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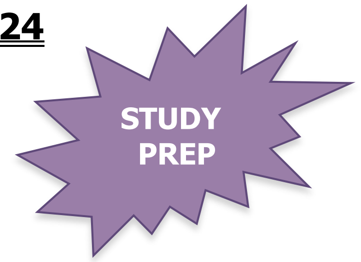
Application Scenarios for Quarterly OASIS Update – April 2024



COS-C Exam Candidates - Simulate exam conditions by:

- answering the following 5 questions in 7 ½ minutes,
- accessing any paper resource you choose for references, &
- recording your response in the corresponding lettered bubble.

Scenario 1: After completing the Resumption of Care comprehensive assessment including OASIS, the assessing clinician receives communication from the external auditor that reviews the agency's OASIS. The communication suggests that the response to M2020 - Management of Oral Medications, which was coded as 2 - Able to take medication(s) at correct times if given reminders, should be changed to 3 - Unable to take medication unless administered by another person solely based on the fact that M1860 - Ambulation/Locomotion was coded as 3 - Able to walk only with the supervision or assistance of another person at all times.

Q1: What is the most compliant approach the assessing clinician could take in this scenario?

A. Automatically change the coding to M2020.

B. Only change the coding to M2020 after going back out to see the patient and reassess their ability to manage their oral medications and ambulate.

C. Review all the available documentation and the suggested recommendation and determine if a change in coding is warranted or if the items were coded correctly based on their assessment and the guidance for M2020.

D. Automatically change the coding to M1860.

1. (A) (B) (C) (D)

Scenario 2: During the discharge assessment, Mr. Weathers demonstrates his ability to bathe in the shower. During the assessment, the assessing clinician determines he requires supervision to go up the stairs to access the only bathroom with a shower located on the 2nd floor. He then transfers into the shower with verbal cues for correct hand placement when using the grab bars. Once Mr. Weathers is in the shower, he is able to sit down on the shower chair and wash his body independently.

Q2: Based on this scenario, how should M1830 - Bathing be coded?

A. 1 - With use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.

B. 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
   a. For intermittent supervision or encouragement or reminders, OR
   b. To get in and out of the shower or tub, OR
   c. For washing difficult to reach areas.

C. 3 - Able to participate in bathing self in shower or tub, but requires presences of another person throughout the bath for assistance or supervision.

D. 4 - Unable to use the shower or tub, but able to participate in bathing self

2. (A) (B) (C) (D)

Scenario 3: During Ms. Stormy's Start of Care assessment, she informs the assessing clinician that prior to her hospitalization for pneumonia, she was able to complete all the activities of self-care independently. She also informs the clinician that twice a week a helper would come over at the insistence of her daughter to "supervise" Ms. Stormy while she took a shower. On all other days of the week, when she took showers, she did not require any assistance. Ms. Stormy states that she doesn't actually need any help from the person that comes over, but her daughter is adamant that someone be there at least a couple of times a week.

Q3: How should GG0100A - Prior Functioning: Everyday Activities; Self Care be coded?

A. 3 - Independent

B. 2 - Needed Some Help

C. 1 - Dependent

D. 9 - Not Applicable

3. (A) (B) (C) (D)

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Scenario 4: While completing the discharge comprehensive assessment including OASIS for your patient, you note in the record that at the beginning of the quality episode the patient experienced a TIA during a nursing visit and subsequently fell to the ground. Only minor injuries such as a skin tear and bruising were noted following the fall.

Q4: Based on this scenario how would you code J1800 - Any Falls Since SOC/ROC on the discharge OASIS?

A. 0 - No

B. 1 - Yes

C. Dash (-)

D. Leave J1800 blank

4. (A) (B) (C) (D)

Scenario 5: Your agency has a policy that when completing a patient's drug regimen review, clinicians must call the physician to inform them of every drug alert identified by the agency's EMR. When completing a Resumption of Care assessment on a patient, after entering the medications into the system, a medication interaction is triggered because the patient is on both coumadin and aspirin. The patient had a TKR performed by a surgeon that places all of their patients on coumadin and aspirin post-surgery for two weeks. Since this is a known and common practice of this surgeon, the assessing clinician does not feel that the medication alert warrants communication to the physician by midnight of the next calendar day. There were no other drug alerts identified by the EMR and the clinician did not find anything else related to the patient's medications that, in their clinical judgment, would require physician communication.

Q5: How should M2001 - Drug Regimen Review be coded for this scenario?

A. Dash (-)

B. 0 - No; No issues found during review

C. 1 - Yes; Issues found during review

D. 9 - NA; Patient is not taking any medications

5. (A) (B) (C) (D)