'd

(M0090) Date Assessment Completed: ___ / ___ / ___ ___
month/ day/ year

- Record the date the agency completes the data collection after learning of the following events:
 - Transfer to inpatient facility - patient not discharged from agency
 - Transfer to inpatient facility – patient discharged from agency
 - Death at home



Item Intent _____
Time Points _____
Response-Specific Instructions _____
Data Sources/
Resources _____



A visit is not necessarily associated with three events: Transfer to an inpatient facility but the patient is not discharged from the agency, Transfer to an inpatient facility but the patient is discharged from the agency, and Death at Home. Record the date the agency completed the data collection after learning of these events. We will provide further clarification when we discuss M0100 Reason for Assessment.

M0090 Date Assessment Completed
Data Sources / Resources

- Gather information from several sources:
 - Calendar
 - Patient/caregiver interview for dates of transfer to inpatient facility or death at home
- Record date you complete data collection after learning of these events.



Item Intent Time Points Response-Specific Instructions Data Sources/ Resources



When determining the date the assessment was completed, you may need to refer to a calendar. You may also need to talk with the patient and/or caregiver to determine the date of death or transfer to an inpatient facility. For M0090, you're recording the date the agency completes the data collection after learning of the event, not the date of death or transfer.

M0090 Scenario

You begin your Start of Care comprehensive assessment on 05/04/2012, but can't complete the entire assessment due to the patient's fatigue.

You make another visit on 05/05/2012, to gather the rest of the data to complete your assessment.



Now let's apply what we just reviewed to this scenario.

You begin your Start of Care comprehensive assessment on May 4, 2012, but can't complete the entire assessment due to the patient's fatigue. You make another visit on May 5, 2012, to gather the rest of the data to complete your assessment.

M0090 Scenario Question

Which date would you enter in M0090 Date Assessment Completed?

(M0090) Date Assessment Completed: __ / __ / ____
month/ day/ year

- A. 05/03/2012
- B. 05/04/2012
- C. 05/05/2012
- D. 05/06/2012

[Review Scenario](#) **Select the correct response for this scenario.** 

Which date would you enter in M0090 Date Assessment Completed?

M0090 Scenario Answer

Which date would you enter in M0090 Date Assessment Completed?

(M0090) Date Assessment Completed: 0 5 / 0 5 / 2 0 1 2

A. 05/03/2012

B. 05/04/2012

C. 05/05/2012

D. 05/06/2012

That is correct! The response-specific guidance for this item states that if the agency policy allows assessments to be performed over more than one visit date, the last date (when the final assessment data are collected) is the appropriate date to record in M0090.

Select the correct response for this scenario. 

That is correct! The response for M0090 is May 5, 2012. The response-specific guidance for this item states that if the agency policy allows assessments to be performed over more than one visit date, the last date (when the final assessment data are collected) is the appropriate date to use in M0090.

M0100 Reason for Assessment

- Reason for Assessment (RFA)
 - Start of Care
 - Resumption of Care
 - Follow-Up
 - Transfer to an Inpatient Facility
 - Death at Home
 - Discharge from Agency – Not to an Inpatient Facility



As you work through the modules in this series and refer to other CMS resources, you will see the term “RFA” used to describe the assessment time points. “RFA” stands for “Reason for Assessment” and refers to the reason why the assessment is being completed at a particular time point.

**M0100 Reason for Assessment
Item Intent & Time Points**

(M0100) This Assessment is Currently Being Completed for the Following Reason:

Start/Resumption of Care

- 1 - Start of care—further visits planned
- 3 - Resumption of care (after inpatient stay)

Follow-Up

- 4 - Recertification (follow-up) reassessment [*Go to M0110*]
- 5 - Other follow-up [*Go to M0110*]

Transfer to an Inpatient Facility

- 6 - Transferred to an inpatient facility—patient not discharged from agency [*Go to M1040*]
- 7 - Transferred to an inpatient facility—patient discharged from agency [*Go to M1040*]

Discharge from Agency — Not to an Inpatient Facility

- 8 - Death at home [*Go to M0903*]
- 9 - Discharge from agency [*Go to M1040*]

Collected at All Time Points

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/Resources _____



One example of an item that illustrates this requirement is M0100 This Assessment is Currently Being Completed for the Following Reason. The intent of this item is for you to identify the time points or reason why the assessment data are being collected and reported. Accurate recording of this response is important as the logic in the data reporting software will accept or reject certain data according to the specific response that has been selected for this item. This item is collected at all of the OASIS time points.

**M0100 Reason for Assessment
Response-Specific Instructions**

(M0100) This Assessment is Currently Being Completed for the Following Reason:

Start/Resumption of Care

- 1 - Start of care—further visits planned
- 3 - Resumption of care (after inpatient stay)

Follow-Up

- 4 - Recertification (follow-up) reassessment [*Go to M0110*]
- 5 - Other follow-up [*Go to M0110*]

Transfer to an Inpatient Facility

- 6 - Transferred to an inpatient facility—patient not discharged from agency [*Go to M1040*]
- 7 - Transferred to an inpatient facility—patient discharged from agency [*Go to M1040*]

Discharge from Agency – Not to an Inpatient Facility

- 8 - Death at home [*Go to M0903*]
- 9 - Discharge from agency [*Go to M1040*]

Item Intent _____ Time Points _____ **Response-Specific Instructions** _____ Data Sources/
Resources 

Notice there are four categories of assessments that can be completed based on the status of the patient and the time point for delivery of care. Let’s review each of these to help you select the correct reason for the current assessment.

M0100 Reason for Assessment Start of Care/ Resumption of Care		
RESPONSE	ASSESSMENT TYPE	TIME POINT-REASON
RFA 1	Start of Care Comprehensive Assessment	<ul style="list-style-type: none"> Conducted when a plan of care is being established. Anytime an initial HIPPS code for a Home Health Resource Group is required.



There are two types of assessments that fall under Start of Care/Resumption of Care responses. Response 1, or RFA 1, is the Start of Care Comprehensive Assessment. This comprehensive assessment is completed when a plan of care is being established. This is required regardless of whether further visits will be provided after the Start of Care. This is the appropriate response anytime an initial HIPPS code for a home health resource group is required for payment under the Home Health Prospective Payment System.

**M0100 Reason for Assessment
Start of Care/ Resumption of Care, cont'd**

RESPONSE	ASSESSMENT TYPE	TIME POINT-REASON
RFA 1	Start of Care Comprehensive Assessment	<ul style="list-style-type: none"> Conducted when a plan of care is being established. Anytime an initial HIPPS code for a Home Health Resource Group is required.
RFA 3	Resumption of Care Comprehensive Assessment	<ul style="list-style-type: none"> Conducted when the patient resumes care following an inpatient stay of 24 hours or longer for reasons other than diagnostic tests.



Response 3, or RFA 3, is the Resumption of Care comprehensive assessment. This comprehensive assessment is conducted when the patient resumes care following an inpatient stay of 24 hours or longer for reasons other than diagnostic tests. You must also remember to update the patient tracking item M0032 Resumption of Care Date when this response is marked. Reason for Assessment 2 has been removed from the data set and is no longer an available response selection.

M0100 Reason for Assessment Follow-up Assessments

RESPONSE	ASSESSMENT TYPE	TIME POINT-REASON
RFA 4	Recertification (Follow-up) Reassessment	<ul style="list-style-type: none"> Conducted during the last five days of the 60-day certification period to continue services into a new episode of care. When the patient is discharged from an inpatient facility and care is resumed within the last 5 days of the episode, an RFA 3 can meet both the resumption and the recertification requirements.



There are two types of Follow-up Assessments. Response 4, or RFA 4, is the Recertification follow-up. This reassessment is conducted during the last 5 days of the 60-day certification period. It is completed when there is a need to continue the patient’s services into the next 60-day episode of care.

When a patient returns home from an inpatient stay in the last five days of an episode and the requirement to complete an RFA 3 Resumption of Care assessment overlaps with the requirement to complete an RFA 4 Recertification assessment, only the Resumption of Care assessment is required. The RFA 3 assessment contains all the necessary quality and payment information to meet the needs of both the Resumption and Recertification needs. The RFA 4 Recertification assessment would not be required.

M0100 Reason for Assessment Follow-up Assessments, cont'd

RESPONSE	ASSESSMENT TYPE	TIME POINT-REASON
RFA 5	Other Follow-up	<ul style="list-style-type: none"> Conducted due to a major decline or improvement in patient's health status occurring at a time other than during the last five days of the episode.



Response 5 is a comprehensive reassessment conducted due to a major decline or improvement in a patient's health status that occurs at a time other than during the last five days of the episode. This assessment is performed to re-evaluate the patient's condition and allows revision to the patient's care plan as appropriate.

**M0100 Reason for Assessment
Transfer to Inpatient Facility (Not Discharged)**

RESPONSE	ASSESSMENT TYPE	TIME POINT-REASON
RFA 6	Transferred to an inpatient facility – not DC'd from agency	<ul style="list-style-type: none"> Completed when the home care patient is admitted to an inpatient facility for 24 hours or longer for reasons other than diagnostic tests with the expectation that home health care will be resumed following discharge. Does not require a home visit.



There are two types of Transfers to an Inpatient Facility. Response 6, or RFA 6, Transferred to an inpatient facility – patient not discharged from the agency, is completed when the home care patient is admitted to an inpatient facility for 24 hours or longer, for reasons other than diagnostic tests. The expectation is home health care will resume following inpatient discharge. Therefore, the patient is not discharged from the agency. Short stay observation periods in a hospital do not meet the definition of a transfer to an inpatient facility. In other words, if the patient is only in the hospital for observation and is never admitted as an inpatient, then no Transfer data collection would be required. This applies even if the observation status continues for several days. This response does not require a home visit. A telephone call may provide the information necessary to complete the required data items. When you resume care of the patient, a Resumption of Care comprehensive assessment will be conducted.

M0100 Reason for Assessment Transfer to Inpatient Facility (Discharged)		
RESPONSE	ASSESSMENT TYPE	TIME POINT-REASON
RFA 7	Transferred to an inpatient facility – DC'd from agency	<ul style="list-style-type: none"> • Same as Response 6 except there is no expectation the patient will resume home health care following discharge. • Does not require a home visit. • No additional OASIS discharge data required.



Response 7, or RFA 7, Transferred to an inpatient facility – patient discharged from agency, is completed when the home care patient is admitted to an inpatient facility for 24 hours or longer for reasons other than diagnostic tests and the agency does not anticipate the patient will be returning to their care. Therefore, the patient is discharged from the agency. This response does not require a home visit. A telephone call may provide the information necessary to complete the required data items. In this case, no additional OASIS discharge data are required. Remember, short stay observation periods in a hospital, regardless of duration, do not meet the definition for either an RFA 6 or an RFA 7 transfer to an inpatient facility. When a patient meets the criteria of being transferred to an inpatient facility, an RFA 6 (Transfer WITHOUT discharge) is preferred over an RFA 7 (Transfer WITH discharge) when there is an assumption that the patient will be returning to the home health agency.

M0100 Reason for Assessment Death at Home

RESPONSE	ASSESSMENT TYPE	TIME POINT-REASON
RFA 8	Death at Home [Go to M0903]	<ul style="list-style-type: none"> Collects data regarding patient death anywhere <u>other than</u> death in an emergency department or inpatient facility. Selected for a patient who dies before being treated in an emergency department or before admission to inpatient facility. Home visit is <u>not</u> required.



Let’s discuss the final two OASIS time points which fall under Discharge from Agency – Not to an Inpatient Facility. Response 8 – Death at home, is selected to collect data regarding a patient’s death that occurred anywhere other than in an emergency department or an inpatient facility. Select this response for a patient who dies before being treated in an emergency department or before being admitted to an inpatient facility. Note the skip pattern included in this response option. It directs you to skip ahead to M0903 Death Date when you select this response. A home visit is not required to select this response. The information necessary to complete the data items may be obtained by telephone.

M0100 Reason for Assessment Discharge from Agency - Not to Inpatient Facility		
RESPONSE	ASSESSMENT TYPE	TIME POINT-REASON
RFA 9	Discharge from Agency [Go to M1040]	<ul style="list-style-type: none"> Conducted when the patient is discharged from the agency for reason other than transfer to an inpatient facility or death at home. A home visit is required. DC OASIS not required when only a single visit is made in a care (quality) episode. Care/Quality episode begins with an SOC/ROC and ends with either a Transfer or DC.

Response 9 – Discharge from Agency is selected when a patient is discharged from the agency for any reason other than a transfer to an inpatient facility or a death at home. This response includes transfer and discharge to another home health agency or an in-home hospice. A patient visit is required to complete this assessment. Note the skip pattern present in this response. It directs you to skip to M1040 Influenza Vaccine after marking this response. The Discharge OASIS is not required when only a single visit is made in a care episode. A care or quality episode begins with a Start of Care or Resumption of Care and ends with either a Transfer or a Discharge.

**M0100 Reason for Assessment
Data Sources / Resources**

- Gather information from several sources:
 - Agency case manager or other care team provider
 - Clinical record
 - Hospital or other health care provider can or may provide information regarding transfer to inpatient facility or death at home.



Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/ Resources _____



When determining the reason for assessment, gather data from several sources. Ask the agency case manager or other care team providers for information. Consider looking in the clinical record for information. Consult with other health care providers for details related to a transfer to an inpatient facility or for death at home. Ask why the assessment is being conducted or the information is being recorded. What happened to the patient? Remember that an accurate response is critical, as the logic in the data reporting software will accept or reject certain data according to the specific response selected for this item.

M0100 Scenario #1

Your patient is admitted to an inpatient bed and stays three days for treatment of congestive heart failure.

You anticipate she will return to your home care.



Let's practice choosing the correct assessment using this scenario.

Your patient is admitted to an inpatient bed and stays three days for treatment of congestive heart failure. You anticipate she will return to your home care.

M0100 Scenario #1 Question

Which assessment should you select for M0100?

(M0100) This Assessment is Currently Being Completed for the Following Reasons:

Start/Resumption of Care

- 1 - Start of care—further visits planned
- 3 - Resumption of care (after inpatient stay)

Follow-Up

- 4 - Recertification (follow-up) reassessment [*Go to M0110*]
- 5 - Other follow-up [*Go to M0110*]

Transfer to an Inpatient Facility

- 6 - Transferred to an inpatient facility—patient not discharged from agency [*Go to M1040*]
- 7 - Transferred to an inpatient facility—patient discharged from agency [*Go to M1040*]

Discharge from Agency—Not to an Inpatient Facility

- 8 - Death at home [*Go to M0903*]
- 9 - Discharge from agency [*Go to M1040*]

Select the correct response for this scenario.



Which assessment would you select in item M0100?

M0100 Scenario #1 Answer

Which assessment should you select for M0100?

(M0100) This Assessment is Currently Being Completed for the Following Reasons:

Start/Resumption of Care

- 1 - Start of care—further visits planned
- 3 - Resumption of care (after inpatient stay)

Follow-Up

- 4 - Recertification (follow-up) reassessment [*Go to M0110*]
- 5 - Other follow-up [*Go to M0110*]

Transfer to an Inpatient Facility

- 6 - Transferred to an inpatient facility—patient not discharged from agency [*Go to M1040*]
- 7 - Transferred to an inpatient facility—patient discharged from agency [*Go to M1040*]

Discharge from Agency — Not to an Inpatient Facility

- 8 - Death at home [*Go to M0903*]
- 9 - Discharge from agency [*Go to M1040*]

That is correct! The Reason for Assessment is RFA 6, Transferred to an inpatient facility—patient not discharged from agency.



That is correct! The Reason for Assessment is RFA 6, Transferred to inpatient facility – patient not discharged from agency.

M0100 Scenario #2

Your home care patient is discharged from the hospital on Day 57 of the current payment episode and returns to your home care.



The graphic includes a calendar for September 2012 with the following dates: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30. The date 15 is circled in red, and 'Day 57' is written in red below the calendar. A larger calendar for the year 2012 is shown in the background.



Consider this scenario. Your home care patient is discharged from the hospital on Day 57 of the current payment episode and returns to your home care.

M0100 Scenario # 2 Question

Which assessment should you select for M0100?

(M0100) This Assessment is Currently Being Completed for the Following Reasons:

Start/Resumption of Care

- 1 - Start of care—further visits planned
- 3 - Resumption of care (after inpatient stay)

Follow-Up

- 4 - Recertification (follow-up) reassessment [Go to M0110]
- 5 - Other follow-up [Go to M0110]

Transfer to an Inpatient Facility

- 6 - Transferred to an inpatient facility—patient not discharged from agency [Go to M1040]
- 7 - Transferred to an inpatient facility—patient discharged from agency [Go to M1040]

Discharge from Agency — Not to an Inpatient Facility

- 8 - Death at home [Go to M0903]
- 9 - Discharge from agency [Go to M1040]

Select the correct response for this scenario.

 CENTERS FOR MEDICARE & MEDICAID SERVICES

[Review Scenario](#)

Which assessment would you select in item M0100?

M0100 Scenario # 2 Answer

Which assessment should you select for M0100?

(M0100) This Assessment is Currently Being Completed for the Following Reasons:

Start/Resumption of Care

- 1 - Start of care—further visits planned
- 3 - Resumption of care (after inpatient stay)

Follow-Up

- 4 - Recertification (follow-up) reassessment [Go to M0110]
- 5 - Other follow-up [Go to M0110]

Transfer to an Inpatient Facility

- 6 - Transferred to an inpatient facility—patient not discharged from agency [Go to M1040]
- 7 - Transferred to an inpatient facility—patient discharged from agency [Go to M1040]

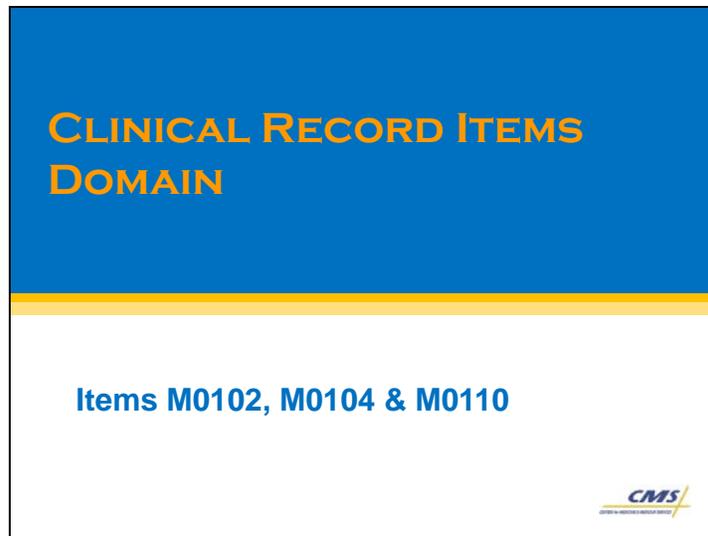
Discharge from Agency — Not to an Inpatient Facility

- 8 - Death at home [Go to M0903]
- 9 - Discharge from agency [Go to M1040]

That is correct! A Resumption of Care assessment (RFA 3) would be completed when a patient's care is resumed within the last five days of the episode. The ROC will take the place of the Recertification assessment in this case.



That is correct! A Resumption of Care assessment (RFA 3) would be completed when a patient's care is resumed within the last five days of the episode. The Resumption of Care will take the place of the Recertification assessment in this case.



This topic addresses items M0102, M0104, and M0110.

Summary of M- Items

- M0080 Discipline of Person Completing Assessment
- M0090 Date Assessment Completed
- M0100 This Assessment is Currently Being Completed for the Following Reason
- M0102 Date of Physician-ordered Start of Care
- M0104 Date of Referral
- M0110 Episode Timing



The Clinical Record Items Domain consists of six items. This topic addresses three of these items: M0102 Date of Physician-ordered Start of Care, M0104 Date of Referral, and M0110 Episode Timing.

M0102 Date of Physician-Ordered SOC/ROC Item Intent & Time Points

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

___ / ___ / _____ *(Go to M0110, if date entered)*
 month / day / year

NA - No specific SOC date ordered by physician (or physician designee)

- Specifies the date that home care services are ordered to begin if the date is specified by the physician.

Collected at SOC & ROC

Item Intent
Time Points
Response-Specific Instructions
Data Sources/
Resources



M0102 Date of Physician-ordered Start of Care or Resumption of Care specifies the date that home care services are ordered to begin, if a date is specified by the physician. The item refers to the order to start home care services. Specifically, it’s referring to the order to provide the first covered service, regardless of the type of services ordered. The collection time points for this item are the Start of Care and the Resumption of Care.

M0102 Date of Physician-Ordered SOC/ROC Guidelines

- Physician has specified a date to initiate care (not a range of dates).
- If a single date is not specified, the initial visit must be conducted:
 - Within 48 hours of the referral
 - Within 48 hours of the patient's return home from the inpatient facility



Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/Resources _____



The response-specific instructions provide guidance for accurate scoring of M0102. In order to be considered a physician-ordered start of care date, the physician must provide a specific date to initiate care, not a range of dates. If a single date to initiate services is not specified, the initial contact, via the initial assessment visit, must be conducted within 48 hours of the referral or within 48 hours of the patient's return home from the inpatient facility.

M0102 Date of Physician-Ordered SOC/ROC Guidelines, cont'd

- Original order date of the Start of Care may be delayed due to the patient's condition or physician request.
- Report the date specified on the updated/revised order to start services as the Start of Care or Resumption of Care.
- Example:
 You receive a referral with a discharge date of May 15. The physician orders home care to begin on May 20 for a specified order, e.g. PT or SQ medication administration. Report the date in the updated orders.

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/Resources _____

In some instances, the original order date of the start of care may be delayed due to the patient's condition or due to a physician request, such as an extended hospitalization. In this situation, the date specified on the updated /revised order to start home care services would be the date of physician-ordered Start of Care or Resumption of Care. For example, you received a referral for a patient with a hospital discharge date of May 15, but at the time of the hospital discharge, the physician ordered home care to begin on May 20 so that a medication could be administered that day. The Start of Care date in the updated orders, May 20, would be reported in M0102.

M0102 Date of Physician-Ordered SOC/ROC Response-Specific Instructions

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

 0 5 / 0 4 / 2 0 1 2 *(Go to M0110, if date entered)*
 month / day / year

NA - No specific SOC date ordered by physician (or physician designee)

- If the date or month is only one digit, that digit is preceded by a "0".
- Enter all four digits of the year.

Item Intent Time Points Response-Specific Instructions Data Sources/Resources 

When the date or month is only one digit, that digit is preceded by a "0". Enter all four digits for the year. If the initial orders did not specify a Start of Care date, select "NA."

M0102 Date of Physician Ordered SOC/ROC
Data Sources / Resources

- Physician orders to initiate home care or resume home care following inpatient facility stay.



Item Intent Time Points Response-Specific Instructions Data Sources/ Resources



When determining the correct response for M0102, refer to the physician orders to initiate home care or resume home care following an inpatient stay to determine if the physician has ordered a specific date to start or resume care.

M0104 Date of Referral
Item Intent & Time Points

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

___ / ___ / ___
month / day / year

- Specifies the most recent date that the verbal, written, or electronic authorization to begin home care was received by the home health agency.

Collected at SOC & ROC

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/Resources _____ 

The intent of item M0104 Date of Referral is to specify the referral date. This is the most recent date that the verbal, written, or electronic authorization to begin home care was received by the home health agency. The collection time points for this item include the Start of Care and Resumption of Care.

M0104 Date of Referral Response-Specific Instructions

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

_ _ / _ _ / _ _ _ _
month / day / year

- Record the date the agency received updated/revised referral information for services to begin if the Start of Care is delayed.
- Does not refer to calls or documentation from others who contact the agency to prepare the agency for possible admission:
 - Assisted living facility staff
 - Family who contact the agency to prepare the agency for possible admission.

Item Intent _____Time Points _____**Response-Specific Instructions** _____Data Sources/
Resources _____



If the Start of Care is delayed due to the patient’s condition or physician request such as an extended hospitalization, the response-specific instructions direct us to use the date the agency received updated or revised referral information for home care services to begin as the date of referral. M0104 does not refer to calls or documentation from others such as assisted living facility staff or family who may contact the agency to prepare them for the possible admission.

M0104 Date of Referral
Response-Specific Instructions, cont'd

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

___ / ___ / _____
month / day / year

- Date authorization was received from the patient's payer is NOT the date of referral.
- If the date or month is only one digit, that digit is preceded by a "0".
- Enter all four digits for the year.

Item Intent _____ Time Points _____ **Response-Specific Instructions** _____ Data Sources/ Resources 

The date authorization was received from the patient's payer is NOT the date of the referral. For example, the date the Medicare Advantage plan case manager authorized service is not considered a referral date. If the date or month is only one digit, that digit is preceded by a "0". For example, May 4, 2012, would be entered as 05/04/2012. Enter all four digits for the year.

M0104 Date of Referral Data Sources / Resources

- Gather information from several sources:
 - Agency referral form
 - Agency records specifying the date the referral was received by the agency
 - Hospital or nursing home discharge information



Item Intent Time Points Response-Specific Instructions Data Sources/ Resources



When determining the date of referral, gather information from several sources. Obtain information from your agency referral form or from other agency records specifying the date the referral was received by the agency. You may even obtain it from the hospital or nursing home discharge information.

M0104 Scenario

Your agency received a referral on 5/4/2012, for skilled nursing for a patient who was hospitalized following an exacerbation of congestive heart failure.

The patient was still in the hospital on Wednesday, 5/6/2012. The discharge planner at the hospital provided updated referral information on 5/7/2012, when the patient was discharged.

The patient was admitted to your agency on 5/8/2012.



Let's apply the guidance we just covered by answering a question regarding this scenario.

Your agency received a referral on May 4, 2012, for skilled nursing for a patient who was hospitalized following an exacerbation of CHF. The patient was still in the hospital on Wednesday, May 6, 2012. The discharge planner at the hospital provided updated referral information on May 7, 2012, when the patient was discharged. The patient was admitted to your agency on May 8, 2012.

M0104 Scenario Question

Which date should you enter for M0104 Date of Referral?

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

___ / ___ / _____
month / day / year

- A. 05/04/2012
- B. 05/06/2012
- C. 05/07/2012
- D. 05/08/2012

[Review Scenario](#) **Select the correct response for this scenario.** 

What date should you enter in M0104 Date of Referral?

M0104 Scenario Answer

Which date should you enter for M0104 Date of Referral?

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

05 / 07 / 2012
month / day / year

A. 05/04/2012
B. 05/06/2012
C. 05/07/2012
D. 05/08/2012

That is correct! The response-specific instructions direct us to enter the date the agency received updated or revised referral information for home care services to begin as the date of referral, when the start of care is delayed due to the patient's condition or physician request.



The correct response is May 7, 2012. The response-specific instructions direct us to enter the date the agency received updated or revised referral information for home care services to begin as the date of referral, when the start of care is delayed due to the patient's condition or physician request.

M0110 Episode Timing Item Intent & Time Points

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?

- 1 - Early
- 2 - Later
- UK - Unknown
- NA - Not Applicable: No Medicare case mix group to be defined by this assessment.

- Identifies placement of the current Medicare PPS payment episode in the patient’s current sequence of adjacent Medicare PPS payment episodes.

Collected at SOC, ROC & FU

Item Intent Time Points Response-Specific Instructions Data Sources/ Resources



The intent of M0110 Episode Timing is to identify the placement of the current Medicare PPS payment episode in the patient’s current sequence of adjacent Medicare PPS payment episodes. PPS is the acronym for Medicare’s prospective payment system. This item is collected at the Start of Care, Resumption of Care, and Follow-up assessments.

M0110 Episode Timing Definitions

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current **sequence of adjacent Medicare home health payment episodes?**

- Means a continuous series of Medicare PPS payment episodes.
- Does not necessarily mean the same home health agency provided care for the entire series.



The response-specific instructions provide definitions to specific words that will assist you in scoring this item accurately. A sequence of adjacent Medicare home health payment episodes is a continuous series of Medicare PPS payment episodes, regardless of whether the same home health agency provided care for the entire series.

M0110 Episode Timing Definitions

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of **adjacent** Medicare home health payment episodes?

- “Adjacent” means there was no gap between Medicare-covered episodes of more than 60 days.
- LUPAs are counted as a Medicare payment episode.
- Periods spent “outside” a Medicare payment episode but on service with a non-Medicare payer (HMO, Medicaid, or private payer) are counted as gap days.

“Adjacent” means that there was no gap between Medicare-covered episodes of more than 60 days. When determining if episodes are adjacent, low utilization payment adjustment episodes, or LUPAs, are counted as a Medicare payment episode. LUPAs are episodes with less than five total visits. A patient may have some time “outside” a Medicare payment episode but on service with a non-Medicare payer such as an HMO, Medicaid, or a private payer. These periods are counted as gap days when counting the sequence of Medicare payment episodes.

M0110 Episode Timing Response-Specific Instructions

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?

<input type="checkbox"/>	1	-	Early	<ul style="list-style-type: none"> Select Response 1 if this is the 1st or 2nd episode of care in a current sequence of adjacent PPS episodes. Select Response 2 if this is the 3rd or later PPS episode in a sequence of adjacent episodes.
<input type="checkbox"/>	2	-	Later	
<input type="checkbox"/>	UK	-	Unknown	
<input type="checkbox"/>	NA	-	Not Applicable: No Medicare case mix group to be defined by this assessment.	

Item Intent
Time Points
Response-Specific Instructions
Data Sources/
Resources

Select Response 1 – Early if the episode of care you are assessing the patient for is the patient’s first or second episode of care in a current sequence of adjacent Medicare home health PPS payment episodes. Select Response 2 – Later if this is the third or later PPS episode in a sequence of adjacent episodes.

M0110 Episode Timing Response-Specific Instructions, cont'd

(M0110) **Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?

<input type="checkbox"/>	1	-	Early	<ul style="list-style-type: none"> Select UK if you don’t know where this episode fits in the sequence of PPS episodes. Has the same effect as “Early” for purposes of assigning a case mix code.
<input type="checkbox"/>	2	-	Later	
<input type="checkbox"/>	UK	-	Unknown	
<input type="checkbox"/>	NA	-	Not Applicable: No Medicare case mix group to be defined by this assessment.	

Item Intent
Time Points
Response-Specific Instructions
Data Sources/
Resources

“UK” means unknown. You would select this response if you don’t know where this episode fits in the sequence of PPS episodes. For the purposes of assigning a case mix code to the episode, selecting “Unknown” will have the same effect as selecting the “Early” response.

M0110 Episode Timing Response-Specific Instructions, cont'd

(M0110) **Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?

<input type="checkbox"/>	1	-	Early	<ul style="list-style-type: none"> Select NA if no Medicare case mix group is to be defined for this episode. Select another response if a case mix code is needed.
<input type="checkbox"/>	2	-	Later	
<input type="checkbox"/>	UK	-	Unknown	
<input type="checkbox"/>	NA	-	Not Applicable: No Medicare case mix group to be defined by this assessment.	

Item Intent
Time Points
Response-Specific Instructions
Data Sources/
Resources

Select “NA” if no Medicare case mix group is to be defined for this episode. If the patient needs a case mix code for billing purposes, a response other than “NA” is required to generate the code. Some payers that are not Medicare fee-for-service payers will use this information to establish an episode payment rate.

M0110 Episode Timing Data Sources / Resources

- Medicare systems, such as Health Insurance Query for Home Health (HIQH)
- Manual calculations



Item Intent Time Points Response-Specific Instructions Data Sources/ Resources



When determining the correct response for this item, you can access the Medicare systems Health Insurance Query for Home Health to obtain your answer or use manual calculations to determine the episode timing as described in the assessment strategies.

**M0110 Episode Timing
Assessment Strategies**

Calculating Episodes Manually

- Medicare home health payment episode comprises 60 days beginning with the SOC or recertification date.
- Can be a gap of up to 60 days between episodes in the same sequence.
- Count from the last day of one episode until the first day of the next episode.
- A sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap.
- Medicare episodes can be provided by different home health agencies.



If you are calculating the episodes manually, note that the Medicare home health payment episode ordinarily comprises 60 days beginning with the Start of Care date or 60 days beginning with the Recertification date. There can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next. Remember that a sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies.

**M0110 Episode Timing
Assessment Strategies, cont'd**

Calculating Episodes Manually, cont'd

- Non-Medicare fee-for-service episodes do not count as part of the sequence.
- If the period of service with a non-Medicare provider is 60 days or more, the next Medicare home health payment episode begins a new sequence.
- The 60-day gap is counted from the end of the Medicare payment episode, not from the date of the last visit or discharge.
- The last visit or discharge may occur earlier than the last day of the payment episode.



Episodes where Medicare fee-for-service is not the payer – such as an HMO, Medicaid, or private pay – do NOT count as part of the sequence. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence. Keep in mind that the 60-day gap is counted from the end of the Medicare payment episode, not from the date of the last visit or discharge. The last visit or discharge can occur earlier. If, however, the episode is ended by an intervening event that causes it to be paid as a partial episode payment, or PEP, adjustment, then the last visit date is the end of the episode.

M0110 Scenario

Your agency is admitting a Medicare patient who was discharged previously from your agency 90 days ago at the end of their certification period.



Now let's apply what we just covered by answering the question regarding this scenario. Your agency is admitting a Medicare patient who was discharged previously from your agency 90 days ago at the end of their certification period.

M0110 Scenario Question

What would be the correct response for M0110 Episode Timing?

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?

- 1 - Early
- 2 - Later
- UK - Unknown
- NA - Not Applicable: No Medicare case mix group to be defined by this assessment.

[Review Scenario](#) **Select the correct response for this scenario.** 

What would be the correct response for M0110 Episode Timing?

M0110 Scenario Answer

What would be the correct response for M0110 Episode Timing?

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an “early” episode or a “later” episode in the patient’s current sequence of adjacent Medicare home health payment episodes?

<input type="checkbox"/>	1 -	Early
<input type="checkbox"/>	2 -	Later
<input type="checkbox"/>	UK-	Unknown
<input type="checkbox"/>	NA-	Not Applicable: No Medicare case mix group to be defined by this assessment.

That is correct! Because the patient’s gap in service from the end of the last payment episode to the beginning of the new payment episode is 90 days, it does not meet the definition of an adjacent episode. In order to be adjacent, there must have been a gap of less than 60 days. Therefore, when the patient is readmitted to your agency, they begin a new sequence of Medicare Prospective Payment episodes, and you would select response 1, indicating it is an early episode.

That is correct! Because the patient’s gap in service from the end of the last payment episode to the beginning of the new payment episode is 90 days, it does not meet the definition of an adjacent episode. In order to be adjacent, there must have been a gap of less than 60 days. Therefore, when the patient is readmitted to your agency, they begin a new sequence of Medicare Prospective Payment episodes, and you would select Response 1, indicating it is an early episode.



We have completed the instruction for this module. You may want to review the material again or refer to the CMS OASIS-C Guidance Manual and Q & As. Let's recap some highlights of what we learned in this module.

Summary of Domain

- Understand each item and individual responses.
- Use Chapter 3 of the OASIS-C Guidance Manual as your reference for the following concepts:
 - Item intent
 - Time points for completion
 - Response-specific instructions
 - Data sources and resources
- Additional guidance can be found in the CMS Q & As and the CMS Quarterly Q & As.



In order to collect the items in the Clinical Record Item domain accurately, it is important for the assessing clinician to understand each item and its individual responses. Use Chapter 3 of the OASIS-C Guidance Manual as your reference to apply concepts and details related to the intent of each OASIS item, when each item should be completed, what the various response options mean, and what data sources and resources you can use to facilitate an accurate assessment. Additional guidance related to data collection of the Clinical Record Items can be found in the CMS Q & As and the CMS Quarterly OASIS Q & As.

Resources / References

- OASIS-C Guidance Manual
 - <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html>
 - Chapter 3 provides guidance on OASIS-C questions.
- CHAMP Program
 - www.champ-program.org/
- Home Health Quality Improvement (HHQI) National Campaign
 - www.homehealthquality.org
- OASIS Answers, Inc.
 - www.oasisanswers.com



Additional resources and references can be accessed at the links listed here. Particularly important is the guidance in Chapter 3 of the OASIS-C Guidance Manual, which served as the foundational content for this educational module. Home care nurses and therapists responsible for collecting OASIS data should consider having a copy of the Chapter 3 guidance accessible while conducting comprehensive assessments to enhance data accuracy.

Questions

- Talk with your clinical managers.
- Check the CMS Q & As.
 - www.qtso.com/hhdownload.html
- Check the Quarterly Q & As.
 - www.oasisanswers.com
- Contact your State OASIS Educational Coordinator.
 - www.cms.gov/OASIS/Downloads/OASISeducationalcoordinators.pdf
- Submit Q & As to CMS.
 - Send email to CMSOASISquestions@oasisanswers.com.
- Email the OASIS training feedback site.
 - oasisctrainingfeedback@cms.hhs.gov

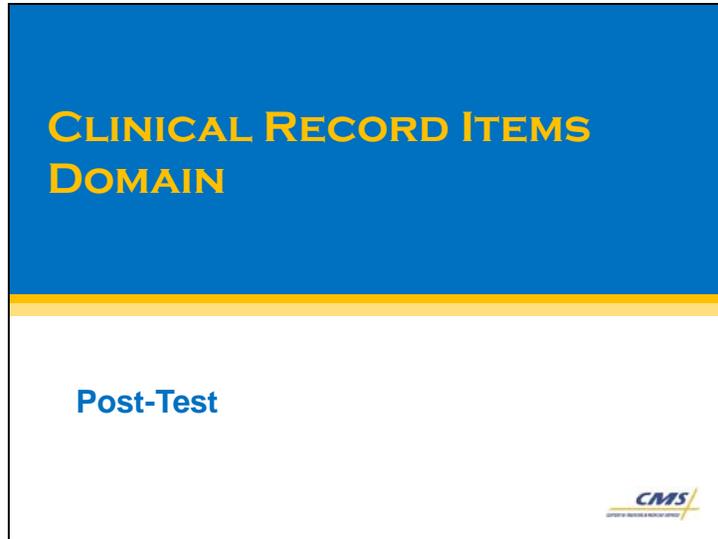


If you have questions, consider talking with your clinical manager, consult the guidance contained in Chapter 3 of the OASIS-C Guidance Manual, and review the additional guidance included in the CMS Q & As and the Quarterly Q & A updates, available at the links provided here. If you still have unanswered questions, contact your State OASIS Educational Coordinator, who can provide free assistance in answering your OASIS data collection questions.

If your question cannot be resolved with the help of your OEC, consider submitting your inquiry to the CMS OASIS mailbox at CMSOASISquestions@oasisanswers.com

If you have comments related to this web module, please consider providing feedback to the OASIS training feedback mailbox at oasisctrainingfeedback@cms.hhs.gov.

Thank you for your commitment to OASIS Accuracy.



This is the Clinical Record Items Domain Module Post-Test. This test consists of five questions covering the material covered in this lesson.

Post-Test Question #1 Scenario

Your patient has been on service for one certification period.

It has been determined in Case Conference that the patient has unmet needs related to balance, gait, and home modifications and requires continued assessment and teaching due to new medications.

Nursing, Physical Therapy, and Occupational Therapy are seeing the patient. During the recertification window (Days 56-60), the RN is scheduled on Day 56, the Occupational Therapist is scheduled on Day 58, and the Physical Therapist is scheduled on Day 59.

Select the Forward button to continue.



Post-Test Question #1

Which of following statements is true regarding the Recertification comprehensive assessment?

- A. The Registered Nurse is the only discipline who would complete the Recertification comprehensive assessment since there are orders for nursing.
- B. The Physical Therapist is the only discipline who would complete the Recertification comprehensive assessment since they are the last discipline to see the patient in the Recertification window.
- C. The Occupational Therapist is the only discipline who would complete the Recertification comprehensive assessment since this is the only assessment this discipline can complete.
- D. The Registered Nurse, Physical Therapist, or Occupational Therapist may perform the Recertification assessment.

The correct answer is Response D. The Registered Nurse, Physical Therapist, or Occupational Therapist may perform the Recertification assessment. The Registered Nurse, Physical Therapist, or Occupational Therapist may perform the ROC, Follow-up, and Discharge assessments as well as complete the Transfer to Inpatient and Death at Home OASIS.



The correct answer is Response D. The Registered Nurse, Physical Therapist, or Occupational Therapist may perform the Recertification assessment. The Registered Nurse, Physical Therapist, or Occupational Therapist may perform the ROC, Follow-up, and Discharge assessments as well as complete the Transfer to Inpatient and Death at Home OASIS.

Post-Test Question #2

M0090 Date Assessment Completed is defined as what?

- A. The same day as Start of Care
- B. A date other than the Start of Care date.
- C. The date when the final assessment data are collected
- D. The date of the first home care visit

The correct answer is Response C. The date when the final assessment data are collected. M0090 Date Assessment Completed is defined as the date when the final assessment data are collected. Per the response specific instructions that define M0090 Date Assessment Completed, enter the last date when final assessment data are collected if agency policy allows for assessments to be performed over more than one visit date. Although the date the final assessment data are collected may be on the Start of Care Date or after the Start of Care Date, the definition remains the last date when final assessment data are collected.



The correct answer is Response C. The date when the final assessment data are collected. M0090 Date Assessment Completed is defined as the date when the final assessment data are collected. Per the response-specific instructions that define M0090, enter the last date when final assessment data are collected if agency policy allows for assessments to be performed over more than one visit date. Although the date the final assessment data are collected may be on the Start of Care date or after the Start of Care date, the definition remains the last date when final assessment data are collected.

Post-Test Question #3

You admit a patient to your agency following an ORIF of the right hip. Three weeks into the episode, the patient experiences a new onset of 2+ pitting edema to calves bilaterally, rales bi-basilar, and shortness of breath. The patient is seen in the ER and diagnosed with a new diagnosis of CHF. The patient is not admitted to the hospital and returns home later in the day with new orders for the RN to educate on CHF, new medications, and instructions to notify the MD if the patient's condition deteriorates. The patient's symptoms meet the agency's policy related to a major decline in condition.

Which comprehensive assessment should the clinician complete?

- A. RFA 3, Resumption of Care Assessment
- B. RFA 6, Transfer to inpatient facility – not discharged from the agency
- C. RFA 5, Other Follow-up Assessment
- D. RFA 4, Recertification Follow-up Assessment

The correct answer is Response C. RFA 5, Other Follow-up Assessment. The patient condition in this scenario meets the agency's definition of a major decline in condition. The response-specific instructions for M0100 Reason for Assessment state that this assessment is conducted due to a major decline or improvement in patient's health status occurring at a time other than during the last five days of the episode.



The correct answer is Response C. RFA 5, Other Follow-up Assessment. The patient condition in this scenario meets the agency's definition of a major decline in condition. The response-specific instructions for M0100 Reason for Assessment state that this assessment is conducted due to a major decline or improvement in patient's health status occurring at a time other than during the last five days of the episode.

Post-Test Question #4

Your agency receives a referral for a patient on 05/20/2012 with orders to provide wound care on 5/21/2012. The patient does not leave the hospital until 5/27/2012. At the time of discharge, the discharge planner updates the referral information with the order for Start of Care and wound care to begin on 5/28/2012.

Based on this scenario, which of the following represents accurate scoring?

- A. M0102 Physician-ordered Start of Care Date is 05/28/2012 and M0104 should be skipped
- B. M0102 Physician-ordered Start of Care Date is 05/21/2012 and M0104 should be skipped
- C. M0102 is NA and M0104 Date of Referral is 05/20/2012
- D. M0102 is NA and M0104 Date of Referral is 05/27/2012

The correct answer is Response A. M0102 Physician-ordered Start of Care Date is 05/28/2012 and M0104 should be skipped. The response-specific guidance for M0102 states that if the originally ordered Start of Care is delayed, then the date specified on the updated/revised order to start services would be considered. If a date is entered in M0102, then M0104 would not be answered.



The correct answer is Response A. M0102 Physician-ordered Start of Care Date is 05/28/2012, and M0104 should be skipped. The response-specific guidance for M0102 states that if the originally ordered start of care is delayed, then the date specified on the updated/revised order to start services would be considered. If a date is entered in M0102, then M0104 would not be answered.

Post-Test Question #5

You are performing the Start of Care Comprehensive Assessment, and your Medicare patient tells you that they were on service with another home care agency last month. You ask the patient how long she was on service with them, and she tells you she was on service with them for 6 months. You verify this information with your supervisor and find that your patient was discharged 30 days ago from the other home care agency, at which she was a patient for 6 months.

What is the correct response for M0110 Episode Timing?

- A. Early
- B. Later
- C. Unknown
- D. Not applicable: No Medicare Case-mix group to be defined by this assessment

The correct answer is Response B. Later. The episodes would be considered adjacent since there are fewer than 60 days between episodes, even though the care was provided by another agency previously for 3 certifications. This episode is reported as "Later" because this admission to home care would represent the fourth episode in a series of adjacent Medicare PPS episodes.



The correct answer is Response B. Later. The episodes would be considered adjacent since there are fewer than 60 days between episodes even though the care was provided by another agency previously for 3 certifications. This episode is reported as "Later" because this admission to home care would represent the fourth episode in a series of adjacent Medicare PPS episodes.
