OASIS ITEM

(M1000) From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? **(Mark all that apply.)**

- ☐ 1 - Long-term nursing facility (NF)
- ☐ 2 - Skilled nursing facility (SNF / TCU)
- ☐ 3 - Short-stay acute hospital
- ☐ 4 - Long-term care hospital (LTCH)
- ☐ 5 - Inpatient rehabilitation hospital or unit (IRF)
- ☐ 6 - Psychiatric hospital or unit
- ☐ 7 - Other (specify) _____
- ☐ NA - Patient was not discharged from an inpatient facility **[*Go to M1016*]**

ITEM INTENT

Identifies whether the patient has been discharged from an inpatient facility within the 14 days (two-week period) immediately preceding the start of care/resumption of care. The purpose of this item is to establish the patient's recent health care history before formulating the plan of care. This determination must be made with sufficient accuracy to allow appropriate care planning. For example, the amount and types of rehabilitation treatment the patient has received and the type of institution that delivered the treatment are important to know when developing the home health plan of care.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Mark all that apply. For example, patient may have been discharged from both a hospital and a rehabilitation facility within the past 14 days.
- An inpatient facility discharge that occurs on the day of the assessment does fall within the 14-day period.
- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any inpatient discharges falling on or after August 6 and prior to the HHA admission would be reported. Discharges on Day 0 should be included.
- Facility type is determined by the facility's state license.
- If the patient was discharged from a Medicare-certified skilled nursing facility, but did not receive care under the Medicare Part A benefit in the 14 days prior to home health care, select Response 1 - Long-term nursing facility.
- Response 2 – Skilled nursing facility means a (a) Medicare certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit or (b) transitional care unit (TCU) within a Medicare-certified nursing facility.

RESPONSE—SPECIFIC INSTRUCTIONS (Cont'd for OASIS ITEM M1000)

Determine responses to the questions below. If all three of the criteria below apply, select Response 2.

1) Was the patient discharged from a Medicare-certified skilled nursing facility? If so, then:

2) While in the skilled nursing facility was the patient receiving skilled care under the Medicare Part A benefit? If so, then:

3) Was the patient receiving skilled care under the Medicare Part A benefit during the 14 days prior to admission to home health care?

- 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 of greater than 25 days.
- 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.
- Intermediate care facilities for the mentally retarded (ICF/MR) should be considered Response 7 – Other.
- If patient has been discharged from a swing-bed hospital, it is necessary to determine whether the patient was occupying a designated hospital bed (Response 3), a skilled nursing bed under Medicare Part A (Response 2), or a nursing bed at a lower level of care (Response 1). The referring hospital can answer this question regarding the bed status.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Referral Information
- For Medicare patients, Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare.

OASIS ITEM

(M1005) Inpatient Discharge Date (most recent):

__ __ /__ __ /__ __ __ __
month / day / year

☐ UK - Unknown

ITEM INTENT

Identifies the date of the most recent discharge from an inpatient facility (within last 14 days). (Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any inpatient discharges falling on or after August 6 and prior to the HHA admission would be reported. Discharges on Day 0 should be included.
- 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.
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Referral information
- For Medicare patients, data in Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare.

OASIS ITEM

(M1010) List each **Inpatient Diagnosis** and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E-codes, or V-codes):

	Inpatient Facility Diagnosis	ICD-9-CM Code
a.	_____	__ __ __ . __ __
b.	_____	__ __ __ . __ __
c.	_____	__ __ __ . __ __
d.	_____	__ __ __ . __ __
e.	_____	__ __ __ . __ __
f.	_____	__ __ __ . __ __

ITEM INTENT

Identifies diagnosis(es) for which patient was actively receiving treatment in an inpatient facility within the past 14 days. This list of diagnoses is intended to include only those diagnoses that required treatment during the inpatient stay and may or may not correspond with the hospital admitting diagnosis. This expanded list allows for a more comprehensive picture of the patient's condition prior to the initiation or resumption of home care.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- "Actively treated" should be defined as receiving something more than the regularly scheduled medications and treatments necessary to maintain or treat an existing condition.
- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. 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.
- 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 hospitalization only for "peptic ulcer disease." 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.
- 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.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Referral information (may include inpatient facility discharge summary, physician history and physical, progress notes, etc.)
- The current ICD-9-CM code book should be the source for coding.

OASIS ITEM

(M1012) List each **Inpatient Procedure** and the associated ICD-9-CM procedure code relevant to the plan of care.

	Inpatient Procedure	Procedure Code
a.	_____	__ __ . __ __
b.	_____	__ __ . __ __
c.	_____	__ __ . __ __
d.	_____	__ __ . __ __

☐ NA - Not applicable

☐ UK - Unknown

ITEM INTENT

Identifies medical procedures that the patient received during an inpatient facility stay within the past 14 days that are relevant to the home health plan of care. This item is intended to allow for a more comprehensive picture of the patient's condition prior to the initiation of home care.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- It is no longer necessary to enter Inpatient Procedures as M1012 is not used for quality or payment functions. The item may not be left blank. Any response of NA, UK, or procedure codes represents an acceptable response.

DATA SOURCES / RESOURCES

- Patient/caregiver interviews
- Physician
- Referral information (may include hospital discharge summary, physician history and physical, progress notes, etc.)
- Home health plan of care
- The current ICD-9-CM code book should be the source for coding

Guidance for this item updated 12/2012

OASIS ITEM

(M1016) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no surgical, E-codes, or V-codes):

	Changed Medical Regimen Diagnosis	ICD-9-CM Code
a.	_____	__ __ __ . __ __
b.	_____	__ __ __ . __ __
c.	_____	__ __ __ . __ __
d.	_____	__ __ __ . __ __
e.	_____	__ __ __ . __ __
f.	_____	__ __ __ . __ __

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

ITEM INTENT

Identifies if any change has occurred to the patient's treatment regimen, health care services, or medications within the past 14 days. The purpose of this question is to help identify the patient's recent history by identifying new diagnoses or diagnoses that have exacerbated over the past 2 weeks. This information helps the clinician develop an appropriate plan of care, since patients who have recent changes in treatment plans have a higher risk of becoming unstable.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- No surgical codes - list the underlying diagnosis.
- No V-codes or E-codes - list the appropriate diagnosis.
- Response to this item may include the same diagnoses as M1010 if the condition was treated during an inpatient stay AND caused changes in the treatment regimen.
- Mark "NA" if changes in the medical or treatment regimen were made because a diagnosis improved.
- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any diagnoses requiring medical or treatment regimen change on or after August 6 and prior to the HHA admission would be reported.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Physician orders
- Referral information
- The current ICD-9-CM code book should be the source for coding

OASIS ITEM

(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

- ☐ 1 - Urinary incontinence
- ☐ 2 - Indwelling/suprapubic catheter
- ☐ 3 - Intractable pain
- ☐ 4 - Impaired decision-making
- ☐ 5 - Disruptive or socially inappropriate behavior
- ☐ 6 - Memory loss to the extent that supervision required
- ☐ 7 - None of the above
- ☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
- ☐ UK - Unknown

ITEM INTENT

Identifies existence of condition(s) prior to medical regimen change or inpatient stay within past 14 days. This information is important for care planning and setting goals.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- 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 regimen.
- 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."
- Select Response "Unknown" if the patient experienced an 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.
- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Referral information (e.g., history and physical)

OASIS ITEM

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. 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 item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. 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.

Code each row according to the following directions for each column:

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 using the following scale:

0 - Asymptomatic, no treatment needed at this time

1 - Symptoms well controlled with current therapy

2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring

3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring

4 - Symptoms poorly controlled; history of re-hospitalizations

Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). Refer to Appendix D for additional instruction related to the coding of M1024.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Continued on next page)

OASIS ITEM (M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses (cont'd)

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Assigning or Coding Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis**.	Complete **only if** the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. _____	**(V-codes are allowed)** a. (__ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)
(M1022) Other Diagnoses b. _____	**(V- or E-codes are allowed)** b. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** b._____ (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** b._____ (__ __ __ . __ __)
c. _____	c. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	c._____ (__ __ __ . __ __)	c._____ (__ __ __ . __ __)
d. _____	d. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	d._____ (__ __ __ . __ __)	d._____ (__ __ __ . __ __)
e. _____	e. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	e._____ (__ __ __ . __ __)	e._____ (__ __ __ . __ __)
f. _____	f. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	f._____ (__ __ __ . __ __)	f._____ (__ __ __ . __ __)

ITEM INTENT

The intent of this item 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. Each patient's overall medical condition and care needs must be comprehensively assessed **BEFORE** the HHA Identifies and assigns each diagnosis for which the patient is receiving home care. Each diagnosis (other than an E-code) must comply with the "Criteria for OASIS Diagnosis Reporting." (See Appendix D – if a patient has a resolved condition that has no impact on the patient's current plan of care, then the condition does not meet the criteria for a home health diagnosis and should not be coded.) The primary diagnosis (M1020) should be the diagnosis most related to the patient's current plan of care, the most acute diagnosis and, therefore, the chief reason for providing home care.

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 or care." In general, M1022 should include not only conditions actively addressed in the patient's plan of care but also any co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. 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 diagnoses that are of mere historical interest and without impact on patient progress or outcome. The diagnosis may or may not be related to a patient's recent hospital stay but must relate to the services rendered by the HHA. Skilled services (skilled nursing, physical, occupational, and speech language pathology) are used in judging the relevancy of a diagnosis to the plan of care and to the OASIS.

ITEM INTENT (cont'd for OASIS Items M1020/1022/1024)

The order that secondary diagnoses are entered should be determined by the degree that they impact the patient's health and need for home health care, rather than the degree of symptom control. For example, if a patient is receiving home health care for Type 2 diabetes that is "controlled with difficulty," this diagnosis would be listed above a diagnosis of a fungal infection of a toenail that is receiving treatment, even if the fungal infection is "poorly controlled."

A case-mix diagnosis (Column 3) is a diagnosis that gives a patient a score for Medicare Home Health PPS case-mix group assignment. A case mix diagnosis may be the primary diagnosis, "other" diagnosis, or a manifestation associated with a primary or other diagnosis. Each diagnosis listed in M1020 and M1022 should be supported by the patient's medical record documentation (i.e., the patient's Plan of Care is in compliance with 42 CFR 484.18(a)). The list of case mix diagnosis codes is included in the HH PPS Grouper documentation available on the CMS web site (see Chapter 5 of this manual for a link to this website).

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS

- V-codes may be entered in row "a" of Column 2 (item M1020); V-codes and E-codes may be entered in the other rows in Column 2 (item M1022). CMS expects HHAs to avoid assigning excessive V-codes to the OASIS. V-codes are less specific to the clinical condition of the patient than are numeric diagnosis codes. In the home health setting, V-codes are appropriately assigned to M1020 and M1022 when a patient with a resolving disease or injury requires specific aftercare of that disease or injury (i.e., surgical aftercare or aftercare for rehabilitation).
- V-codes and E-codes <u>may not</u> be entered in optional Columns 3 or 4 as these columns pertain to the Medicare PPS case mix diagnosis only.
- In optional Columns 3 and 4, complete only if a V-code is assigned under certain circumstances to column 2 in place of a case mix diagnosis. (Refer to below and Appendix D, Section D (4)).
- To prevent the loss of case mix points when an underlying case mix diagnosis is associated with the primary V-code diagnosis, HHAs should code the numeric case mix code to the primary diagnosis line (a) of M1024 when the following conditions apply: (1) the primary diagnosis (M1020) is a V-code; (2) the V-code displaces a numeric diagnosis that is a case mix diagnosis, and (3) the numeric case mix diagnosis is contained within one of the following three HH PPS diagnosis groups and to comply with ICD-9-CM coding guidelines, the secondary diagnosis, if needed to support the primary V-code diagnosis, (if appropriate for ICD-9-CM reporting in the home health setting), is reported in M1022 sequenced immediately following the V-code. The three HH PPS diagnosis groups are:
  - Diabetes
  - Skin 1-Traumatic Wounds, burns, and post-operative complications
  - Neuro 1-Brain disorders and paralysis
- ICD-9-CM coding guidelines stipulate that the acute fracture code is only to be used for the initial, acute episode of care, which is why the acute fracture code is no longer appropriate once the patient has been discharged from the hospital to home health care. In this scenario, if a V-code replaces the fracture code in either M1020 or M1022, the HHA can code the acute fracture code in the corresponding occurrence of M1024.
- Complete Columns 1 and 2 from top to bottom, leaving any blank entries at the bottom.
- In Columns 3 and 4 (optional), there may be blank entries in any row. When code(s) are entered in Columns 3 and 4 (optional), ensure that they are placed in the row that shows the corresponding V-code.
- No surgical codes – list the underlying diagnosis.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Items M1020/1022/1024)

Assessment strategies: **M1020/M1022: Primary and Other Diagnoses**

- Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician.
- Review current medications and other treatment approaches. Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician.
- The current ICD-9-CM guidelines should be followed in coding these items.
- Assessing degree of symptom control includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities. Assess the patient to determine if symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

Assessment strategies: **M1024: Case Mix Diagnoses (OPTIONAL)**

- Select the code(s) that would have been reported as the primary diagnosis under the OASIS-B1 (8/2000) instructions.
- No surgical codes —list the underlying diagnosis.
- V-codes cannot be used in case mix group assignment. If a provider reports a V-code in M1020/1022 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M1024.
- If the case mix diagnosis requires multiple diagnoses under ICD-9-CM coding guidelines, enter these codes in Columns 3 and 4 (e.g., if coded as a combination of an etiology and a manifestation code, the etiology code should be entered in Column 3 and the manifestation code should be entered in Column 4).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Physician orders
- Referral information
- Current medication list
- The current ICD-9-CM code book should be the source for coding
- See Appendix D for further guidance on assigning and coding diagnoses in M1020/M1022
- For degree of symptom control, data sources may include patient/caregiver interview, physician, physical assessment, and review of past health history.

OASIS ITEM

(M1030) Therapies the patient receives at home: **(Mark all that apply.)**

- ☐ 1 - Intravenous or infusion therapy (excludes TPN)
- ☐ 2 - Parenteral nutrition (TPN or lipids)
- ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 - None of the above

ITEM INTENT

Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy **at home**, whether or not the home health agency is administering the therapy. This item is not intended to identify therapies administered in outpatient facilities or by any provider outside the home setting.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS

- This item addresses only therapies administered at home, defined as the patient's place of residence. Exclude therapies administered in outpatient facilities or by any provider outside the home setting.
- If the patient will receive such therapy as a result of this SOC/ROC or follow-up assessment (e.g., the IV will be started at this visit or a specified subsequent visit; the physician will be contacted for an enteral nutrition order; etc.), mark the applicable therapy.
- Select Response 1 if a patient receives intermittent medications or fluids via an IV line (including heparin or saline flushes). If IV catheter is present but not active (e.g., site is observed only or dressing changes are provided), do not mark Response 1.
- Select Response 1 if ongoing infusion therapy is being administered at home via central line, subcutaneous infusion, epidural infusion, intrathecal infusion, or insulin pump.
- Select Response 1 if the patient receives hemodialysis or peritoneal dialysis in the home.
- Do not select Response 1 if there are orders for an IV infusion to be given when specific parameters are present (e.g., weight gain), but those parameters are not met on the day of the assessment.
- An irrigation or infusion of the bladder is not included when completing M1030, Therapies at Home.
- Select Response 3 if any enteral nutrition is provided. If a feeding tube is in place, but not currently used for nutrition, Response 3 does not apply. A flush of a feeding tube does not provide nutrition.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician orders
- Referral information
- Review of past health history
- Physical assessment

OASIS ITEM

(M1032) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

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

ITEM INTENT

Identifies patient characteristics that may indicate the patient is at risk for hospitalization in the care provider's professional judgment.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Select all responses 1-6 that apply.
- If Response 7 is selected, none of the other responses should be selected.
- Response 3 includes witnessed and reported (unwitnessed) falls.
- In Response 4, medications includes OTC medications.
- 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.
- Frailty includes weight loss in the last year, self-reported exhaustion, and slower movements (sit to stand and while walking).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Review of health history
- Referral information
- Physical assessment

OASIS ITEM

(M1034) Overall Status: Which description best fits the patient's overall status? **(Check one)**

☐ 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).

☐ 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).

☐ 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.

☐ 3 - The patient has serious progressive conditions that could lead to death within a year.

☐ UK - The patient's situation is unknown or unclear.

ITEM INTENT

Identifies the general potential for health status stabilization, decline, or death in the care provider's professional judgment.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- 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 the physician and patient/family on expectations for recovery or life expectancy.
- A "Do Not Resuscitate" order does not need to be in place for Responses 2 or 3.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Review of health history
- Referral information
- Physical assessment
- Advance Directive

OASIS ITEM

(M1036) Risk Factors, either 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

ITEM INTENT

Identifies specific factors that may exert a substantial impact on the patient's health status, response to medical treatment, and ability to recover from current illnesses, in the care provider's professional judgment.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Select all responses, 1-4, that apply.
- 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.
- Amount and length of exposure should be considered when responding (e.g., smoking one cigarette a month may not be considered a risk factor).
- 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.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Review of past health history
- Physical assessment
- Links to Body Mass Index guidelines for obesity can be found in Chapter 5 of this manual.

OASIS ITEM

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?

☐ 0 - No

☐ 1 - Yes **[** ***Go to M1050*** **]**

☐ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. **[** ***Go to M1050*** **]**

ITEM INTENT

Identifies whether the patient received an influenza vaccine for the current influenza season from the home health agency during this episode of care This item does not assess flu vaccine given by another care provider or provision of the vaccine by your agency prior to the most recent SOC/ROC, as that information will be reported in M1045. Responses to M1040 and M1045 are combined to report the percentage of eligible patients who received influenza immunization for the current flu season.

TIME POINTS ITEM(S) COMPLETED

Transfer to inpatient facility

Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- A care episode is one that includes both SOC/ROC and Transfer/Discharge. Therefore, when completing this item at Transfer or Discharge, only go back to the most recent SOC or ROC to determine if the patient received the flu vaccine.
- This year's influenza season means the current flu season as established by the Centers for Disease Control (CDC). Each year, flu vaccine manufacturers only release the vaccine per CDC recommendations. Therefore, if the flu vaccine is available for administration, it is flu season.
- October 1 through March 31 means the time period utilized in the computation of the process measures and for the purpose of identifying if the episode of care (SOC/ROC to Transfer/Discharge) is outside of the flu season.
- If no part of the care episode (from most recent SOC/ROC to Transfer or Discharge) occurs during the time period from October 1 through March 31, mark "NA."
- Only select Responses 0 or 1 if **any** portion of the home health episode (from SOC/ROC to Transfer or Discharge) occurs during the current influenza season.
- Only select Response 1 if the patient received the flu vaccine from your agency during this episode of care (SOC/ROC to Transfer/Discharge).
- This item meets NQF requirements for harmonization of influenza measures across care settings.

DATA SOURCES / RESOURCES

- Clinical record
- Patient/caregiver interview
- For each influenza season, identify the period of time for which the Centers for Disease Control recommends influenza vaccines be administered. See Chapter 5 of this manual for links to CDC resources.

OASIS ITEM

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:

- ☐ 1 - Received from another health care provider (e.g., physician)
- ☐ 2 - Received from your agency previously during this year's flu season
- ☐ 3 - Offered and declined
- ☐ 4 - Assessed and determined to have medical contraindication(s)
- ☐ 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine
- ☐ 6 - Inability to obtain vaccine due to declared shortage
- ☐ 7 - None of the above

ITEM INTENT

Specifies the reason that a patient did not receive an influenza vaccine from your agency during this home health care episode of care (from SOC/ROC to transfer or discharge). For each influenza season, the Centers for Disease Control (CDC) recommend the timeframes for administration of the influenza vaccines. Responses to M1040 and M1045 are combined to report the percentage of eligible patients who received influenza immunization for the current flu season.

TIME POINTS ITEM(S) COMPLETED

Transfer to an inpatient facility
Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Complete if Response 0 for M1040 is selected. Select one response.
- Select Response 1 if there is documentation in the medical record that the patient received the influenza vaccine for the current flu season from another provider. The provider can be the patient's physician, a clinic, or health fair providing influenza vaccines, etc.
- Select Response 2 if your agency provided the flu vaccine for this year's flu season prior to this home health episode, (e.g., if the SOC/ROC for this episode was in winter, but your agency provided the vaccine for the current flu season during a previous home health episode in the fall when the vaccine for the current flu season became available).
  - You may select Response 2 if a current patient was given a flu vaccine by your agency during a previous roster billing situation during this year's flu season.
- Responses 1 and 2 may be selected even if the flu vaccine for this year's influenza season was provided prior to October 1 (i.e., flu vaccine was made available early).
- Select Response 3 if the patient and/or healthcare proxy (e.g., someone with power of attorney) refused the vaccine.
  - It is not required that the agency offered the vaccine, only that the patient was offered the vaccine and he/she refused."
- Select Response 4 if the influenza vaccine is contraindicated for medical reasons. Medical contraindications include anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, or bone marrow transplant within 6 months.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1045)

- Select Response 5 if age/condition guidelines indicate that influenza vaccine is not indicated for this patient. Age/condition guidelines are updated as needed by the CDC. Detailed information regarding current influenza age/condition guidelines is posted to the CDC website (see link in Chapter 5). It is the agency's responsibility to make current guidelines available to clinicians.
- Select Response 6 only in the event that the vaccine is unavailable due to a CDC-declared shortage.
- Select Response 7 only if the home health agency did not provide the vaccine due to a reason other than responses 1-6. If an agency has elected not to administer vaccines to their patients, and the reasons listed in Responses 1-6 (such as vaccine received from another health care provider) do not apply, then Response 7 - None of the above, would be the appropriate response.

DATA SOURCES / RESOURCES

- Clinical record
- Patient/caregiver interview
- Physician or other health care provider
- For each influenza season, identify the period of time for which the Centers for Disease Control recommends influenza vaccines be administered. A link to CDC Guidelines can be found in Chapter 5 of this manual.

OASIS ITEM

(M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?

☐ 0 - No

☐ 1 - Yes ***[Go to M1500 at TRN; Go to M1230 at DC]***

ITEM INTENT

Identifies whether the patient received a PPV from the home health agency during this episode of care (from SOC/ROC to transfer or discharge). This item does not assess PPVs given by another care provider or provision of the PPV by your agency prior to the most recent SOC/ROC, as that information will be reported in M1055. Responses to M1050 and M1055 are combined to report the percentage of eligible patients who ever received PPV.

TIME POINTS ITEM(S) COMPLETED

Transfer to an inpatient facility

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Select Response1 only if the patient received the pneumococcal (PPV) vaccine from your agency during this episode (most recent SOC/ROC to Transfer/Discharge).

DATA SOURCES / RESOURCES

- Clinical record
- Patient/caregiver interview

OASIS ITEM

(M1055) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:

- ☐ 1 - Patient has received PPV in the past
- ☐ 2 - Offered and declined
- ☐ 3 - Assessed and determined to have medical contraindication(s)
- ☐ 4 - Not indicated; patient does not meet age/condition guidelines for PPV
- ☐ 5 - None of the above

ITEM INTENT

Explains why the patient did not receive a PPV from the home health agency during this episode of care (from SOC/ROC to transfer or discharge). Responses to M1050 and M1055 are combined to report the percentage of eligible patients who ever received PPV.

TIME POINTS ITEM(S) COMPLETED

Transfer to an inpatient facility

Discharge from agency - not to an inpatient facility

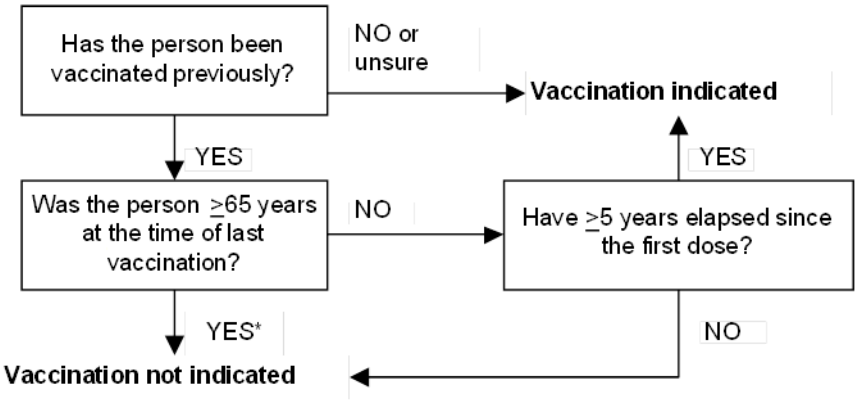
RESPONSE—SPECIFIC INSTRUCTIONS

- Response 1 should be selected if the patient received the PPV from your agency or from another provider, (including the patient's physician, a clinic or health fair, etc.) **at any time in the past.** The patient's PPV does not need to be up-to-date to select this response.
- Response 2 should be selected if the patient and/or healthcare proxy (e.g., someone with power of attorney) refused the vaccine.
- Response 3 should be selected if PPV administration is medically contraindicated for this patient. Medical contraindications include anaphylactic hypersensitivity to component(s) of the vaccine, acute febrile illness bone marrow transplant within past 12 months, or receiving course of chemotherapy or radiation therapy within past 2 weeks.
- Select Response 4 if CDC age/condition guidelines indicate that PPV is not indicated for this patient. Age/condition guidelines are updated as needed by the CDC. Detailed information regarding current PPV age/condition guidelines are posted to the CDC's website (see link in Chapter 5). It is the agency's responsibility to make current guidelines available to clinicians.
- When responding to this item, the clinician only needs to report whether the patient has ever received PPV. However, when determining whether PPV is appropriate for a patient, the clinician should also consider the following CDC recommendations:
  - Persons 65 years or older should be administered a second dose of vaccine (booster vaccine) if they received the first dose of vaccine more than 5 years earlier and were less than 65 years old at the time of the first dose.
  - Also, note that the CDC has evaluated inactivated Influenza vaccine co-administration with the Pneumococcal Polysaccharide Vaccine (PPV) systematically among adults. Simultaneous vaccine administration is safe when administered by a separate injection in the opposite arm. If the patient is an amputee or intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to clinical standards of care.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1055)

Note: The following algorithm may be used to assist in determining if PPV should be administered to immunocompetent patients ages 65 and older.

FIGURE 1. Algorithm for vaccinating immunocompetent persons aged 65 years and older.



***For any immunocompetent person who has received a dose of pneumococcal polysaccharide vaccine at age 65 years and older, revaccination is not indicated.**

Figure 1 Adapted from the CDC Recommendations and Reports. Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR April 1997;46(RR-08);1-24.

The CDC also recommends a second (booster) dose for persons who are immunocompromised due to:

- A damaged spleen or no spleen
- Sickle-cell disease
- HIV infections or AIDS
- Cancer, leukemia, lymphoma, multiple myeloma
- Kidney failure
- Nephrotic syndrome
- History of an organ or bone transplant
- Medication regimens that lowers immunity (such as chemotherapy or long-term steroids)

When any of the above conditions are present, persons older than 10 years old (including those 65 years of age and older) should get the second (booster) dose 5 years after the first dose.

- Response 5 should only be selected if the home health agency did not provide the vaccine due to a reason other than Responses 1-4. If an agency has elected not to administer vaccines to their patients, and the reasons listed in Responses 1-4 (such as vaccine received from another health care provider) do not apply, then Response 5 - None of the above, would be the appropriate response.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Resources for CDC Guidelines for PPV administration can be found in Chapter 5 of this manual.