

OASIS C Pulling it all Together

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Produced by the Alabama Department of Public Health
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Overview

- The OASIS data set was first implemented in June of 1999
- We have been collecting OASIS data for over 10 years
- It was time to overhaul the OASIS!

Overview

- The Center for Medicare and Medicaid Services, (CMS), eliminated several MO items that were too subjective and not well defined
- Examples
 - MO260 Overall Prognosis
 - MO208 Life Expectancy
 - MO430 Intractable Pain

Overview

- MO730 Transportation
- MO740 Laundry
- MO760 Shopping
- MO items redesigned, reinvented or that received minor or major changes
 - MO830 Emergent Care which captured a doctor's office visit as an emergent care

Overview

- In the OASIS C
 - M2300
 - Considers only a hospital emergency department visit as an emergent care
 - Follow up question M2310 Reason for Emergent Care, gives us 19 choices!

Overview

- There are 3 major types of Data Elements in OASIS C
 - Case-mix and risk adjustment
 - Demographics, diagnosis, history, living arrangements
 - May be multiple responses

Overview

- Outcome
 - Measure improvement and stabilization
 - Only one response
- Process
 - Specific care delivery actions the agency took!

Overview

- There are 3 types of Process Data Elements in OASIS C
 - Assessment/screening for a real or potential problem
 - Interventions to address the problem
 - Implementation of interventions or compliance with regulatory requirements

Overview

- A simplified definition of a process data element is
 - An M item that asks about a specific care delivery action
 - Then captures information about what interventions the agency used based on Evidenced Based Practice

Overview

- **An example of a Process Data Element**
 - **M1500 Symptoms in Heart Failure Patients**

Overview

- **The “Item Intent” is to identify whether patient with a diagnosis of heart failure experienced one or more symptoms of heart failure at time of most recent OASIS assessment**
 - **Responses are no, yes, not assessed, and not applicable**

Overview

- **Follow up M item is M1510 which asks “If the patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what actions have been taken?”**

Overview

- **There are 5 choices for the answer, ranging from no action taken, to sent the patient to the emergency room**
 - **Capturing information about what the Agency did**

Overview

- **OASIS data are collected using a variety of strategies**
 - **Observation or patient demonstration**
 - **Interview**
 - **Discussion with other team members**
 - **Measurements**

Overview

- **Some M items can be answered with a patient/caregiver interview**
 - **Examples being most of your patient demographic information**
- **The majority of M items require patient demonstration and the only way to accurately answer those M items is by observing the patient**

Overview

- OASIS C is another giant step toward agency reimbursement being tied to patient outcomes
- OASIS C will result in major changes to our Quality Improvement Program

Overview

- Always important to accurately complete OASIS data set, but with OASIS C, it is more important since CMS is getting ready to link patient outcomes with reimbursement

Overview

- The new OASIS Item Guidance has the “Time Points” and the “Response Specific Instructions” sections just like the previous Item-By-Item Tips.
- The new OASIS Item Guidance has made the following changes in terminology

Overview

- “Item Intent” instead of “Definition”
- “DATA Sources/Resources” instead of “Assessment Strategies”

Overview

- The “Item Intent” for an M item may be a major change!
- MO830
 - The “Definition” was to identify whether the patient received an unscheduled visit to any (emergent) medical services other than home care

Overview

- The “Intent” for M2300 is to identify whether the patient was seen in a hospital emergency department since the previous OASIS assessment

Overview

- Points for you as a clinician
 - Imperative you become very familiar with OASIS C before trying to use new data set
 - It will take more than 1 educational session to become proficient
 - It will be a very intense afternoon of training!

OASIS C Impact on Reporting Schedule and Change in Numbering System

Quality of Care

“The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

-Institute of Medicine

Expanding HH Quality Measures

- Conceptually, quality of care can be measured in several areas ,including
 - Access
 - Assessment related to patient obtaining timely appropriate care
 - Structure
 - Capacity of the organization to provide care

Expanding HH Quality Measures

- Patient Experience
 - Obtained through the HHCAHPS Survey coming first quarter 2010
- Outcome
 - Areas that need improvement
- Process
 - Evaluate if a specific area in health care provided

Expanding HH Quality Measures

- Process measures
 - Assess the health care services provided
 - Assess adherence to recommendations for clinical practice based on evidence or consensus

Expanding HH Quality Measures

- Can identify specific areas of care that may require improvement
 - CHF
 - Diabetes
 - Pressure Wounds
 - Falls
 - Depression
 - Pain

Benefits of Measuring Processes

- Agency performance improvement activities
- Promoting the use of best practices across the home health industry and across settings of care
- Public Reporting of care processes that are under agency control
- Possible quality-based purchasing systems in the future

Incorporating Process Items into OASIS

- But why is CMS putting process items into OASIS?
 - Isn't the OASIS a patient assessment tool?
 - Not exactly...

Incorporating Process Items into OASIS

- OASIS is a dataset designed to collect information on the quality of home health care
- Integrating process items into OASIS data set is the least burdensome method of collecting data needed to calculate process measures for HHAs

Changes to OASIS Reports

- There are now 37 Outcome & Utilization Items
 - 4 Utilization Outcomes
 - 13 End Result Health Outcomes
 - 20 End Result Functional Outcomes

Changes to OASIS Reports

- Adverse Event Reports are going to change to Potentially Avoidable Events
 - 12 Events including two new measures added
 - 10 Outcome Avoidable Event Measure will be dropped

Home Health Compare and CASPER Performance Reporting Schedule

Measure Type	Report Method	Date Available	Date Period of:
OASIS- B1	CASPER	12/2009	10/2008-9/2009
OASIS-B1	HH Compare	1/2010	10/2008-9/2009
OASIS-B1	HH Compare	4/2010	1/2009-12/2009
OASIS-C Process	CASPER	9/2010	1/2010-6/2010
OASIS-C Process	HH Compare	10/2010	1/2010-6/2010
OASIS-C Outcome	CASPER	5/2011	3/2010-2/2011
OASIS-C Outcome	HH Compare	07/2011	4/2010-3/2010

Risk Adjustment

- Since the Risk Adjustment models for OASIS- C based quality measures have not been developed, the possible role of each OASIS-C item in risk adjustment is not yet known
- The flagged variables are considered to have potential and will be tested for their value in risk adjustment

Numbering System Changes

- The “MO” numbering system has been replaced with a new numbering system now called “M” items
 - The only exception is the tracking items MO903 and MO906

Numbering System Changes

- The IFMC specifically requested that these two items not be renumbered because of their data system constraints
- In the current version of the OASIS C data set these ideas appear at the end, although they have not been renumbered

Numbering System Changes

- Each section has now been assigned to a range of numbers referred to as a domain for example
 - Integumentary Status items are numbered M1300-M1350
- Medication management is now a separate domain, outside the ADL/IADL section

New Numbering System

SYSTEM	NUMBER
Tracking Items	M0010-M0150
Clinical Record Items	M0080-M0110
Patient History and Diagnoses	M1000s
Living Arrangements	M1100s
Sensory Status	M1200s
Integumentary Status	M1300s
Respiratory Status	M1400s
Cardiac Status	M1500s

New Numbering System

SYSTEM	NUMBER
Elimination Status	M1600s
Neuro./Emotional/Behavioral Status	M1700s
ADLs/IADLs	M1800s
Medications	M2000s
Care Management	M2100s
Therapy Need and Plan of Care	M2200
Emergent Care	M2300s
Data Collected at TF/DC	M2400s,MO903+MO906

OASIS Data Set Time Points

- CMS dictates what M items will be used at what time points
- Time points are not changing
- SOC/ROC, Follow-Up/Other Follow-Up, Transfer, Discharge and Death at Home
- Electronic and paper based forms are written to use the correct OASIS items at the correct time points

OASIS Data Set Time Points

- Reminder: CMS states
 - “All of these assessments, with the exception of transfer to inpatient facility and death at home, must be conducted during a home visit because all require the clinician to have an in-person encounter with the patient.”

First Set of M Items Patient Tracking Sheet

- Demographic items that contain information about the patient, agency or attending physician
- The Patient Tracking Items remain M0010-M0069 and M0140-M0150
- Most items have no changes to number or content

First Set of M Items Patient Tracking Sheet

- Most patient tracking items are collected prior to the first visit
- In electronic documentation the tracking items are populated when the document is opened
- In paper documentation, most items are part of intake and are part of a referral/intake form

First Set of M Items Patient Tracking Sheet

- If item is electronically pre-populated, do not change it in OASIS document
 - If you discover an error, consult with office staff
- If item is corrected in office, the electronic OASIS document should be refreshed to correct item

First Set of M Items Patient Tracking Sheet

- Alert
 - If you accidentally change a pre-populated item, refresh the document
- Even an extra space will cause OASIS submission warnings and errors

Patient Tracking Items Important to the Clinician

- M0030-Start of Care Date
- Must coincide with a billable visit
- Alert: When Skilled Nurse completes the SOC OASIS for therapy only cases
 - For therapy only cases, the M090 date cannot be prior to the SOC date

M0063 - Medicare Number

- Contains the Medicare number for all patients who have Medicare, even if traditional Medicare is not the payor for the admission
- Do not use the Medicare Advantage insurance number in this M item

M0063 - Medicare Number

- If the patient does not have Medicare or the Medicare number is not available, mark NA
- Always ask to see the patient's Medicare card and verify the number

Patient Tracking Item Modified

- M0140- Race/Ethnicity
 - No longer have 'Unknown' option
 - If the patient does not self-identify, obtain information from referral source or by observation
 - Major purpose of this item is for CMS to track differences in access and use of health care services

Patient Tracking Item Modified

- M00150- Current Payment Source for Home Care
 - Small changes made to instructions
 - Mark all payors for the admission
 - Primary and Secondary

Patient Tracking Item Modified

- Do not include any payor that will not be billed for the Home Health admission
- Important to get right for OASIS submission

Clinical Record Items Next Set of M Items

- M0080-M0110 remains unchanged
- M0080-Discipline of Person Completing Assessment
- M0090-Date Assessment Completed
- M0100-Reason for Assessment
- M0110-Episode Timing

M0090 Clarification

- “The assessment completion date (to be recorded in M0090) should be the last date that data necessary to complete the assessment is collected” [Q&A Edited 08/07, Q18]
- The M0090 date is not the date the electronic document is completed/locked

M0090 Clarification

- The M0090 date is not the date of the last review
- The M0090 date is not the date when an item is corrected prior to completion/locking

M0110 Episode Timing

- This item is a payment item and is necessary to determine the payment
- Answer either 1 or 2 for all Episodic Payors
 - Medicare
 - Certain Medicare Advantage Plans
 - Tricare
 - Others?

M0110 Episode Timing

- If this is not answered correctly for episodic payors, then we can't bill
- Select Response 1: Early
- If the episode of care you are assessing the patient for is the patient's first or second episode of care in a current sequence of adjacent home health PPS payment episodes

M0110 Episode Timing

- A “sequence of adjacent home health payment episodes” is a continuous series of PPS payment episodes, regardless of whether the same home health agency provided care for the entire series

M0110 Episode Timing

- “Adjacent” means that there was no gap between covered episodes of more than 60 days
- Select Response 2
 - If this episode is the third or later episode of care in a current sequence of adjacent home health PPS payment episodes

M0110 Episode Timing

- Example
 - M-0110, Payment episodes are payor specific

New Clinical Record Items

- M0102-Date of Physician-ordered Start of Care (Resumption of Care)
- M0104- Date of Referral

Why Were These Items Added?

- Added to support process measures on ‘Timely Care’
- Regulation: G332
 - Initial assessment visit must be held within 48 hours of referral, within 48 hours of the patient’s return home, or on the physician-ordered start of care date

M0102 Physician Ordered SOC/ROC

- Used when a physician orders a specific date for home health services to begin
 - Can use communication from the hospital/SNF [Q & A October, 2009]
 - Mark NA if the physician does not specify a SOC/ROC date

M0102 Physician Ordered SOC/ROC

- Do not enter a date in this item if not justified
- If the original physician-ordered SOC/ROC date gets delayed, the updated/revised date would be entered

M0104

- Date of Referral
- Skipped if date in M0102
 - The most recent date that verbal, written, or electronic authorization to begin home care was received by the agency

M0104

- This date can be updated if the patient's condition changes and we receive further communication from the referral source
- Does not include communication from others if not the referral source (family)

M0102 and M0104

- Will be compared to M030 SOC/ROC date
- Quality Measures
- Will be included in HH Compare when resumed in 2010

**OASIS-C
M1000, M1005, M1010,
M1012, M1016, M1018,
M1020, M1022,
M1024, M1030**

M1000

- Not new – was M0175
- Considered for Risk Adjustment
- Item has been enhanced to give clinician more choices
- Identifies whether patient has been discharged from inpatient facility within 14 days (two-week period) immediately preceding start of care/resumption of care

M1000

- The purpose of this item is to establish the patient's recent health care history before formulating the plan of care
- The manual has been improved upon and has clear instructions to help the clinician in determining the correct response

M1000

- If the patient was discharged from Medicare-certified skilled nursing facility, but did not receive care under the Medicare Part A benefit in the last 14 days prior to home health care, select Response 1- Long-term nursing facility

M1000

- Response 2- Skilled nursing facility
 - Medicare certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit
 - Transitional care unit (TCU) within a Medicare-certified nursing facility

M1000

- Response 3 - Short-stay acute hospital
 - Applies to most hospitalizations
- Response 4 - Long term care hospital
 - Applies to a hospital that has an average inpatient length of stay greater than 25 days

M1000

- Response 5 - Inpatient rehabilitation hospital or unit (IRF)
 - Means a freestanding rehab hospital or a rehabilitation bed in a rehabilitation distinct part unit of a general acute care hospital
- Immediate care facilities for the mentally retarded (ICR/MR) should be considered Response 7-Other

M1005

- Was MO180
- Considered for Risk Adjustment
- Identifies date of most recent discharge from an inpatient facility (within last 14 days)
 - Past 14 days encompasses two-week period immediately preceding start/resumption of care

M1005

- Even though the patient may have been discharged from more than one facility in the past 14 days, use the most recent date of discharge from any inpatient facility

M1010

- Was MO190
- Considered for Risk Adjustment
- Only had 2 slots but now has 6
- Identifies diagnoses for which the patient was receiving treatment in an inpatient facility within the past 14 days

M1010

- List of diagnoses intended to include only those diagnoses that required treatment during inpatient stay and may or may not correspond with hospital admitting diagnosis
- Expanded list allows for more comprehensive picture of patient's condition prior to initiation or resumption of home care

M1010

- The term “past fourteen days” is the two-week period immediately preceding the start/resumption of care
 - This means for purposes of counting 14 day-period, date of admission is day 0 and day immediately prior to date of admission is day 1

M1010

- For example, if the patient's SOC date is August 20, any diagnoses related to inpatient stays with discharges falling on or after August 6 and prior to the HHA admission would be reported

M1010

- If a diagnosis was not treated during an inpatient admission, it should not be listed
 - Example: The patient has a long-standing diagnosis of “osteoarthritis,” but was treated during the hospitalization only for “peptic ulcer disease”

M1010

- Do not list “osteoarthritis” as an inpatient diagnosis
- No surgical codes
 - List the underlying diagnosis that was surgically treated
 - If a joint replacement was done for osteoarthritis, list the disease, not the procedure

M1010

- No V-codes or E-codes
 - List the underlying diagnosis
- It is not necessary to fill in every line (a-f) if the patient had fewer than six inpatient diagnoses
 - But remember these diagnoses are considered for Risk Adjustment

New M Item M1012

- Considered for Risk Adjustment
- Identifies medical procedures the patient received during inpatient facility stay within the past 14 days that are relevant to the home health plan of care

New M Item M1012

- This item is intended to allow for a more comprehensive picture of the patient’s condition prior to the initiation of home care
- The procedure can be longer than 14 days ago, as long as the hospital stay ended within the 14 days

New M Item M1012

- Include only those procedures that occurred during inpatient stay that are relevant to home health plan of care, based on information available at start or resumption of care
 - A joint replacement surgery that requires home rehabilitation services

M1016

- Was M0210
- Considered for Risk Adjustment
- Identifies if any change has occurred to the patient’s treatment regimen, health care services, or medications within the past 14 days

M1016

- This question helps identify patient's recent history by identifying new diagnoses, or diagnoses that have exacerbated over past 2 weeks
- Information helps clinician develop appropriate plan of care, since patients who have recent changes in treatment plans have higher risk of becoming unstable

M1016

- No surgical codes
 - List the underlying diagnosis
- No V-codes or E-codes
 - List the appropriate diagnosis

M1016

- Response to this item may include same diagnoses as M1010 if condition was treated during inpatient stay AND caused changes in the treatment regimen
- New guidance
 - Mark "NA" if changes in medical or treatment regimen were made because diagnosis improved

M1018

- Was M0220
- Considered for Risk Adjustment
- Identifies existence of conditions prior to medical regimen change or inpatient stay within past 14 days
 - This information is important for care planning and setting goals

M1018

- Select Response 7- None of the above- if the patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, and none of the indicated conditions existed prior to the inpatient stay or change in medical or treatment record

M1018

- Select Response 'NA' if no inpatient facility discharge and no change in medical or treatment regimen in past 14 days
 - Note that both situations must be true for this response to be marked "NA"

M1018

- Our clinicians need to be careful here, in the past clinicians have automatically marked Response NA if the patient had not been in the hospital and that is wrong
- The patient could have had a treatment or medical change without being in the hospital

M1018

- Select Response “Unknown” if patient experienced inpatient facility discharge or change in medical or treatment regimen within the past 14 days, and it is unknown whether the indicated conditions existed prior to the inpatient stay or change in medical or treatment regimen

M1018

- Avoid marking ‘unknown’ automatically without checking into this item!!!
- Risk Adjusted

M1020/1022/1024

- Was M0230/M0240/M0246
- Considered for Risk Adjustment
- Has not really changed
 - More instructions
- Diagnoses, Symptom Control, and Payment Diagnoses

M1020/1022/1024

- List each diagnosis for which the patient is receiving home care (Column 1) and enter the ICD-9-CM code at the level of highest specificity
 - No surgical/procedure codes (Column 2)

M1020/1022/1024

- Choose one value that represents the degree of symptom control appropriate for each diagnosis
 - V-codes (for M1020 or M1022)
 - E-codes (for M1022 only) may be used

M1020/1022/1024

- ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses
 - If a V-code is reported in place of a case mix diagnosis, then optional M1024 Payment Diagnoses (Columns 3 and 4) may be completed

M1020/1022/1024

- A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group
- Do not assign symptom control ratings for V or E codes
- Refer to Attachment D for additional instructions on M1024

M1020/1022/1024

- Intent is to accurately code each diagnosis in compliance with Medicare's rules and regulations for coverage and payment
 - CMS expects HHAs to understand each patient's specific clinical status before selecting and assigning each diagnosis

M1020/1022/1024

- Each patient's overall condition and care needs must be comprehensively assessed **BEFORE** the HHA identifies and assigns each diagnosis for which the patient is receiving home care

M1020/1022/1024

- Secondary diagnoses in M1022 are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment of care"

M1020/1022/1024

- In general, M1022 should include not only conditions actively addressed in patient's plan of care but also any co-morbidity affecting patient's responsiveness to treatment and rehabilitative prognosis
 - Even if condition is not focus of any home health treatment itself

M1020/1022/1024

- Ensure that the secondary diagnoses assigned to M1022 are listed in the order to best reflect the seriousness of the patient's condition and justify the disciplines and services provided
- Agencies should avoid listing diagnosis that are of mere historical interest and without impact on patient progress or outcome

M1020/1022/1024

- The diagnosis may or may not be related to the patient's recent hospital stay but must relate to the services rendered by the HHA
- Skilled services (nursing, physical therapy, occupational, and speech language pathology) are used in judging the relevancy of a diagnosis to the plan of care and to the OASIS

Coding Example

- Your patient is referred to home care S/P femoropopliteal bypass due to diabetic angiopathy
 - Wound care is ordered for surgical dressings
 - The patient is on Coumadin therapy and needs PT/INRs drawn

M1030

- Was M0250
- No change
- Considered for Risk Adjustment
- New instruction Select Response 1 if the patient receives hemodialysis or peritoneal dialysis in the home
 - This came from the Q's and A's and has been added for further clarification

M 1032 Risk for Hospitalization

- New "M" item
- Risk Adjusted
- Item Intent
 - Identifies patient characteristics that may indicate the patient is at risk for hospitalization in the care provider's professional judgment

M 1032 Risk for Hospitalization

- Risk for Hospitalization
 - Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply)

**M 1032
Risk for Hospitalization**

1. Recent decline in mental, emotional, or behavioral status
2. Multiple hospitalizations (2 or more) in the past 12 months
3. History of falls (2 or more falls - or any fall with an injury - in the past year)

**M 1032
Risk for Hospitalization**

4. Taking five or more medications
5. Frailty indicators, e.g., weight loss, self-reported exhaustion
6. Other
7. None of the above

**M 1032
Risk for Hospitalization**

- Select all responses that apply, unless you select response 7
- IF response 7 is selected, none of the other responses should be marked
- Response 3 includes witnessed and reported
- In response 4, medications include OTC medications

**M 1032
Risk for Hospitalization**

- Recent decline in mental, emotional, or behavioral status refers to significant changes occurring over the past year that may impact the patient's ability to remain safely in the home and increase the likelihood of hospitalization

**M 1032
Risk for Hospitalization**

- Frailty includes weight loss in the last year, self-reported exhaustion, and slower movements
 - Sit to stand and while walking

M 1034 Overall Status

- New "M" item
- Risk Adjusted
- Item Intent
 - Identifies the general potential for health status stabilization, decline, or death in the care provider's professional judgment

M 1034 Overall Status

- Overall Status
 - Which description best fits the patient’s overall status?

M 1034 Overall Status

- 0 - Patient stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient’s age)
- 1- Patient temporarily facing high health risk(s) but likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient’s age)

M 1034 Overall Status

- 2 - Patient likely to remain in fragile health and have ongoing high risk(s) of serious complications and death
- 3 - Patient has serious progressive conditions that could lead to death within a year
- UK - Patient’s situation is unknown or unclear
 - Minimize use of UK

M 1034 Overall Status

- Use information from other providers and clinical judgment to select the response that best identifies the patient’s status
- Consider current health status, medical diagnoses, and information from physician and patient/family on expectations for recovery or life expectancy

M 1034 Overall Status

- This item is similar to the old MO280 life expectancy
- A “Do Not Resuscitate” order does not need to be in place for Responses 2 or 3

M 1036 Risk Factors

- Number changed from MO 290
- Risk Adjusted
- Item Intent
 - Identifies specific factors that may exert substantial impact on patient’s health status, response to medical treatment, and ability to recover from current illnesses, in care provider’s professional judgment

M 1036 Risk Factors

- Risk Factors, present or past, likely to affect current health status and/or outcome (mark all that apply)
 - 1- Smoking
 - 2 - Obesity
 - 3 - Alcohol dependency
 - 4 - Drug dependency
 - 5 - None of the above
 - UK – Unknown (minimize use)

M 1036 Risk Factors

- Only change is from High Risk Factors to Risk Factors
- If Response 5 is selected, none of the other responses should be selected
- CMS does not provide a specific definition for each of these factors

M 1036 Risk Factors

- Amount and length of exposure should be considered when responding
 - Smoking one cigarette a month may not be considered a risk factor

M 1036 Risk Factors

- Care providers should use judgment in evaluating risks to current health conditions from behaviors that were stopped in the past
- For determination of obesity, consider using Body Mass Index guidelines

M 1036 Risk Factors

- You can find BMI scale by going to the [Homecare website](#) under [OASIS C resources Chapter 5](#)
 - Click on hyperlink and scroll half way to [Risk Assessment Tools & Conditions Specific Resources](#)
 - Click on “Body Mass Index Guidelines”

M 1036 Risk Factors

- Drug dependency – Question
- A consultant instructed our agency to interpret drug dependency as drugs the patient depends on and should be marked on most patients. For example: a patient is dependent on respiratory drugs to remain stable. We interpreted this to mean dependency on illegal drugs. Please clarify.

M 1036 Risk Factors

- Answer
 - Intent is not to address medications/drugs individual takes/consumes/administers to achieve therapeutic effect, (insulin, blood pressure, cardiac arrhythmia and respiratory medications, etc.) Also, situations can occur where once-therapeutic use of medication becomes a true dependency situation, e.g. pain medications

Immunization Status

- The next 4 items, M1040, M1045, M1050, and M1055 are new items
 - They were added to track immunizations across the Care Continuum
- These items are quality measures and are a risk adjustment

Influenza Vaccine

- M1040 - Did the patient receive the flu vaccine from your agency for this year's flu season (October 1 through March 31) during this episode of care
- This is referring to seasonal flu not H1N1
- Key words your agency and episode of care

Influenza Vaccine

- In this item the episode of care refers to the period of time from SOC/ROC to Discharge/Transfer not a 60 day episode
- The influenza season is established by the Center for Disease Control (CDC) and recommendations may change from year to year

Influenza Vaccine

- Example
 - If the flu vaccine was given by your agency in late September (early due to the H1N1 flu preparation) you would answer “Yes,” assuming that part of the home health episode occurred within the October 1st – March 31st time frame

Influenza Vaccine

- If your response is “No” to M1040, you must answer M1045
 - M1045 – State the reason why the patient did not receive the flu vaccine from your agency during the episode of care?

Influenza Vaccine

- Prior to answering this question refer to the OASIS Item Guidance Specific Instructions to assist with responses 1 through 6
- If your response is "7-none of the above," you must have supporting documentation in the clinical note

Pneumococcal Vaccine

- M1050 Pneumococcal Vaccine is asking if the patient received the PPV from your agency during this episode of care
 - Remember, this episode of care refers to the period of time from SOC/ROC to Discharge/Transfer not a 60 day episode

Pneumococcal Vaccine

- If your response is "No" to M1050, you must answer M1055
- M1055 - State the reason why the patient did not receive the PPV vaccine from your agency during the episode of care?
- If your response is "7-none of the above" you must have supporting documentation in the clinical record

Pneumococcal Vaccine

- Prior to answering this question refer to the OASIS Item Guidance Specific Instructions with special attention to the algorithm in Figure 1

Living Arrangements

- M1100 is a new item
 - OASIS B briefly addressed this item in M0300
- Allows you to make better assessment regarding assistance patient may need to remain safely in their home environment
- A quality measure and risk adjustment

Vision

- M1200
 - No change to this item, only the number has changed
- Not a Quality Measure
- A Risk Adjustment

Hearing

- M1210 has been modified and only relates to the patients ability to hear, not ability to understand spoken language
 - OASIS B combined hearing with ability to understand verbal content
- Not a Quality Measure
- A Risk Adjustment

Understanding of Verbal Content

- M1220 is a new item and only relates to the patient's functional ability to comprehend spoken words and instructions in their primary language

Understanding of Verbal Content

- Prior to answering this question refer to the OASIS Item Guidance Specific Instructions regarding lip reading
- This item is not a quality measure but is a risk adjustment

Speech

- M1230 is M0410 in OASIS B
 - No change in content, only change is in the number
- Quality Measure
- Risk Adjustment

M 1240 Pain Assessment

- New item
- Quality Measure
- Risk Adjusted

M 1240 Pain Assessment

- Item Intent
 - Identifies if a standardized pain assessment is conducted and whether a clinically significant level of pain is present, as determined by the assessment tool used

**M 1240
Pain Assessment**

- This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment.
- The best practices stated in the item are not necessarily required in the Conditions of Participation

**M 1240
Pain Assessment**

- Has this patient had a formal Pain Assessment using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?
 - 0 - No standardized assessment conducted

**M 1240
Pain Assessment**

- 1 - Yes, and it does not indicate severe pain
- 2 - Yes, and it indicates severe pain

**M 1240
Pain Assessment**

- Response-Specific Instructions
 - A standardized tool is one that includes a standard response scale (e.g., a scale where patients rate pain from 0-10)
 - The standardized tool must be appropriately administered as indicated in the instructions and must be relevant for the patient's ability to respond

**M 1240
Pain Assessment**

- Severe pain is defined according to the scoring system for the standardized tool being used
- CMS does not endorse a specific tool

**M 1240
Pain Assessment**

- Select Response 0 if such a tool was not used to assess pain
- In order to select Response 1 or 2, the pain assessment must be conducted by agency staff during the time frame specified by CMS for completion of the assessment (SOC within 5 days; ROC within 48 hours following inpatient discharge)

M1242 Frequency of Pain Interfering with Activity

- Quality Measure
- Affects Medicare payment
- Risk Adjusted
- Changed from MO420 with addition of one item
 - “0” is: Patient has no pain

M1242 Frequency of Pain Interfering with Activity

- Question 1
 - If a patient uses a cane for ambulation in order to relieve low back pain, does the use of a cane equate to the presence of pain interfering with activity?

M1242 Frequency of Pain Interfering with Activity

- Answer
 - If cane provides adequate pain relief and patient can ambulate pain free without affecting distance or performance of other tasks, patient would not have pain interfering with activity

M1242 Frequency of Pain Interfering with Activity

- However, if use of cane does not fully alleviate pain or pain affects, and even with use of a cane, the patient limits ambulation or requires additional assistance with gait activities, then activity would be considered as affected or interfered with by pain and frequency of such interference should be assessed when responding to 1242

M1242 Frequency of Pain Interfering with Activity

- Question 2
 - Would a patient who restricts his/her activities in order to be pain free, be considered to have pain interfering with activity?

M1242 Frequency of Pain Interfering with Activity

- Answer
 - YES! A patient who restricts his/her activities to be pain free does indeed have pain interfering with activity

M1242 Frequency of Pain Interfering with Activity

- M 1242 should be scored to reflect the frequency that the patient's activities are affected or limited by pain, even if the patient is pain free at present due to activity restriction

M1242 Frequency of Pain Interfering with Activity

- Question 3
 - A patient takes a narcotic pain medication continuously and is currently pain free. Medication side effects, including constipation, nausea and drowsiness affect patient's interest and ability to eat, walk and socialize. Is this pain interfering with activity?

M1242 Frequency of Pain Interfering with Activity

- Answer
 - In this scenario, the patient is described as being pain free, but also is described as having medication side effects that interfere with activity

M1242 Frequency of Pain Interfering with Activity

- Medication side effects are not addressed in responding to M1240 and given the information in the scenario: pain apparently is not interfering with the patient's activity