FAQ from the webinar:

OASIS-E CAM

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On January 1, 2023, the Centers for Medicare & Medicaid Services (CMS) implemented the new OASIS-E, which updated many of the Outcome and Assessment Information Set (OASIS) assessment processes. If conducted correctly, the Confusion Assessment Method (CAM©) can provide significant insights that can support care planning decisions and facilitate setting achievable and relevant patient goals, which will inform OASIS-E.

In a recent educational webinar from WellSky®, home health & hospice consultant, Beth Noyce, RN, BSJMC, HCS-C, BCHH-C, COQS, Noyce Consulting, presented a breakdown of the CAM, the correct way to execute the evaluation, and how to apply the results to patient care while setting realistic goals for the patient's overall well-being. This webinar is now available to watch on-demand. **In this new tip sheet, Beth provides answers to the most frequently asked questions from the webinar.**

Q: Do the CAM questions have to be asked in front of the patient or can the clinician use clinical judgement to report the OASIS scores?

A: The OASIS-E Manual describes the CAM as, "*an instrument that screens for overall cognitive impairment as well as features to distinguish delirium or reversible confusion from other types of cognitive impairments.*" Here is some additional information on the CAM's development.

CAM stands for Confusion Assessment Method and is, rather than an interview of its own, a way of looking at the patient's responses to the clinician's interactions with the patient, especially during the Brief Interview for Mental Status (BIMS).

Q: We see a lot of scrubber errors in the electronic health record (EHR) with dementia and depression patients responding to M1745 if patients are not disruptive. How can we move forward with this?

A: The scrubber errors you are receiving likely are warnings that what you documented at M1745 has a high likelihood of contradicting something documented elsewhere in the OASIS-E comprehensive assessment. It does not generally mean that what you've documented cannot be true. However, when you receive such an alert, I recommend documenting in your narrative why **both** the response you selected at M1745 **and** whatever the scrubber is pointing at as contradictory are both true. Remember that the OASIS items are not intended to capture all information and the scrubber is queueing you to make your documentation complete. A reviewer reading the information you enter may have the same qualms as the scrubber if you don't explain the apparent discrepancy.

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Q: How would you conduct the BIMS if your patient has expressive aphasia? Meaning that they can understand the questions but cannot make clear what they are trying to say as their answer. They aren't necessarily "rarely understood" but cue cards wouldn't really help either. What do we do in this case?

A: I recommend determining if the patient can be understood in any way. If no form of communication would allow the patient with expressive aphasia to express their responses in understandable ways, I recommend entering 0 at C0100 and describing in your narrative why you determined through your clinical judgement that the patient would be unable to complete the BIMS.

Q: What do you do about patient refusals?

A: The patient has a right to refuse any assessment or treatment, as is indicated in patient rights. If the beneficiary refuses to answer C0200 – C0400C, enter 0 when a patient refuses to answer, gives an incorrect answer, or gives a nonsensical response, unless the item itself provides a different accurate response. No responses other than 0 are correct when the patient refuses. If the patient refuses to continue the BIMS at any point, enter a dash in each of the remaining items, indicating the interview was stopped. Then enter 99 in C0500. Or, if you've entered a dash in all other items in the BIMS, enter a dash at C0500 as well, and document why in your narrative.

Watch CMS' YouTube video here on how to code a stopped or incomplete BIMS.

Q: What can an agency do if acute mental status changes are identified at discharge?

A: If an acute mental status change is identified at discharge, use your clinical judgement to determine whether the patient should still be discharged or continue to receive, and still qualifies for, home health services. At a minimum, inform the patient's physician of the change and assess the patient for potential causes of the acute change. If your clinical judgement indicates that the change is an emergency, facilitate further treatment for the patient either directly through the patient's physician or by sending the patient to a nearby emergency department. If needed, alert the Emergency Medical System (EMS) system for transport.

Q: Why does the BIMS have to be done before the CAM?

A: The CAM cannot be completed without first conducting the BIMS because responses to the items in the CAM depend on how the patient responds to the BIMS as well as other sources such as caregivers and the patient's healthcare record. If the clinician determines that the BIMS should not be performed on the particular beneficiary because the individual is rarely or never understood, or because the patient refuses, the clinician must rely on the patient's responses to other interactions with the patient during the comprehensive assessment as well as other available sources to respond to the items found within the CAM.

Q: How does the CAM determine that delirium is present in the patient?

A: The OASIS-E manual, page 86, shows the CAM Assessment Scoring Methodology. Remember that the assessing clinician is not diagnosing delirium, but rather determining whether the patient has signs and symptoms of delirium which must be reported to the physician. A key word here is "acute," meaning that any change witnessed is not normal for the patient and developed recently or suddenly and is potentially harmful. That said, determining if the patient is experiencing an acute change in mental status is central to getting the patient urgent treatment. The CAM provides multiple opportunities to capture this change through assessing whether a change has occurred, then indicating which type or symptoms of delirium, including inattention, disorganized attention and/or altered level of consciousness, are present in the patient. These symptoms of delirium can be manifestations of dangerous, but often reversible problems, such as untoward medication reactions, electrolyte imbalance, infection or other maladies that could cause serious morbidity if not addressed promptly. Below is the scoring for the CAM assessment, which shows how each of the delirium-pointing symptoms can help identify delirium.

CAM Assessment Scoring Methodology

The indication of delirium by the CAM requires the presence of:

Item A = 1 **OR** Item B, C, or D = 2

AND

Item B = 1 OR 2

AND EITHER

Item C = 1 OR 2 **OR** Item D = 1 OR 2

Q: Should a clinician repeat the CAM after a patient receives treatment to reverse delirium?

A: No regulation from Medicare requires repeating the CAM once a patient receives care to reverse delirium. However, doing so would provide helpful documentation showing that the symptoms are gone or have changed. Each agency should have a policy in place to determine when the patient should receive an OASIS comprehensive assessment based on a Significant Change in Condition (SCIC) for the better or for the worse. If an agency determines that a level of consciousness change indicates that the SCIC OASIS assessment should be performed, the clinician should follow the agency's policy and do so.

References

- OASIS-E Manual Chapter 3, Section C
- CMS' YouTube video on the BIMS and BIMS Summary Score
- Graphic source: The OASIS-E manual, page 8

About the author

Beth Noyce, RN, BSJMC, HCS-C, is a home health and hospice consultant, mentor, educator and regulatory expert. She draws on her 25-year home health and hospice leadership and patient-care experience to help agencies know when they are at risk. Beth was Executive Director of the Utah Hospice and Palliative Care Organization and the Utah Association for Home Care in 2018 and 2019. Beth was a hospice and home health associate with The Corridor Group and with Pinnacle Enterprise Risk Consulting Services and has created study guides and questions for industry coding and compliance certification exams and online courses.

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