



April 2018 CMS Quarterly OASIS Q&As

Category 2

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.

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.

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.

QUESTION 3: After review of the Expansion of the One Clinician Convention Q&A, I have a question for clarification. Does the statement "other agency staff" refer to staff within our agency?

ANSWER 3: Yes, the statement “other agency staff” in the context of the collaboration refers to staff within the assessing clinician’s home health agency, including staff contracted by the agency.

QUESTION 4: The Q&A expanding the one clinician convention indicates that it “supersedes all previously published guidance related to application of the one clinician convention.” For questions that have a reference related to the old rules that did not allow collaboration or that limit the unexpected discharge to the last qualifying clinician’s visit, should the entire Q&A be considered out-of-date/ignored? Or just the portions of the Q&A that restrict collaboration?

ANSWER 4: You are correct in your understanding that the Expansion of the Home Health One Clinician Convention - CMS OASIS Q&A August 2017 “supersedes all previously published guidance related to the application of the one clinician convention.” Some posted Q&As address multiple concepts. Only the portion of a response that conflicts with the expanded collaboration guidance is superseded by the new Q&A. It should not automatically be assumed that guidance that is contained within a posted response, and that does not pertain to collaboration, is outdated or otherwise affected by the one clinician convention expansion.

Category 4b

M0102

QUESTION 5: Please clarify the changes, if any, to the M0102 as it relates to physician-ordered Resumption of Care dates.

ANSWER 5: Prior to 1/13/18, if the physician-ordered ROC date was within 2 days of the patient being discharged from an inpatient facility, M0102 was coded with the physician-ordered ROC date. Previously, if the physician-ordered ROC date was outside of the 2 days following discharge from an inpatient facility, then M0102 was coded as NA because there was no regulatory allowance for ROC date beyond 2 calendar days of facility discharge.

With the Home Health Conditions of Participation, effective 1/13/18, the assessment time frame for completing a Resumption of Care assessment was expanded to include allowance of a physician-ordered Resumption of Care date that is later than 2 days post-discharge. Effective 1/13/18, M0102 may be coded with the physician-ordered ROC date, even if the physician-ordered ROC date is later than 2 days post discharge.

M1060

QUESTION 6: In a situation where my patient is unable to be weighed, for example, when he has poor balance and can’t stand safely by himself on the bathroom scale, may I use any actual weight obtained by myself or other agency staff on any visit within the 30 days prior to my assessment visit requiring M1060 Height and Weight? A Q&A from the HH QRP Provider Training says I should use “a previous agency obtained weight from an M1060 reporting.” We often weigh our heart failure patients on routine visits throughout the episode. Could I use a weight from one of those routine visits within the 30-day window that would be more current and relevant than the one from a SOC/ROC?

ANSWER 6: When there is an unsuccessful attempt to weigh a patient at SOC/ROC, and there is a documented agency-obtained weight from one or more previous home health visits, an agency-obtained weight from a documented visit conducted within the previous 30-day window may be used to complete M1060 for this SOC/ROC assessment. However, it should be emphasized that whenever possible, a current weight should be obtained by the agency as part of the SOC/ROC assessment

M1306, M1311, M1320, M1322, M1324

QUESTION 7: We are seeking clarification regarding the reporting of pressure ulcers on the OASIS that are not identified on the initial visit. If a clinician conducts an initial assessment to meet the immediate needs of the patient and does not document the presence of a pressure ulcer and a pressure ulcer is found 2 days later when the comprehensive assessment is performed, is the pressure ulcer reported on the OASIS?

ANSWER 7: The OASIS pressure ulcer items should be coded based on findings from the first skin assessment that is conducted on or after, and as close to the SOC or ROC date as possible. If the first time a skin assessment could be done is on the second home health visit, and a pressure ulcer is identified during that assessment, then it should be reported on OASIS, as that would represent the initial skin assessment. If a skin assessment was conducted on the SOC visit and no pressure ulcer was identified, then a subsequent skin assessment was conducted on the second visit and a pressure ulcer was identified, the pressure ulcer would not be reported on the OASIS at that time point, since the pressure ulcer status should be based on the first skin assessment conducted at the SOC/ROC time points.

QUESTION 8: Regarding OASIS collaboration and pressure ulcer assessment, in a situation where the patient refuses to let the admitting nurse see his/her back in order to check for pressure ulcers because the patient was already up in wheelchair, would it be appropriate to have the next nurse who sees the patient within the next five days check for pressure ulcer/wounds and convey the information to the assessing clinician?

ANSWER 8: Because the skin assessment was not conducted on the first visit, the original assessing clinician may collaborate with the second nurse (who is completing the first clinical skin assessment) regarding the presence/status of any pressure ulcer(s), as long as the assessment is completed within 5 days of the SOC date. Providers are encouraged to complete the assessment as close to the SOC/ROC as possible.

M1306, M1311, M1320, M1322, M1324, M1340, M1342

QUESTION 9: If a patient has a non-removable dressing on when the assessing clinician admits, could a different clinician report the wound status to the assessing clinician if the dressing is removed within the assessment time frame?

ANSWER 9: The answer to this question is dependent on the type of wound involved:

Pressure Ulcers: To support consistency of data collection related to pressure ulcers across all post-acute care (PAC) providers, cross-setting guidance states that for pressure ulcers, the first clinical skin assessment is the assessment used to complete the SOC OASIS pressure ulcer items. For example, a pressure ulcer that is known to be present but that is covered with a non-removable dressing at the admission visit would be reported as Unstageable due to a non-removable dressing/device, even if the ulcer becomes observable by the 2nd visit. The guidance to assess and report the pressure ulcer stage and status as close to SOC/ROC as possible applies to all OASIS *pressure ulcer* items.

Surgical Wounds: OASIS guidance allows the agency to use any skin assessment conducted during the assessment time frame to code the OASIS surgical wound items. Guidance does not limit coding to only data from the first clinical skin assessment. For example, when a patient has a surgical wound under a non-removable dressing at the admission visit, and the dressing is changed the next day by a different nurse, the assessing clinician may report the surgical wound as non-observable based on the his/her admission visit, or may collaborate with the second nurse for information to code the surgical wound items based on observation after the dressing was removed.

M2001, M2003

QUESTION 10: With the expanded one clinician convention – would it be appropriate if a second clinician completed the Drug Regimen Review (DRR) in its entirety by phone and collaborated with the assessing clinician to respond to M2001/M2003?

ANSWER 10: While the expanded one clinician convention allows a second clinician to complete the DRR in its entirety and collaborate with the assessing clinician, it is expected that an in-person assessment would be included as appropriate in the process. While portions of the DRR may be conducted over the phone and/or by a clinician in the office (i.e., evaluating the medication list to assist with reconciling discrepancies), other portions of the DRR would require in-person assessment (i.e., evaluating the patient for effectiveness of medications or for the presence of significant side effects). The assessment must be completed within the required timeframe, and all requirements for the collaboration must be met. (See Expansion of the Home Health One Clinician Convention -CMS OASIS Q&A August 2017 <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment->

M2250

QUESTION 11: Our patient came back out of the hospital on Tuesday, and the MD ordered home health services to resume care on Friday. Orders included interventions to monitor and mitigate pain. We completed the ROC visit on Friday. Can we answer M2250e 1-yes, even though the assessment and best practice is done more than 48 hours after the discharge date?

ANSWER 11: The Home Health [Conditions of Participation \(CoP\)](#), effective 1/13/18, revised the time frame for completing a Resumption of Care assessment to include: “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.**”

Based upon this CoP revision, the response for M2250 at ROC is “1 – Yes” when the Plan of Care orders are in place within two days of inpatient discharge, or within two days of becoming aware of an inpatient discharge, **or on the physician-ordered resumption of care date.**

In the example stated, since necessary orders to monitor and mitigate pain were received on the physician-ordered Resumption of Care date, M2250e would be coded as “1- Yes”.

This document is intended to provide guidance on OASIS questions that were received by CMS help desks. Responses contained in this document may be time-limited and may be superseded by guidance published by CMS at a later date.