One Clinician Convention Expansion/Collaboration

QUESTION 1: (Note: This guidance was first posted on the CMS Home Health Quality Initiative website in August 2017 as “CMS OASIS Q&A – Expansion of the One Clinician Convention”.)

I am aware that it is my responsibility as the assessing clinician to complete the comprehensive assessment document that includes appropriate OASIS data items and the drug regimen review. Can I get help from my interdisciplinary team when collecting OASIS data and selecting responses?

ANSWER 1: Yes. Effective January 1, 2018, as the assessing clinician, you may elicit input from the patient, caregivers, and other health care personnel, including the physician, the pharmacist and/or other agency staff to assist you in your completion of any or all OASIS items integrated within the comprehensive assessment document. Some elements, for instance the Clinical Records Items (Patient Name, Birth Date, Medicare Number, etc.), may be completed initially by clerical staff as part of the intake/referral process; but should be verified by the assessing clinician when completing the assessment. For OASIS items requiring a patient assessment, the collaborating healthcare providers (e.g., other agency clinical staff: LPN/LVN, PTA, COTA, MSW, HHA) should have had direct in-person contact with the patient, or have had some other means of gathering information to contribute to the OASIS data collection (health care monitoring devices, video streaming, review of photograph, phone call, etc.) Of course, in their collaborative efforts, all staff, including professional assistants or non-clinical staff, are expected to function within the scope of their practice and state licensure. For OASIS items that reflect clinical/patient assessment (e.g., height, weight, functional status, pressure ulcer status), HHA’s should base OASIS responses on assessment by agency staff, and not directly on documentation from previous care settings. It is the responsibility of the agency to ensure the completeness and accuracy of the OASIS. Agencies should follow practices in accordance with provider policies and procedures related to staff communication and patient information to track and/or identify those staff members contributing to the patient assessment information.

In the case of an unplanned or unexpected discharge (an end of home care where no in-home visit can be made), the last qualified clinician who saw the patient may complete the discharge comprehensive assessment document based on information from his/her last visit. The assessing clinician may supplement the discharge assessment with information documented from patient visits by other agency staff that occurred in the last 5 days that the patient received visits from the agency prior to the unexpected discharge. The “last 5 days that the patient received visits” are defined as the date of the last patient visit, plus the four preceding days. If desired, agencies may continue to limit the OASIS to only that data directly assessed and collected by the single assessing clinician. This guidance became effective January 1, 2018, and since that time should be considered to supersede all previously published guidance related to application of the one clinician convention.

QUESTION 2: The aide who visited the patient on Monday, discovered the patient had been hospitalized for two days and discharged home on Sunday. The RN visits the patient on Tuesday to do the ROC assessment and the PT visits on Wednesday, and the OT visits the patient on Thursday. Based on the expanded collaboration allowed effective January 2018, could the nurse use information from the aide and the PT and OT visits to complete ROC OASIS items?
**ANSWER 2:** At ROC, the assessing clinician may supplement his/her assessment with information from visits conducted by other agency staff within the assessment timeframe. A ROC assessment must be completed within 2 calendar days of facility discharge or knowledge of the patient’s return home, or (effective 1/13/18) on the physician’s ordered ROC date. In this scenario, the ROC date is Monday (the date of the first visit following a qualifying inpatient stay) and the assessment must be completed by Wednesday (2 calendar days of agency knowledge of the patient’s return home). If desired, the nurse may use the information from the three visits that occur within the assessment time frame (i.e., the HHA visit on Monday, the RN assessment on Tuesday, and the PT visit on Wednesday) to complete the ROC assessment. The OT visit on Thursday is outside the assessment timeframe and information from that visit may not be considered when determining OASIS responses. When collaboration is utilized, the assessing clinician is responsible for considering available input from these other sources and selecting the appropriate OASIS item response(s), within the appropriate timeframe and consistent with data collection guidance. M0090 (Date Assessment Completed) will indicate the last day the assessing clinician gathered or received any input used to complete the comprehensive assessment document, which includes the OASIS items. The comprehensive assessment is a legal document and when signed by the assessing clinician, the signature serves as an attestation that to the best of his/her knowledge, the document, including OASIS responses, reflects the patient status as assessed, documented and/or supported in the patient’s clinical record.

**M0030 Q36. Could you explain what the term “start of care” actually means? Is it related to payment?** [Q&A Reviewed 09/09]

**Answer:** The start of care is established on the date the first billable service is provided.

**Q36.1 M0030 I understand that comprehensive assessment cannot be completed before the SOC date. Does this mean it’s OK to start it at the initial assessment as long as it is not completed until on or after the SOC date?** [Q&A EDITED 06/14; Previously CMS OCCB 01/08 Q&A #1]

**A36.1:** The SOC is established on the day the first billable service is provided. The SOC comprehensive assessment must be completed on or within 5 days after the start of care date. An initial assessment may be performed prior to the SOC date, (e.g. RN admitting for a therapy only case). If agency policy is for the RN to perform the initial assessment during a non-billable visit in order to meet the Condition of Participation {484.55} time requirement of 48 hours for the completion of the initial assessment, and the RN does not provide a billable service, the SOC is not yet established. If the PT does not visit that same day, the date of the RN’s assessment visit is not the SOC date. If the PT visits the next day, the SOC date is the day the PT visits and provides a billable service. While the RN likely conducted at least part of a comprehensive assessment in order to meet the requirements of an initial assessment visit to determine immediate care and support needs of the patient, any information collected on that date may not contribute to the SOC comprehensive assessment, as it was collected prior to the SOC date. The SOC comprehensive assessment that will include the OASIS data that will be transmitted to the OASIS system as the SOC assessment must be collected on or within 5 days after the SOC date, not before.
QUESTION 3: A complete referral is received from a physician at an inpatient facility on 01/01/2020 and has a diagnosis that does not fall into a PDGM clinical grouping; patient is discharged to home health on 01/01/2020. Intake staff calls physician requesting a more specific diagnosis. The more specific diagnosis is received on 01/04/2019 and care is started on 01/05/2020. Will M0104 be changed to 01/04/2020 based on the update to the specificity of the diagnosis?

ANSWER 3: M0104 specifies the referral date, which is the most recent date that verbal, written, or electronic authorization to begin or resume home care was received by the home health agency.

A valid referral is considered to have been received when the agency has received adequate information about a patient (name, address/contact info, and diagnosis and/or general home care needs) and the agency has ensured that the referring physician, or another physician, will provide the plan of care and ongoing orders. In the scenario described, if your agency received adequate information as outlined above (including a relevant diagnosis) a valid referral is present on 1/1/2020 to allow the home health admission to be initiated and the M0104 date would be based on the date the referral was received. The assessment process, along with collaboration with the physician, may lead to identification of additional diagnoses for care planning and/or reimbursement purposes.

In the scenario described, if your agency received adequate information as outlined above (including a relevant diagnosis) a valid referral is present on 1/1/2020 to allow the home health admission to be initiated and the M0104 date would be based on the date the referral was received. The assessment process, along with collaboration with the physician, may lead to identification of additional diagnoses for care planning and/or reimbursement purposes.
Q23.11.3. M0104. The home health agency received a referral on June 1st, and then on June 2nd received a faxed update with additional patient information that indicates a possible delay in the patient’s hospital discharge date. What is the referral date for M0104? [Q&A ADDED 01/11; Previously CMS OCCB 10/09 Q&A #3]

A23.11.3. If start of care is delayed due to the patient’s condition or physician request and no date was specified as the start of care date, then the date the agency received updated/revised referral information for home care services to begin would be considered the date of referral. In your scenario, June 2 is the correct response for M0104.

Q23.11.2.01 M0102/M0104. When following the guidance in Cat 2 Q61 for a late F2F situation, how should M0102 – Date of Physician ordered SOC/ROC and M0104 Date of Referral be answered, as M0030 (Start of Care date) will change based off of the first billable visit? This “workaround” for the late F2F has the potential to have a negative impact on the timely initiation of care process measure.

Category 2 Q61: If the face-to-face does not occur within 30 days after the start of care (SOC), but it does occur, for example, on the 35th day, how should OASIS data be collected and submitted?

Answer (excerpt): Where a face-to-face encounter did not occur within the 90 days prior to the SOC or within 30 days after the SOC, a provider may use an existing OASIS assessment to generate another OASIS with a reported SOC date equal to the first visit date after all Medicare HH eligibility criteria are met. If multiple OASIS assessments exist, the data from the assessment conducted closest to the date of Medicare eligibility should be used.

[Q&A ADDED 10/16; Previously CMS Qtrly 01/16 Q&A #2]

A23.11.2.01 In the scenario cited, where a new Start of Care date is established based on the completion of a late face-to-face encounter for Medicare eligibility, report M0102 – Date of Physician-ordered SOC as “NA” and report M0104 -Date of Referral, as the day prior to the new Start of Care date.

QUESTION 1: With the expansion of the One Clinician Convention noted in the CMS OASIS Q&A August 2018, information gathered during the last 5 days that visits were provided can be used to contribute to completion of an unexpected discharge. Can this 5-day collaboration lookback also be used for ROC, Recert, or a planned discharge OASIS?

ANSWER 1: For a planned or unplanned discharge, the assessment must be completed within 2 days of the discharge date, and information from the last five days the agency provided visits may be considered by the assessing clinician when selecting OASIS responses. The “last 5 days that the patient received visits” are defined as the date of the last patient visit, plus the four preceding calendar days. For a Resumption of Care, the current data collection guidance states that the assessment time frame (the maximum number of days in which the assessment must be completed) is within two days of the inpatient facility discharge (or knowledge of the discharge), or on the physician-ordered ROC date; and the time-period under consideration (the period of time in which the patient’s status can be considered when selecting a response) for most items is the “day of assessment”, which is defined as “24 hours immediately preceding the visit and the time spent in the home.” For a Recertification, the assessment time frame is the last five days of the certification period, and the time-period under consideration for most items is the “day of assessment,” which is defined as “24 hours immediately preceding the visit and the time spent in the home.”
QUESTION 4: The new HH CoPs state that the comprehensive assessment (including OASIS) must be updated within 48 hours of the patient’s return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician-ordered resumption date. I understand that I must provide the ROC visit on the physician ordered ROC date, but do I need to also complete the entire ROC assessment on that date? Or do I have 48 hours from the physician-ordered ROC date to complete the assessment?

ANSWER 4: When the physician specifies a date that home care services must resume (a physician-ordered Resumption of Care date), the agency is expected to conduct the ROC visit on that date. The agency has up to 2 calendar days from the ROC date (M0032) to complete the ROC assessment document (M0090). For example, if the patient is discharged from the hospital on September 1, and the physician orders home care to resume on September 4, the M0102 - Date of Physician-ordered Resumption of Care date is 09-04-XXXX, the M0032 Resumption of Care date is 09-04-XXXX, and the M0090 Date Assessment Completed can be anytime on or between 09-04-XXXX and 09-06-XXXX.

M0102, M0104

QUESTION 5: Now that the physician can order a ROC date that goes beyond 48 hours from hospital discharge, can that date ever be extended? Our patient was discharged from the hospital on Tuesday and the referral included orders to resume his care on Friday. When we called to arrange the time of the visit, he said he had other medical appointments on Friday and to come Monday. We called the ordering physician Friday requesting a delay in the ROC and received a call back on Monday approving the delay in ROC. How do we answer M0102?

ANSWER 5: To report this new updated/revised physician’s ordered resumption of care date in M0102, it must have been received on or before the date of the previous physician’s ordered resumption of care. If the order to extend the physician's ordered resumption of care date is received after the date of the previous physician’s ordered resumption of care date has passed, report NA for M0102 and report the original referral date in M0104. In your scenario, since you received the updated physician ordered resumption of care date after the original physician ordered resumption

Q23.11.2.2. M102 & M104. We received a referral for home care but were unable to reach the patient for several days. We notified the physician of the problem. When we finally reached the patient, he requested we start care a week after the original order date. We sent a fax to the MD 5 days after the original order was received requesting a delay in the SOC with a specific date 3 days from then. If we received the order back from the MD prior to that new date, how do we answer M0102, Physician-ordered SOC date and M0104, Date of Referral?

A23.11.2.2. The OASIS-C Guidance Manual, Chapter 3, Response-Specific Instructions state "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)." In order to report this new updated/revised physician’s ordered start of care date in M0102, it must have been received before the end of the 48 hour initial assessment timeframe (or before the date of the previous physician's ordered start of care date, if one was provided). If the order to extend the physician's ordered start of care date is
received after the 48 hour initial assessment time frame (or after the date of the previous physician's ordered start of care date, if one was provided), report NA for M0102 and report the original referral date in M0104. In your scenario, since you received the updated physician ordered resumption of care date after the original physician ordered resumption of care date had passed, report NA for M0102 and the original referral date (Tuesday) in M0104.

RISK FOR HOSPITALIZATION

Q17. M1033 Please provide any definitions or parameters for M1033 Risk for Hospitalization, response 5 – Decline in Mental, Emotional, or Behavioral Status in the past 3 months? [Q&A POSTED 10/19]

Answer: A decline in mental, emotional, or behavioral status is considered a change in which the patient, family, caregiver or physician has noted a decline regardless of the cause. A decline may be temporary or permanent. Physician consultation or treatment may or may not have occurred.

Q18. M1033 What medications are included in M1033 Risk for Hospitalization, response 7 – Currently taking 5 or more Medications? Are herbals and oxygen included?

Answer: Medications include prescribed and over the counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route. Medications may also include total parenteral nutrition (TPN) and oxygen (as defined in M2001 Drug Regimen Review).

INFLUENZA AND PNEUMONIA VACCINATIONS

Q62.5. M1046, M1051 & M1056. Due to state law and/or agency policies, some home health staff may not be allowed to transport meds (including vaccines)? Patient and/or the family members might need to pick the vaccine up for the agency to administer. How would the agency get credit for these outcome measures? [Q&A EDITED & M number updated 06/14; ADDED 01/11; Previously CMS OCCB 01/10 Q&A #5]

A62.5. The process measures describing the best practice gives credit not only when the agency provides the immunization(s) (regardless of who transports the vaccine to the patient’s home), but the agency also may get credit by facilitating the patient’s receipt of the immunization through other health care providers. This facilitation will be represented in M1046 and M1056, and computation of these related process measures will rely on both M1041 and M1046 (for influenza) and M1051 and M1056 (for pneumonia).

HEIGHT/WEIGHT
Q2. M1060 The new OASIS submission specifications state that the Item Values for M1060 Height have been revised to allow a minimum value of 50 inches and a maximum value of 80 inches. How would a clinician record a height of less than 50 inches or greater than 80 inches? Also, item Values for M1060 Weight have been revised to allow a minimum of 65 pounds and a maximum value of 440 pounds. How would patient weight falling outside of these parameters be recorded? [Q&A POSTED 01/19]

A2: The OASIS submission specifications indicate values entered for height and weight that fall outside of the provided parameters will cause a fatal error and prevent an OASIS assessment from being transmitted.

It is correct that the parameters for M1060 Height are a minimum value of 50 inches and a maximum value of 80 inches and the parameters for M1060 Weight are a minimum value of 65 pounds and a maximum value of 440 pounds.

In the unique situation that the patient’s height and/or weight falls outside of the parameters, a dash should be used to enable the OASIS assessment to be submitted.

SEN SOR Y

Q64.1 M1200 If a patient has a physical deficit, such as a neck injury, limiting his range of motion, which affects his field of vision and ability to see obstacles in his path how is M1200, Vision to be answered? Is the physical impairment to be considered? Visual acuity has not been affected. [Q&A added 08/07; M number updated 09/09; Previously CMS OCCB 07/07 Q&A #6]

Answer Q64.1. : When selecting the correct response for M1200, Vision, the clinician is assessing the patient’s functional vision, not conducting a formal vision screen or distance vision exam to determine if the patient has 20/20 vision. Therefore physical deficits or impairments that limit the patient’s ability to use their existing vision in a functional way would be considered. If a patient sustained an injury that limits neck movement, the patient may not be able to see obstacles in their path. A patient who has sustained a facial injury may have orbital swelling that makes it impossible for them to see and they must locate objects by hearing or touching them. Conversely, it is possible for a patient to be blind in one eye (technically not “normal vision”), but still be appropriately scored a “0” on M1200 if with the patient’s existing vision, they are able to see adequately in most situations and can see medication labels or newsprint.

Q71. M1242. If a patient uses a cane for ambulation in order to relieve low back pain, does the use of the cane equate to the presence of pain interfering with activity? [Q&A ADDED 06/05; M number updated 09/09; Previously CMS OCCB 08/04 Q&A #6]

A71. If use of the cane provides adequate pain relief that the patient can ambulate in a manner that does not significantly affect distance or performance of other tasks, then the cane should be considered a “non-pharmacological” approach to pain management and should not, in and of itself, be considered as an “interference” to the patient’s activity. However, if the use of the cane does not fully alleviate the pain (or pain effects), and even with the use of the cane, the patient limits ambulation or requires additional assistance with gait activities, then activity would be
considers as “affected” or “interfered with” by pain, and the frequency of such interference should be assessed when responding to M1242.

**Q73. M1242.** A patient takes narcotic pain medications continuously and is currently pain free. Medication side effects, including constipation, nausea, and drowsiness affect the patient’s interest and ability to eat, walk, and socialize. Is pain interfering with the patient’s activity? [Q&A ADDED 06/05; Previously CMS OCCB 10/04 Q&A #3]

A73. M1242 identifies the frequency with which pain interferes with a patient’s activities, taking into account any treatment prescribed. If a patient is pain-free as a result of the treatment, M1242 should be answered to reflect the frequency that the patient’s activities are affected or limited by pain. In this scenario, the patient is described as being pain-free, but also is described as having medication side effects that interfere with activity. Medication side effects are not addressed in responding to M1242 and, given the information in the scenario; pain apparently is not interfering with the patient’s activity.

**Q73.1. M1242.** Could you clarify the time period under consideration when answering M1242 Frequency of Pain Interfering With Activity or Movement? If a patient reports they have no pain currently because they have modified their activity level several weeks or months ago to exclude an activity they know will cause pain, do we answer M1242 based on the fact that they have modified their activity level (e.g. aren't even attempting to perform that activity due to the possibility of the pain returning), or do we not even consider that activity when answering the questions because the patient has excluded it from their activities a “long” time ago. And if that is true, what would be the time frame for a “long” time ago?

A73.1. The timeframe under consideration when answering M1242, Frequency that pain interferes with activity or movement is the day of assessment and recent pertinent past. If the patient has stopped performing an activity in order to be free of pain, the patient HAS pain that is interfering with activity.

If a patient at some point stopped performing the activity again, an assessing clinician’s judgment may determine that the activity is not considered to be in the pertinent past.

Examples: stopped skiing after a knee injury 20 years ago.

**Q73.3. M1242.** For M1242, could you define the term “All of the time”? Does pain have to keep a patient awake all night long in order to select it? [Q&A ADDED 06/14; Previously CMS Qtrly 07/13 Q&A #7]

A73.3. M1242 Response “4-All the time” is selected, when the patient reports and/or the clinician observes that pain is interfering with the patient's ability to move and/or perform desired activities at all times. "At all times" means constantly throughout the day and night with little or no relief. Pain is also considered to be interfering if a patient stops performing an activity in order to avoid the pain. For the pain to be interfering "all the time" the frequency of the activity that was stopped in order to avoid pain must collectively represent all the hours of the day/night. Pain must wake them frequently at night. The clinician must use judgment based on observation and patient interview to determine if pain is interfering all the time.

**INTEGUMENTARY**
From October 2018 qtso quarterly Q&A: CMS QUESTION 4: Are diabetic foot ulcers classified as pressure ulcers or stasis ulcers?

ANSWER 4: A patient with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when reporting whether a patient with DM has an ulcer/injury that is caused by pressure or other factors. Once etiology is determined, the ulcer would be reported in the appropriate OASIS item(s), if applicable. If, for example, a patient with DM has a heel ulcer/injury from pressure, the etiology of the ulcer would be considered pressure, not a diabetic or stasis ulcer, and would therefore be reported in the OASIS pressure ulcer items. The key to coding pressure ulcers is to determine if the primary etiology of the ulcer is pressure. The OASIS includes specific items to capture pressure ulcers, stasis ulcers or surgical wounds. Not all types of wounds will be captured in these items.

Q88.5. M1306. If you have two Stage 4 pressure ulcers with intact skin in-between them and a tunnel that connects them underneath the wound surface, do you have one pressure ulcer or two?

A88.5. If a patient develops two pressure ulcers that are separated by intact skin but have a tunnel which connects the two, they remain two pressure ulcers.

Q88.6 M1306 We are seeking direction regarding serum filled blisters that are caused by shoes rubbing against the foot. Some of our clinicians consider these “trauma wounds” and others consider them “stage 2 pressure ulcers”. Please advise. [Q&A EDITED 10/18; ADDED 10/16; Previously CMS QTRLY 01/16 Q&A #14]

A88.6 If the cause of a wound is solely friction force which leads to visible skin impairment, such as the serum filled blister cited in the scenario, it would NOT be categorized as a pressure ulcer. The 2009 International NPUAP-EPUAP Pressure Ulcer Prevention and Treatment Clinical Practice Guideline eliminated reference to friction as a primary factor in pressure ulcer development.

Q89.5. M1306-M1322. On SOC, the RN assesses a scar from a closed pressure ulcer. Upon further interview and assessment, the patient's family states that the patient had a pressure ulcer but they are not able to give the RN any staging information. There is no written history on the referral of a previous pressure ulcer. After contacting the physician, the RN still does not have a definitive answer on what stage the pressure ulcer was at its worst. How would this pressure ulcer be documented in M1311, Current Number of Unhealed Pressure Ulcers at Each Stage? [Q&A. Edited 10/16. ADDED 06/14; Previously CMS Qtrly 04/14 Q&A #9]

A89.5. If the assessing clinician becomes aware that the patient had a full-thickness (Stage 3 or 4) pressure ulcer in the past that is now closed, the ulcer is considered healed and no longer reportable as a pressure ulcer.

Q98. M1306. Can a previously observable Stage 4 pressure ulcer that is now covered with slough or eschar be categorized as Stage 4? [Q&A EDITED 10/18; EDITED 06/14, ADDED06/05]

A98. No. In order to stage the pressure ulcer as a Stage 4, bone, muscle, tendon, or joint capsule (Stage 4 structures) must be visible. A pressure ulcer that has some degree of necrotic tissue
The status of the pressure ulcer needs to correspond to the visual assessment by the skilled clinician on the date of the assessment. This is documented on the Wound, Ostomy, and Continence Nurses (WOCN) Association website at www.wocn.org in the WOCN Guidance Document and at the NPUAP site at www.npuap.org.

**QUESTION 16: M1307. If the patient had a Stage 1 pressure ulcer at SOC that progressed to a Stage 2, how do we answer M1307 at discharge?**

**ANSWER 16:** If a patient had a Stage 1 pressure ulcer at SOC/ROC and it advanced to a Stage 2 by discharge, Response “2-Developed since the most recent SOC/ROC assessment” would be appropriate due to the fact that the ulcer, caused by pressure, was not present as a Stage 2 at the most recent SOC/ROC assessment.

**Q89.6. M1311.** If a patient has an unstageable pressure ulcer due to black stable eschar at SOC and during the episode it peels off and leaves an area of newly epithelialized tissue, how should this be staged at Discharge on M1311? [Q&A EDITED 10/16; ADDED 04/15; Previously CMS Qtrly 10/14 Q&A #6]

A89.6. Once the full thickness pressure ulcer is completely covered with new epithelial tissue, the wound is considered healed and no longer reportable as a pressure ulcer on the OASIS.

**Q98.4.2. M1311.** My patient had a closed Stage 4 pressure ulcer at SOC. Two weeks later, it appeared to be a shallow open ulcer. Can I report it as a Stage 2 or do I have to say it is an Unstageable Stage 4 because I can't visualize bone, muscle or tendon?

A98.4.2. A previously closed Stage 3 or Stage 4 pressure ulcer that opens again should be reported at its worst stage. As long as the wound bed is free of slough and eschar, it may be reported as a Stage 4. If slough or eschar is present that the clinician believes may be obscuring the visualization of Stage 4 structures (bone, muscle, tendon or joint capsule) in the wound bed, it may not be staged and is reported in M1311 as E1: Known but not stageable due to coverage of wound bed by slough and/or eschar.

**Q5. M1311.** Our patient has a Stage 3 pressure ulcer that we have been treating during the episode. At the reassessment, it is covered with a scab. I know it’s Unstageable if it has a non-removable dressing or is covered with eschar or slough but I do not know how a scab would affect the staging for M1311 – Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. [Q&Q POSTED 10/18]

A5. A pressure ulcer that was staged and now has a scab indicated it is healing therefore, staging does not change. In this scenario it is a healing Stage 3. Scabs and s=eschar are different. A scab is made up of dried blood cells and serum, sits on top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.).

**Q98.4.3.1. M1311.** Upon admission, our patient had two distinct pressure ulcers (one Stage 2 and one Stage 3) in close proximity. Over the course of the episode the ulcers deteriorated and no longer had any separating tissue. How would this be reported on M1311, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage at SOC and
**at discharge?** [Q&A EDITED 10/18. EDITED 10/16. Q&Q ADDED 04/15; Previously CMS Qtrly 04/15 Q&A #2]

A.98.4.3.1 Assuming the patient had no other pressure ulcers, on the SOC assessment, M1311A1, Number of Stage 2 pressure ulcers, would be coded “1”. M1311B1, Number of Stage 3 pressure ulcers, would be coded as “1”.

In the Scenario you describe, at discharge the surface areas of the pressure ulcers extended to the point that the assessing clinician could no longer differentiate one pressure ulcer from the other. In this case, the patient would be considered to have one pressure ulcer. If at discharge, the pressure ulcer was stageable and had not progressed in anatomic depth, the patient would have one Stage 3 pressure ulcer. On the discharge assessment, M1311B1, Number of Stage 3 pressure ulcers, would be coded “1”. M1311B2, Number of these Stage 3 pressure ulcers that were present at the most recent SOC/ROC would be coded “1”.

Q100.01 M1330 Our patient’s lower extremity wound originated as a trauma wound due to a fall. The patient also has diagnoses of venous insufficiency and stasis dermatitis. The physician stated the wound is not healing due to the venous insufficiency. Is there a point in time when the wound is no longer classified as a traumatic wound and considered a stasis ulcer for M1330? [Q&A ADDED 06/14; Previously CMS Qtrly 01/13 Q&A #9]

A100.01. M1330, Does this patient have a Stasis Ulcer, identifies patients with ulcers caused by inadequate circulation in the area affected. The healing process of other types of wounds, e.g. traumatic wounds, surgical wounds, burns, etc., may be impacted by the venous insufficiency, but it would not change the traumatic or surgical wound into a venous stasis ulcer.

Q5. M1340 We are looking for some guidance on a diabetic ulcer that was covered with a skin graft and how to code it at SOC? Is it a diabetic ulcer or does it become a surgical wound, like pressure ulcers?

A5. For OASIS coding purposes, when any type of ulcer is treated surgically with any kind of graft or flap, it is considered a surgical wound for M1340 until approximately 30 days after complete re-epithelialization.

Q8. M1340 Are burn wounds that have been surgically grafted considered a surgical wound even if the graft fails? [Posted 7/19]

A8. For OASIS coding purposes, when any type of ulcer or burn is treated surgically with any kind of graft or flap, it is considered a surgical wound for M1340 until approximately 30 days after complete re-epithelialization.

Q108.1. M1340 & M1342. Recently released guidance states that a surgical wound becomes "healed" or no longer reportable as a surgical wound on M1340 once re-epithelialization has been present for approximately 30 days. Determining a specific timeframe in regards to complete epithelialization presents some issues. For instance, if we get a post surgery patient who has been in the nursing home and then to home health, we may not know when complete epithelialization occurs. Please provide further clarification. [Q&A EDITED 01/12; ADDED 09/09; Previously CMS OCCB 10/08 Q&A #6]

A108.1. If, at the SOC or other assessment time points, the clinician assesses the wound to be completely epithelialized (including no sign of infection or separation), and the date of complete epithelialization is unknown, the clinician will have to make a determination regarding the wound
status based on the history of the date of surgery, any reported wound healing progress/complications and clinical assessment findings.

Since for the purposes of the OASIS, a surgical wound is considered healed and no longer counted as a current surgical wound once re-epithelialization has been present for approximately 30 days (assuming no sign of infection or separation), then if based on the surgery date, it is clear that the completely epithelialized wound could not possibly have been fully epithelialized for at least 30 days, Response 0-Newly epithelialized should be reported.

If the wound appears completely epithelialized (no sign of infection or separation) and the date of epithelialization is unknown, but based on the known wound history and date of surgery it is possible that the wound could have been fully epithelialized for at least 30 days, then the wound status is deemed “healed” and no longer reportable as a surgical wound. CMS will remind HHAs of their responsibility to comply with the HH Conditions of Participation, (see 42 CFR 484.18), when a surgery date is not provided on the referral. CMS expects the documentation within the patient’s medical record to reflect consultation with the patient’s physician therefore it is difficult to envision the HHA being unable to ascertain the patient’s date of surgery.

Q109.1. M1340 & M1342. How would M1340 – Surgical Wound and M1342 – Status of Most Problematic Surgical Wound be answered, if the clinician determines that the steri-strips completely obscure the incision preventing visual assessment of the wound? Would the clinician need to obtain an order from the physician stating the steri-strips are a “non-removable dressing” for the wound to be considered not observable in M1340? [Q&A ADDED 04/15; Previously CMS Qtrly 04/15 Q&A #3]

A.109.1. M1340 & M1342. Steri-strips are skin closures (similar in intent to sutures or staples) and not a dressing or device. Steri-strips will remain in place until they fall off, unless there is a specific clinical reason and/or physician’s order to remove them sooner. While they are in place, if the placement of the steri-strips allows sufficient visualization of the wound, the assessing clinician can determine and report on M1342 the appropriate healing status response, based on the WOCN guidance. If the steri-strips completely obscure the incision, or obscure the incision to the point that the assessing clinician is unable to visualize the incision well-enough to determine the healing status, then M1340 - Surgical Wound should be reported as Response 2 - Surgical wound known but not observable due to non-removable dressing/device, and M1342 would be skipped. Note that while steri-strips are clinically different than a dressing or a device, the limitations of the OASIS data responses make this the best response in the situation described.

Q112.5.2. M1342. In reference to M1342, Status of Most Problematic Surgical Wound that is Observable, for surgical incisions healing by primary intention is it true that the only correct responses are “0-newly epithelialized” and “3-Not healing” as there are no open wound beds with granulation tissue? [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 07/11 Q&A #10]

A112.5.2. Surgical incisions healing by primary intention do not granulate. Because of this the only response that could be appropriate for a surgical wound healing by primary intention would be 0-Newly epithelialized or 3-Not healing. “Newly epithelialized” should be chosen if the surgical incision has epidermal resurfacing across the entire wound surface, and no signs/symptoms of infection exist.

Q112.6.10. M1342 Where in the OASIS do I report staple insertion sites and the related edema and bruising that result after surgery? [Q&A EDITED 10/18, Q&A ADDED 01/12; Previously CMS OCCB 07/11 Q&A #10]
A112.6.10. The staple sites are expressly excluded from consideration as a surgical wound. Since they are not a surgical wound, they may be reported in the clinical documentation. Edema or bruising that result secondary to a surgical insult that is integral to the surgical wound and requires no additional interventions would not be considered separately. If the assessing clinician determines the bruising or edema requires additional intervention, separate from the surgical wound interventions, it may documented in clinical documentation.

Q112.6.1.1. M1342 I have a question about M1340. I have a patient receiving peritoneal dialysis every night. I understand that the peritoneal dialysis catheter site is considered a surgical wound (4b Q102.1). What would the site’s healing status be for M1342? [Q&A ADDED 10/16; Previously CMS Qtrly 07/16 Q&A #5]

A112.6.1.1. Assuming the assessing clinician determines the peritoneal catheter site is the most problematic observable surgical wound, the clinician would determine the healing status of the wound following the definitions provided in the OASIS Guidance Manual, Chapter 3, M1342 Status of Most Problematic Surgical Wound that is Observable Response-Specific Instructions located at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html. The peritoneal catheter exit site cannot fully granulate and/or epithelialize because of the presence of the catheter. In this scenario, Response 3 – Not healing for M1342 would be appropriate.

RESPIRATORY

Q113.1. M1400. What is the correct response for the patient who is only short of breath when supine and requires the use of oxygen only at night, due to this positional dyspnea? The patient is not short of breath when walking more than 20 feet or climbing stairs. [Q&A ADDED 08/07; M number updated 09/09; Previously CMS OCCB 07/06 Q&A #31]

A113.1. Since the patient’s supplemental oxygen use is not continuous, M1400 should reflect the level of exertion that results in dyspnea without the use of the oxygen. The correct response would be “4 – At rest (during day or night)”. It would be important to include further clinical documentation to explain the patient’s specific condition.

Q113.2. M1400. What is the correct response to M1400, Dyspnea, if a patient uses a CPAP or BiPAP machine during sleep as treatment for obstructive sleep apnea? [Q&A ADDED 08/07; Previously CMS OCCB 07/07 Q&A #12]

A113.2. Sleep apnea being treated by CPAP is not the same as dyspnea at rest (Response 4 for M1400). M1400 asks about dyspnea (shortness of breath), not sleep apnea (absence of breath during sleep).
The two problems are not the same. Dyspnea refers to shortness of breath, a subjective difficulty or distress in breathing, often associated with heart or lung disease. Dyspnea at rest would be known and described as experienced by the patient. Sleep apnea refers to the absence of breath. People with untreated sleep apnea stop breathing repeatedly during their sleep, though this may not always be known by the individual. If the apnea does not result in dyspnea (or noticeable shortness of breath), then it would not be reported on M1400. If, however, the sleep apnea awakens the patient and results in or is associated with an episode of dyspnea (or noticeable shortness of breath), then Response 4 - At rest (during day or night) should be reported.

Q113.3. M1400. Patient currently sleeps in the recliner or currently sleeps with 2 pillows to keep from being SOB. They are currently not SOB because they have already taken measures to abate it. Would you mark M1400, #4 At Rest or 0, Not SOB? [Q&A EDITED 04/15; ADDED 08/07; Previously CMS OCCB 07/07 Q&A #13]

A113.3. M1400 reports what is true on the day of the assessment (the 24 hours immediately preceding the home visit and the time spent by the clinician in the home). If the patient has not demonstrated or reported shortness of breath during that timeframe, the correct response would be “0-Not short of breath” even though the environment or patient activities were modified in order to avoid shortness of breath.

ELIMINATION

Q119.2 M1610 How should we answer M1610 for a patient with a nephrostomy tube? Can we interpret M1610 to mean if the urinary diversion is pouched with an ostomy appliance it is not a catheter but if it is accessed with a tube or catheter {external or otherwise} then the patient has a catheter? What about patients with continent urinary diversions? They have a stoma but are accessing with intermittent catheterizations. Would they be reported as having a catheter on M1610? [Q&A EDITED 12/12; ADDED 09/09; Previously CMS OCCB 04/08 Q&A #11]

A119.2 When a patient has urinary diversion, with or without a stoma that is pouched for drainage the appropriate M1610 response would be “0- No incontinence or catheter”. The appropriate response for a patient with urinary diversion, with or without a stoma that has a catheter or “tube” for urinary drainage would be “2-Patient requires a urinary catheter {i.e., external, indwelling, intermittent, suprapubic}. A patient that requires intermittent catheterization would be represented by Response 2, even if they have continent urinary diversions.

MENTAL

Q124.1. M1710 & M1720. What does unresponsive mean? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 07/06 Q&A #33]

A124.1. It means the patient is unable to respond or the patient responds in a way that you can’t make a clinical judgment about the patient’s level of orientation. A patient who only demonstrates reflexive or otherwise involuntary responses may be considered unresponsive. A patient with language or cognitive deficits is not automatically considered “unresponsive”. A patient who is unable to verbally communicate may respond by blinking eyes or raising a finger. A patient with dementia may respond by turning toward a pleasant, familiar voice, or by turning away from bright lights, or by attempting to remove an uncomfortable clothing item or bandage.
A patient who simply refuses to answer questions should not automatically be considered "unresponsive". In these situations, the clinician should complete the comprehensive assessment and select the correct response based on observation and caregiver interview.

**Q124.5. M1730.** We are seeking clarification about the PHQ-2 depression screening tool and whether it can be used in certain situations. Instructions for PHQ2 imply that screening entails interview of the patient. However, the “Specific Instructions” in the OASIS manual state: “depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or other.” [Q&A EDITED 06/14; ADDED 01/11; Previously CMS OCCB 04/10 Q&A #18]

1. Is it acceptable to use the PHQ-2 to screen for depression by asking the questions of a caregiver if the patient is unable to respond to the two questions?
2. Is it acceptable for the home health clinician to complete the PHQ-2 based on observations if the patient is unable to respond to the two questions?

**A124.5.** No, it is not acceptable to use the PHQ-2 to screen for depression by asking the questions of a caregiver, or to respond to the two questions based on clinician observations. The PHQ-2 tool is a standardized, validated screening tool in which the patient is the source of report. The PHQ-2 instructions clearly define how the tool should be administered. The clinician is to ask the patient a specific question related to two problems. The information may also be self-reported, precluding the need for the interview. When evaluating the patient, the clinician must first assess whether the PHQ-2 is the appropriate depression screening tool. If the PHQ-2 is appropriate (the patient appears to be cognitively and physically able to respond), then the instrument may be used. If, however, the patient is unable to answer the specific PHQ-2 questions when asked by the assessing clinician, e.g. the patient can't quantify how many days they have experienced the problems, the clinician can report in M1730 that the PHQ-2 was administered (Response 1), and select N/A - Unable to respond. Response 1-Yes may NOT be selected if the patient refuses to hear the questions or states they are too personal.

If the PHQ-2 is not appropriate due to limitations such as cognitive status or communication deficits, the clinician may choose to administer a different standardized, validated depression screening tool with instructions that may allow for information to be gathered by observation and caregiver interview as well as self-report. In this case, the clinician would select Response 2 or 3 for M1730, depending on the outcome of the assessment. If the clinician chooses not to assess the patient (because there is no appropriate depression screening tool available or for any other reason), Response 0, "No" should be selected.

Note that patients who have been assessed as “Unresponsive”, based on M1710, When Confused and/or M1720, When Anxious, will not be included in the process measure for depression screening.

**Q124.5.1. M1730.** I don't understand when I would ever select "NA - Unable to respond" in the PHQ-2 in M1730, Depression Screening. Please clarify. [Q&A EDITED 12/12; ADDED 01/12; Previously CMS OCCB 10/11 Q&A #8]

**A124.5.1.** The PHQ-2 is only used for patients that appear to be cognitively and physically able to answer the two included questions. After determining the PHQ-2 is an appropriate tool, the patient may be unable to answer the questions, e.g. the patient may not be able to quantify how many days they have experienced the problems. In this case, the clinician could report in M1730 that the PHQ-2 was administered (Response 1), and select N/A – Unable to respond as the PHQ-2 finding.
Q124.5.3. M1730. During the admission visit, the nurse attempt to administer the PHQ-2 to screen for depression but the patient refuses to answer the questions. She has no cognitive issues and state “This is none of your business.” Should the response to M1730 be 0-No or 1-Yes (NA)?

A124.5.3. M1730. Response 1 – Yes, NA may be selected for the patient who is cognitively intact and physically able to answer questions but is unable to answer the specific PHQ-2 questions when asked by the assessing clinician, (e.g. the patient can’t quantify how many days they have experienced the problems.) Response 1-yes may NOT be selected if the patient refuses to answer the questions or states they are too personal. Response 2 or 3 may be selected if the assessing clinician is able to administer a different standardized, validated depression screening. If the clinician chooses not to assess the patient (because there is no appropriate depression screening tool available or for any other reason), Response 0 – No should be selected.

Q124.5.5.1.M1740. Would "hoarding" be considered disruptive behavior triggering a "yes" response on M1740 – Cognitive, behavioral, and psychiatric symptoms? [Q&A ADDED 04/15; Previously CMS Qtrly 01/15 Q&A #7]

A124.5.5.1. M1740 identifies specific behaviors associated with significant neurological, developmental, behavioral, or psychiatric disorders that are demonstrated at least once a week. If a patient had a diagnosis, such as hoarding disorder, and the clinician determined the associated behaviors resulted in concern for the patient and/or caregiver's safety or wellbeing, then it would meet the intent of M1740. In such a case, the assessing clinician may determine that the hoarding behaviors meet the intent of Response 2 – Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions and/or Response 5 – Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions).

FUNCTIONAL

Q130.1. M01800 & M1830. Is hair washing/shampooing considered a grooming task, a bathing task, or neither? [Q&A ADDED 08/07; M numbers updated 09/09; Previously CMS OCCB 07/06 Q&A #34]

A130.1. The task of shampooing hair is not considered a grooming task for M1800. Hair care for M1800 includes combing, brushing, and/or styling the hair. Shampooing is also specifically excluded from the bathing tasks for M1830, therefore the specific task of shampooing the hair is not included in the scoring of either of these ADL items.

Q131. [Q&A RETIRED 09/09; Duplicative of OASIS Guidance Manual]

Q132. M1810. What if the patient must dress in stages due to shortness of breath? What response must be marked? [M number updated 09/09]

A132. If the patient is able to dress herself/himself independently, then this is the response that should be marked, even if the activities are done in steps. If the dressing activity occurs in stages because verbal cueing or reminders are necessary for the patient to be able to complete the task, then Response 2 is appropriate. (Note that the shortness of breath would be addressed in M1400.)

Q134. M1830. Given the following situations, what would be the appropriate responses to M1830? [Q&A EDITED 06/14; M number updated 09/09]

- a) The patient's tub or shower is nonfunctioning or is not safe for use.
- b) The patient is on physician-ordered bed rest.
c) The patient fell getting out of the shower on two previous occasions and is now afraid and unwilling to try again.

d) The patient chooses not to navigate the stairs to the tub/shower.

A134. a) The patient’s environment can impact his/her ability to complete specific ADL tasks. If the patient’s tub or shower is nonfunctioning or not safe, then the patient is currently unable to use the facilities. Response 4, 5, or 6 would apply, depending on the patient’s ability to participate in bathing activities outside the tub/shower.

b) The patient’s medical restrictions mean that the patient is unable to bathe in the tub or shower at this time. Select Response 4 (Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode), 5 (Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.) or 6 (Unable to effectively participate in bathing and is bathed totally by another person), whichever most closely describes the patient’s ability at the time of the assessment.

c) If the patient’s fear is a realistic barrier to her ability to get in/out of the shower safely, then her ability to bathe in the tub/shower may be affected. If due to fear, she refuses to enter the shower even with the assistance of another person; either Response 4, 5, or 6 would apply, depending on the patient’s ability at the time of assessment. If she is able to bathe in the shower when another person is present to provide required supervision/assistance, then Response 3 would describe her ability.

d) The patient’s environment must be considered when responding to the OASIS items. If the patient chooses not to navigate the stairs, but is able to do so with supervision, then her ability to bathe in the tub or shower is dependent on that supervision to allow her to get to the tub or shower. While this may appear to penalize the patient whose tub or shower is on another floor, it is within this same environment that improvement or decline in the specific ability will subsequently be measured.

Q134.2. M1830. At SOC, the patient was not taking a shower due to a fear of falling. The patient was safely sponge bathing at the sink without assistance. She had fallen in the shower and is fearful of falling again. The RN, at SOC, had the patient get into the shower using her tub/bench and after cues for proper technique, determined the patient needed contact guard for the transfer. Once sitting, she was able to bathe herself using a long-handled sponge. How should M1830, Bathing be answered? [Q&A ADDED 06/14; Previously CMS Qtrly 10/13 Q&A #7]

A134.2. Response 4 - Unable to bathe in tub/shower but independent in bathing at sink, would be selected if, on the day of the assessment, the patient's usual status was that she was unable to bathe in the tub/shower due to fear, even with assistance, but was independent in bathing at the sink. In your scenario the patient’s ability changed after clinical intervention. After the nurse’s instruction, the patient could bathe herself in the tub/shower with the intermittent assistance of another person for the tub transfer only, but the new changed ability was not the patient's usual status (more than 50% of the time) on the day of assessment. At the next OASIS data collection time point, if the patient remained at that new functional level it would be appropriate to select M1830 Response 2 - Able to bathe in tub/shower with intermittent assistance.
Q135. M1830. How should I respond to this item for a patient who is able to bathe in the shower with assistance, but chooses to sponge bathe independently at the sink? [Q&A EDITED 06/14]

A135. The item addresses the patient’s ability to bathe in the shower or tub, not actual performance, regardless of where or how the patient currently bathes. Willingness and adherence are not the focus of the item. If assistance is needed to bathe in the shower or tub, then the level of assistance needed must be noted, and Response 1, 2, or 3 should be selected.

Q141.3. M1830. For M1830 even the normal person requires a long-handled sponge or brush to wash their back. If a patient can do everything except wash their back & requires a long-handled sponge or brush, would they be marked a "1"? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #27]

A141.3. Assistive devices promote greater independence for the user by enabling them to perform tasks they were previously unable to, or had great difficulty safely performing. The intention of the use of the term “devices” in the Response 1 for M1830 is to differentiate a patient who is capable of washing his entire body in the tub/shower independently (Response 0), from that patient who is capable of washing his entire body in the tub/shower only with the use of (a) device(s). This differentiation allows a level of sensitivity to change to allow outcome measurement to capture when a patient improves from requiring one or more assistive devices for bathing, to a level of independent function without devices. Individuals with typical functional ability (e.g. functional range of motion, strength, balance, etc.) do not "require" special devices to wash their body. An individual may choose to use a device (e.g., a long-handled brush or sponge) to make the task of washing the back or feet easier. If the patient's use of a device is optional (e.g., it is their preference, but not required to complete the task safely), then the score selected should represent the patient’s ability to bathe without the device. If the patient requires the use of the device in order to safely bathe, then the need for the device should be considered when selecting the appropriate score. CMS has not identified a specific list of equipment that defines “devices” for the scoring of M1830. The clinician should assess the patient’s ability to wash their entire body and use their judgment to determine if a device, assistance, or both is required for safe completion of the included bathing tasks.

Q141.4. M1830. If a patient uses the tub/shower for storage, is this an environmental barrier? Is the patient marked a 4 or 5 in M1830? [Q&A EDITED 09/09; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #28]

A141.4. Upon discovering the patient is bathing at the sink, the clinician should evaluate the patient in attempts to determine why he/she is not bathing in the tub/shower. If it is the patient’s personal preference to bathe at the sink (e.g. “I don’t get that dirty.” “I like using the sink.”), but they are physically and cognitively able to bathe in the tub/shower; the clinician will pick the response option that best reflects the patient’s ability to bathe in the tub/shower. If the patient no longer bathes in the tub/shower due to personal preference and has since begun using the tub/shower as a storage area, the patient would be scored based on their ability to bathe in the tub/shower when it was empty.

If the patient has a physical or cognitive/emotional barrier that prevents them from bathing in the tub/shower and therefore has since starting using the tub/shower as a storage area, the clinician will score the patient either as a Response 4, 5, or 6, depending on the patient’s ability at the time of assessment. Note that the responses of 4, 5, and 6 are due to the patient’s inability to safely bathe in the tub/shower (even with help) due to the physical and/or cognitive barrier, not due to the alternative use of the tub for storage.
Q146.1 M1840 My male patient is bedfast and can place and remove the urinal, but not the bedpan. What response should be selected for M1840, Toilet Transferring? [Q&A ADDED 01/12; Previously CMS OCCB 07/11 Q&A #13]

A146.1 If the bedfast patient needs assistance to get on/off the bedpan, the appropriate M1840 Response is “4 – Is totally dependent in toileting” even if they can place and remove the urinal.

Q148.02 M1840; Question 3: If you have a patient that does not have a toilet in his home would he be dependent in toilet transfers? [Q&A ADDED 10/16; Previously Qtrly 10/15 Q&A #3]

A148.02: For M1840 Toilet Transferring, in the absence of a toilet in the home, the assessing clinician would need to determine if the patient is able to use a bedside commode (with or without assistance) (Response 2) or is able to use a bedpan/urinal independently (Response 3). If he is not able to use the bedside commode or a bedpan/urinal as defined in the responses, or if such equipment is not present in the home to allow assessment, then Response 4 – Is totally dependent in toileting would be appropriate.

Q150.1. M1850. When completing M1850, Transferring, do I consider the patient’s gait impairment if they must ambulate 12 feet from the bed to get to the closest sitting surface and the need for assistance of another person? [Q&A EDITED 12/12; ADDED 01/12; Previously CMS OCCB 10/11 Q&A #9]

A150.1. The need for assistance with gait may impact the M1850, Transferring score if the closest sitting surface applicable to the patient's environment is not next to the bed. M1850 reports the patient's ability to move from the supine position in bed (or the current sleeping surface) to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a sitting surface at the bedside. If there is no chair at the bedside, report the ability to transfer from the sleeping surface to whatever sitting surface is applicable to the patient's environment and need. If the sleeping surface is in the bedroom and the sitting surface is down the hall in the bathroom and the patient is independent moving from the supine to sitting position, sitting to standing, and then standing to sitting, but requires minimal human assistance or an assistive device to ambulate from the bed to the sitting surface, the appropriate M1850 score would be a “1”. If the patient requires more than minimal assistance or requires both minimal human assistance and an assistive device to be safe, the appropriate score would be a “2”.

Q151.3. M1850. A quadriplegic is totally dependent, cannot even turn self in bed, however, he does get up to a gerichair by Hoyer lift. For M1850, is the patient considered bedfast? [Q&A ADDED 08/07; M item updated 09/09; Previously CMS OCCB 05/07 Q&A #29]

A151.3. A patient who can tolerate being out of bed is not “bedfast.” If a patient is able to be transferred to a chair using a Hoyer lift, Response 3 is the option that most closely resembles the patient’s circumstance; the patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast (“confined to the bed”) even though he cannot help with the transfer. Responses 4 and 5 do not apply for the patient who is not bedfast. The frequency of the transfers does not change the response, only the patient's ability to be transferred and tolerate being out of bed.
Q151.6. M1850. When scoring M1850, Transferring, the assessment revealed difficulty with transfers. The patient was toe touch weight bearing on the left lower extremity and had pain in the opposite weight bearing hip. The patient had a history of falls and remained at risk due to medication side effects, balance problems, impaired judgment, weakness, unsteady use of device and required assistance to transfer. The concern is the safety of the transfers considering all of the above. Would "2" or "3" be the appropriate response? [Q&A ADDED 09/09; M item updated 09/09; Previously CMS OCCB 10/07 Q&A #22]

A151.6. Safety is integral to ability, if your patient requires more than minimal human assistance or they need minimal assistance and an assistive device to safely transfer, and can bear weight and pivot safely, Response 2 should be reported. If you determine the bearing weight and pivoting component of the transfer is not safe even with assistance, then the patient is not able to bear weight or pivot and the appropriate selection would be Response 3 – Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

Q151.6.1. M1850. When answering M1850, Transferring, do the responses that reference weight bearing and pivoting include an individual that uses a sliding board and would be weight bearing and pivoting using only the upper extremities, not the lower? [Q&A ADDED 06/14; Previously CMS Qtrly 07/13 Q&A #15]

A151.6.1. The term "bear weight and pivot" in M1850, Transferring, may include both a standing pivot transfer and multiple sitting pivot transfers, such as those utilized when performing a bed-to-chair transfer with a sliding board.

If the patient does not have use of the lower extremities and transfers with the use of a sliding board, but no human assistance, select Response “1-Able to transfer with minimal human assistance or with use of an assistive device.” If the patient requires both minimal human assistance and the sliding board to transfer safely, select Response “2-Able to bear weight and pivot during the transfer process but unable to transfer self.” If the patient can bear weight and pivot utilizing their upper extremities, but requires more than minimal human assist, Response 2 should be marked. The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, select Response “3- Unable to transfer self and is unable to bear weight or pivot when transferred by another person.”

Q151.7. M1850. For M1850, Transferring, does the transfer from bed to chair include evaluation from a seated position in bed to a seated position in a chair or from supine in bed to seated in a chair?

A151.7. The bed to chair transfer includes the patient’s ability to get from the bed to a chair and from the chair back into bed. For most patients, this will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair.

Q151.14. M1850 & M1860. How is “bedfast” defined for M1850, Transferring and M1860, Ambulation/Locomotion? Do I only count what my patient could do during the visit? [Q&A EDITED 06/14; ADDED 01/12; Previously CMS OCCB 04/11 Q&A #10]

A151.14. M1850, Transferring and M1860, Ambulation/Locomotion report the patient's ability on the day of the assessment. Day of assessment is the 24 hours before the clinician arrives in the patient's home and the time spent in the home performing the comprehensive assessment. Ch. 3 of the current OASIS Guidance Manual in the M1850 Response-Specific Instructions defines
“Bedfast refers to being confined to the bed, either per physician restriction or due to a patient’s inability to tolerate being out of the bed.” If the patient can tolerate being out of bed, they are not bedfast unless they are medically restricted to the bed. The patient is not required to be out of bed for any specific length of time. The assessing clinician will have to use her/his judgment when determining whether or not a patient can tolerate being out of bed. For example, a severely deconditioned patient may only be able to sit in the chair for a few minutes and is not considered bedfast as she/he is able to tolerate being out of bed. A patient with Multiple System Atrophy becomes severely hypotensive within a minute of moving from the supine to sitting position and is considered bedfast due to the neurological condition which prevents him from tolerating the sitting position.

Q154. M1860. If a patient uses a wheelchair for 75% of their mobility and walks for 25% of their mobility, then should they be scored based on their wheelchair status because that is their mode of mobility >50% of the time? Or should they be scored based on their ambulatory status, because they do not fit the definition of “chairfast?” [Q&A EDITED 09/09; ADDED 06/05; Previously CMS OCCB 08/04 Q&A #17]

A154. Item M1860 addresses the patient’s ability to ambulate, so that is where the clinician’s focus must be. Endurance is not included in this item. The clinician must determine the level of assistance is needed for the patient to ambulate and choose Response 0, 1, 2, or 3, whichever is the most appropriate.

Q155.2. M1860. For M1860, does able to walk “on even and uneven surfaces” mean inside the home or outside the home or both? If the patient is scored a 0, does this mean the patient is a safe community ambulator and therefore is not homebound? [Q&A EDITED 01/10; ADDED 08/07; Previously CMS OCCB 05/07 Q&A #30]

A155.2. “Even and uneven surfaces” refers to the typical variety of surfaces that the particular home care patient would routinely encounter in his environment. Based on the individual residence, this could include evaluating the patient’s ability to navigate carpeting or rugs, bare floors (wood, linoleum, tile, etc.), transitions from one type or level of flooring to another, stairs, sidewalks, and uneven surfaces (such as a graveled area, uneven ground, uneven sidewalk, grass, etc.).

To determine the best response, consider the activities permitted, the patient’s current environment and its impact on the patient’s normal routine activities. If, on the day of assessment, the patient’s ability to safely ambulate varies among the various surfaces he must encounter, determine if the patient needs some level of assistance at all times (Response 3), needs no human assistance or assistive device on any of the encountered surfaces (Response 0), needs a one-handed device but no human assistance, (Response 1) or needs a two-handed device and/or human assistance at times but not constantly (Response 2).

Response 0, Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e. needs no human assistance or assistive device), is not intended to be used as a definitive indicator of homebound status. Some patients are homebound due to medical restrictions, behavioral/emotional impairments and other barriers, even though they may be independent in ambulation.

Q155.3. M1860. A patient is able to ambulate independently with a walker, but the patient chooses to not use the walker, therefore not being safe. When selecting a response for M1860 Ambulation/Locomotion, should I select Response #2, that the patient is able to
ambulate safely with the walker or should I select Response #3 that the patient is only safe when walking with another person at all times, because he chooses to not use his walker? [Q&A EDITED 06/14; ADDED 09/09; Previously CMS OCCB 01/09 Q&A #12]

A155.3. The OASIS items should report the patient’s physical and cognitive ability, not their actual performance, adherence or willingness to perform an activity. You state the patient is able to ambulate independently with a walker, so we will assume you meant that the patient is able to ambulate without human assistance safely with the walker. This would be scored a “2” for M1860 Ambulation/Locomotion. You state the patient’s actual performance is that he is unsafe ambulating because he chooses not to use his walker. This patient would still be scored a “2” unless, as you pointed out, the clinician identified some other physical, cognitive or environmental barrier that prevents the patient from utilizing his walker to assist with ambulation, e.g. fear, memory impairment, undisclosed pain associated with walker use, or other emotional, behavioral or physical impairments. If there was a barrier preventing the patient from safely utilizing the walker during ambulation, the clinician would need to determine if the patient needed someone to assist at all times in order to ambulate safely and if so, the appropriate score for M1860 would be a “3”. If the patient only needed assistance intermittently, the correct response would be a “2”.

Q155.3.1. M1860. We have a patient who is ambulating in the home. The clinician assesses that the patient is not safe ambulating with an assistive device, even with the supervision of another person at all times. The patient does not have a wheelchair in the home. What is the appropriate response to M1860, Ambulation/Locomotion, for this patient? [Q&A ADDED 01/12; Previously CMS OCCB 04/11 Q&A #11]

A155.3.1. A patient is considered chairfast if they cannot be made safe ambulating even with the combination of a device and the assistance of another person at all times. They are not bedfast unless they are medically restricted to the bed or cannot tolerate being out of bed. If there is no wheelchair in the home, the assessing clinician cannot make assumptions about their ability to propel it safely. The appropriate M1860 response in this case is “5-Chairfast, unable to ambulate and is unable to wheel self”.

Q155.3.3. M1860. Our patient requires maximum assistance to ambulate (over 75% of the effort necessary for ambulation is contributed by someone other than the patient) and only ambulates with the therapist during gait training activities. The patient is extremely unsafe when attempting to ambulate without the therapist’s assistance. Is this patient considered ambulatory for M1860 and scored as “3” (with constant assistance) or is this patient chairfast and scored as “4” or “5”, at this time? [Q&A ADDED 06/14; Previously CMS Qtrly 01/13 Q&A #12]

A155.3.3. If the assessing clinician determines the patient is safe ambulating with constant human assistance, they are ambulatory. This is true whether the assistance needed is verbal cueing, reminders, contact guard, or any level of hands-on assistance. If the patient is not bedfast, and is not safe ambulating even with a combination of continuous assistance and a device, they are chairfast. If the patient can only take a couple of steps safely, they are not ambulatory.
MEDICATIONS

M2001, M2003, M2005

QUESTION 8: The new CoPs indicate it is mandatory that an office nurse does the medication review. Our agency is letting the LPNs do this. Is this compliant with OASIS guidelines and the COPs? [January 2020 CMS Qtrly OASIS Q&A]

ANSWER 8: While the new CoPs continue to allow an RN, PT, OT, or SLP to complete a comprehensive assessment and collect OASIS, the new Interpretive Guidelines §484.55(c)(5) do state that in rehabilitation therapy only cases, the therapist must submit a list of patient medications to an HHA nurse for review. According to the Home Health Survey Mailbox Team, in therapy only cases, an agency RN should review the medication list.

Further questions related to the Interpretive Guidelines may be directed to the home health regulations and compliance team via the Home Health Survey Mailbox at hhasurveyprotocols@cms.hhs.gov.

Q164. M2020. Some assisted living facilities require that facility staff administer medications to residents. If the patient appears able to take oral medications independently, how would the clinician answer M2020? [M number updated 09/09]

A164. M2020 refers to the patient’s ability to take the correct oral medication(s) and proper dosage(s) at the correct times. Your assessment of the patient’s vision, strength and manual dexterity in the hands and fingers, as well as cognitive ability, will allow you to evaluate this ability, despite the facility’s requirement. You would certainly want to document the requirement in the clinical record.

Q167.1. M2020. A patient is typically independent in managing her own oral medications. At the time of assessment, the patient’s daughter and grandchildren have moved in to help care for the patient, and the daughter has placed the meds out of reach for safety. This now requires someone to assist the patient to retrieve the medications. How should M2020 be answered? [EDITED 01/12]

A167.1. M2020 assesses the patient's ability to prepare and take oral medications reliably and safely. Tasks include the ability to obtain the medication from where it is routinely stored, ability to read the label (correct medication), open the container, select the pill/tablet or milliliters of liquid (correct dosage), and orally ingest at the prescribed time (take). In some cases, a patient lives in an environment where the facility or caregiver may impose a barrier that limits the patient's ability to access or prepare their medications, e.g. an Assisted Living Facility that keeps all medications in a medication room or a family that keeps the medications out of the
reach of children for the child's safety - not the patient's. In these cases, the clinician will assess the patient's vision, strength and manual dexterity in the hands and fingers, as well as their cognitive status to determine the patient's ability to prepare and take their oral medications despite access barriers imposed by family or facility caregivers.

Q167.5.2. M2020. If the patient does not have her prescribed medications in the home because she cannot afford them and she does not plan on getting them, what is the most appropriate response for M2020? [Q&A ADDED 01/12; Previously CMS OCCB 01/11 Q&A #19]

A167.5.2. When completing M2020, Management of Oral Medications, you are reporting the patient's ability to take all oral medications reliably and safely at all times on the day of the assessment. If the patient did not take her medications on the day of the assessment because they were not present in the home, you cannot make assumptions about a patient's ability to take medications she doesn't have. If the medications were not in the home, you would not be able to determine if she could take each medication at the correct time and dose. The patient's status would be reported as “3-Unable to take medications unless administered by another person”.

Q167.5.2.1. M2020. Regarding a previous CMS Q&A which states that a patient who doesn’t have medication in the home because they can’t afford them would be reported as a “3-Unable to take medication unless administered by another person” on M202, would a patient also be scored a “3” if he simply chooses not to fill a prescription? The assessing clinician determines the patient does not have a disorder that is contributing to his non-adherence. He is making a choice not to comply completely with the physician’s orders, cognizant of the implications of that choice. [Q&A EDITED 06/14; ADDED 12/12; Previously CMS Qtrly 04/12 Q&A #20]

A167.5.2.1. M2020. If a patient who is cognitively intact chooses not to take medications, and therefore does not have them delivered or picked up, the patient’s non-adherent behavior would not impact their ability to manage oral medications when selecting a response for M2020. If, however, there was a barrier preventing the patient from having the medications in the home, e.g. inability to pay for drugs, delivery/pick-up of drugs was delayed, etc., it would impact their ability to manage their medications.

Q167.5.4. M2020. Are inhaled meds and sublingual meds considered in M2020, Management of Oral Medications? [Q&A ADDED 12/12; Previously CMS Qtrly 10/12 Q&A #8]

A167.5.4. No. Medication giver per an inhaler or sublingually are note considered when answering M2020. When you assess M2020 consider those medications which are administered per the oral route. P.O. medications are swallowed and absorbed through the GI system. Sublingual medications are absorbed through the mucosal membranes under the tongue.

167.6. M2020 & M2030. It is our understanding that if the nurse is ordered to administer a medication, the patient is considered dependent for that (oral or injectable) medication.
At SOC, if a patient has been in the hospital where all medications were administered by hospital nursing staff, would this make the patient dependent because the medications over the past 24 hours were administered by the acute care nurse at the hospital? [Q&A EDITED 01/12; ADDED 09/09; Previously CMS OCCB 1/09 Q&A #13]

A167.6. In the case of an admission to home care following a discharge from an inpatient facility, M2020 and M2030 should be scored based on the orders relevant to medications that will be taken/administered in the home and will not include a reporting of medications that were administered while the patient was an inpatient. Restrictions imposed during a recent hospitalization should not impact the reporting of the patient's current status.

If the patient had been discharged from an inpatient facility on the day of the assessment (24 hours immediately prior to the clinician's visit and the time spent in the home), the clinician would gather information by report regarding the patient's cognitive and physical status prior to the visit and assess the patient's status during the visit and make a determination regarding the patient's ability to manage all the medications ordered to be administered in the home at all times. At the SOC, the clinician has up to five days after the SOC date to complete the comprehensive assessment, including the patient's ability to manage medications.

The intent of M2020 is to identify the patient’s ability to take all oral medications reliably and safely at all times. If the patient’s ability to manage the home medications varied on the day of the assessment, the clinician would report the patient’s ability to manage the medication for which the most assistance was needed.

QUESTION 10: For the GG functional items, I understand that verbal cueing during an activity would be coded a 04 – Supervision or touching assistance. Can a verbal cue provided prior to the initiation of the task be considered as 05 – Setup or clean-up assistance, as long as no further cues were provided during the actual activity? For example, prior to the “Picking up an item from the floor” activity, the therapist needed to cue the patient on where to place their hand for stability; then the patient completed all of the activity safely and without any assistance or additional cues. Would this be 05 - Setup or 04 - Supervision? Additionally, the OASIS Guidance Manual indicates via an example for bed to chair transfers that “locking chair brakes” prior to the transfer is 05 – Setup, as long as no further assistance was required during the activity. Could a verbal cue reminding a patient to lock wheelchair brakes prior to the initiation of the transfer be considered 05 - Setup as well, as long as no further cueing or touching was provided during the activity? [April 2020 CMS Quarterly OASIS Q&As]

ANSWER 10: When assessing self-care and mobility activities, allow the patient to complete each activity as independently as possible, as long as he/she is safe. At admission, the self-care or mobility performance code is to reflect the patient’s baseline ability to complete the activity prior to benefit of services provided by your agency staff. This may be achieved by having the patient attempt the activity prior to providing any instruction that could result in a more independent code, and then coding based on the type and amount of assistance that was required prior to the benefit of services provided by your agency staff.
Communicating the activity request (e.g., “Can you stand up from the toilet?”) would not be considered verbal cueing. If additional prompts are required in order for the patient to safely complete the activity (e.g., “Push down on the grab bar”, etc.), the assessing clinician may need to use clinical judgment to determine the most appropriate code, utilizing the Coding Section GG Activities Decision Tree found at [https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual)

In the scenarios described, assuming the verbal cues were only required prior to the activity, were provided prior to the benefit of services, and no other assistance was needed in order for the patient to complete the activity safely, then the verbal cues fit the definition for 05 – Setup or clean-up assistance.

**QUESTION 9:** The OASIS Guidance Manual for section GG clarifies that Code 03-Partial/moderate assistance indicates the helper is providing less than half the effort and Code 02 – Substantial/maximal assistance indicates the helper is providing more than half the effort. If a helper provides exactly half the effort, how would the item be coded? [April 2020 CMS Quarterly OASIS Q&As]

**ANSWER 9:** In the situation you describe, the helper and patient each are providing exactly half of the effort to complete a GG activity. If the patient performs exactly half of the effort, code the item 03 - Partial/moderate assistance.

**QUESTION 15:** If the patient requires two helpers to carry him 10 feet from the bed to the chair, would this be coded 01- Dependent for GG0170I Walk 10 feet? [January 2020 CMS Quarterly OASIS Q&As]

**ANSWER 15:** The walking activities cannot be completed without some level of patient participation. A helper cannot entirely complete a walking activity for a patient.

**QUESTION 16:** When the therapist must provide contact guard assist to the patient during ambulation and there is a second person helping to manage an Oxygen tank (or IV pump tubing), how are the GG walking items scored? [January 2020 CMS Quarterly OASIS Q&As]

**ANSWER 16:** If two helpers are required to assist the patient to safely walk, (one to provide support to the patient and a second to manage necessary equipment to allow the safe walk), code 01 – Dependent, as two helpers are required for the patient to safely complete the activity.

**QUESTION 20:** For GG0170Q, the patient was coded at admission as yes for wheelchair use but was also ambulating. In the instances where a patient is both ambulating and using a wheelchair should both the walking activities and the wheelchair activities be coded? At discharge, if the same patient is ambulating and no longer using a wheelchair, can GG0170Q be coded “no”? [January 2020 CMS Quarterly OASIS Q&As]

**ANSWER 20:** The intent of the item GG0170Q - Does the patient use a wheelchair/scooter? is to document whether a patient uses a wheelchair or scooter at the time of the assessment. The responses for the gateway wheelchair item (GG0170Q1 and GG0170Q3) do not have to be the same on SOC/ROC and discharge assessments. If at the time of the SOC assessment, the patient is using a wheelchair, GG0170Q would be coded 1 – Yes.
If at SOC the patient is both walking and using a wheelchair, then code both the walking and the wheelchair activities based on the type and amount of assistance required for the patient to safely complete each activity.

If at discharge, the patient does not use a wheelchair, then GG0170Q would be coded 0 -No.

If at discharge, the patient is both walking and using a wheelchair, then code both the walking and the wheelchair activities based on the type and amount of assistance required for the patient to safely complete each activity.