Master OASIS-C2: Minimize Productivity Losses, Comply with New Guidance

Ann Rambusch, MSN, HCS-D, HCS-O, RN

Can you say "road trip"?

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OASIS Matters

- Multiple uses of the OASIS tool:
  - Condition of Participation (CoP)
  - Measurement of quality of care and care processes
  - Episode payment / reimbursement
  - Measurement of resource utilization
  - Identification of patterns of fraud and abuse
  - Pay for Reporting (current) and Values based Purchasing (2018)
- Ongoing pressure to "get it right":
  - Best possible outcomes and reimbursement for care provided
  - Compliance with ever-changing rules and regulations
- Requires significant depth of knowledge.
  - Guidance not always clear, language can be confusing

But Why OASIS-C2? Why Now?

- CMS is focused on Post Acute Care (PAC):
  - Increasing costs associated with PAC
  - Lack of data standards/interoperability across PAC
  - Goal of establishing payment rate based on patient characteristics, not care settings
- Solution? Create rules and regulations requiring:
  - Increased standardization with patient assessment item sets for post-acute care (LTACH, SNF, HH, and RF) settings.
  - Calculation and reporting of standardized, quality measures across the same PAC settings.
  - Implement additional PAC measures pertaining to resource use, hospitalization, and discharge to the community.

Improving Medicare Post-Acute Care Transformation Act of 2014 (the Impact Act)

- Requires CMS to develop/implement quality measures using cross-setting standardized patient assessments from post acute care settings (LTACHs, SNFs, IRFs, and HHAs). For example:
  - Skin integrity
  - Functional status and cognitive function
  - Medication reconciliation
  - Incidence of major falls
  - Medical conditions and co-morbidities

Home Health IMPACT Act Measures – CY2016 and CY2017

Domain	Measure
Skin Integrity	% of patients with new or worsening pressure ulcers (OASIS-based)
Medication Reconciliation	Drug Regimen Review with follow-up for identified issues (OASIS-based)
Resource Use	Total Medicare estimated spending per Beneficiary (Claims-based)
Resource Use	Discharge to Community (Claims-based)
Resource Use	Potentially Preventable 30 day Post-discharge readmission (Claims-based)

IMPACT Act Requires OASIS Changes

- OASIS-C2 data set implementation date: 1/1/2017.
- Changes to OASIS-C1 include:
  - Formatting changes to convert to response entry boxes rather than a line or multiple lines and boxes.
  - Conversion of pressure ulcers stages to Arabic numbers (1, 2, 3, 4).
  - Change in lookback period in 6 items: M1501, M1511, M2005, M2016, M2301, M2401.
  - 3 new standardized items: M1028, M1060, GG0170c.
  - Modification/Renumbering of medication and integumentary items to standardize with other post acute settings: M1308, M1309, M2000, M2002, M2004.

Six Months After Implementation What Do We Know About OASIS-C2?

- CMS believes monitoring patients for new or worsening pressure ulcers and publicly reporting the outcomes is an important aspect of the HH Quality Reporting Program.
- CMS also believes the process of medication reconciliation is a best practice and quality of care issue that should be monitored and reported publicly.
- Agencies will need to pay attention to any/all items that contribute to these new home health quality measures.

Objectives:
(Where are we going?)

- Identify OASIS-C2 items related to the new OASIS-based quality measures mandated by the IMPACT Act 2014.
  - New or Worsening Pressure Ulcers
  - Medication Reconciliation
- Discuss OASIS guidance and instructions related to the new quality measure items.
- Review the concept of risk adjustment as it relates to the quality measure for New or Worsening Pressure Ulcers
- Identify strategies for responding correctly to new OASIS-C2 items related to these quality measures.
- Correctly respond to M items related to the new measures in selected scenarios.

New IMPACT Quality Measure:

Percent of Patients with Pressure Ulcers that are New or Worsened

Quality Measure: Percent of Patients With Pressure Ulcers That are New or Worsened

- Adopted as a cross-setting measure to meet requirements of IMPACT Act, effective 1/1/17.
  - Domain: Skin integrity and changes in skin integrity.
  - Data obtained from OASIS.
  - Risk adjusted.
- Percent of patients with Stage 2 – 4 pressure ulcers present at discharge that are new or worsened since the beginning of the quality episode.
  - Stage 2 (M1313a) > 0, OR
  - Stage 3 (M1313b) > 0, OR
  - Stage 4 (M1313c) > 0
- ***Author's Note:*** *Agencies should strongly consider a quality review of* ***all*** *records where M1313a-c are > 0.*

Pressure Ulcer Measure is Risk Adjusted

- Measure is risk-adjusted based on an evaluation of potential covariates and their significant impact on the outcome.
  - Strategy is used to account for the medical and functional complexity of the patient population.
- "Covariates" are conditions or characteristics that put patients at risk for skin breakdown or impact ability to heal.
  - Patients with these characteristics are treated differently when calculating the measure.
- 3 of 4 covariates identified for this measure resulted in new items in OASIS-C2.

Risk Adjustment Covariates – Worsening of Pressure Ulcer Measure

- Active diagnosis of diabetes, PVD, or PAD (M1028).
- Low Body Mass Index (BMI) based on Height (M1060a) and Weight (M1060b) on SOC/ROC assessment. *(BMI >/ 12 and </ 19)*
- Bowel incontinence (M1620) at least occasionally on the initial assessment. *(Responses 2 – 5)*
- Indicator of supervision / touching assistance or more at SOC/ROC for functional mobility item GG0170C. *(Responses 01 – 04, 07, 09, 88)*

(HHQRP Program: Specifications for the Cross-Setting Pressure Ulcer Measure CY2016 Final HH PPS Rule, November 2015)

(M1028) *New in C-2*

(M1028) Active Diagnoses- Comorbidities and Co-existing Conditions—Check all that apply

See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

☐ 1 – Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)

☐ 2 – Diabetes Mellitus (DM)

- Identifies whether two specific diagnoses are present and **active** at the SOC/ROC**.**
  - Must be associated with the home health episode of care.
  - Not collected at Follow-Up
- An active diagnosis of PVD, PAD, **or** diabetes identified in M1028 impacts the risk adjustment of the Worsening of Pressure Ulcer Quality Measure.

M1028: Active Diagnoses (Response 1)

- **Select Response 1** if the patient has an active diagnosis of:
  - Peripheral Vascular Disease (PVD)
    - ICD-10 codes that start with the first 3 characters of I73

      For example: "Venous stasis" and peripheral vascular disease, unspecified code to I73.9
    - If the physician documents stasis ulcers, chronic venous insufficiency, or stasis dermatitis – assign diagnosis code I87.2, not I73.9. Do not select Response 1.
  - Peripheral Arterial Disease (PAD)
    - Codes that start with the first 4 characters of: I70.2 –, Atherosclerosis of native arteries of the extremities

M1028: Active Diagnoses (Response 2)

- **Select Response 2** if the patient has an active diagnosis of Diabetes Mellitus (DM) indicated by any one of the following diagnosis codes that start with:
  - E08. – DM d/t underlying conditions
  - E09. – Drug or chemical induced DM
  - E10. – Type 1 DM
  - E11. – Type 2 DM
  - E13. – Other specified DM

For example: Diabetic PAD

E11.51 (Type 2 DM with peripheral angiopathy w/o gangrene))

E11.52 (Type 2 DM with peripheral angiopathy and gangrene)

(M1028) Active Diagnoses

- Active diagnoses are those diagnoses that have a **direct relationship** to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.
  - **DO NOT** include diseases or conditions that have been resolved.
  - A diagnosis may not be inferred by association with other conditions
    - For example: Documentation of elevated blood sugar should not be inferred to mean "diabetes".
  - **"Nurse monitoring"** includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management).

(M1028) Guidance

- Only those diagnoses confirmed and documented by the physician . . . should be considered when responding to this item.
- Diagnoses communicated verbally must also be documented in the medical record by the physician.
  - Conversation with MD may be documented in interim order for MD signature. *(CMS HHQRP Provider Training Q&AS, May 2017, published on YouTube 6/14/17)*
- Diagnostic information, including past medical and surgical history obtained from family members and close contacts, must also be documented in the medical record by the physician.

(M1028) Guidance

- Physician must document in the record that the disease or condition is an **active** diagnosis.
  - The physician . . . may specifically indicate that a diagnosis is active.
    - Specific documentation areas in the medical record may include, but are not limited to, progress notes, admission history and physical, transfer notes, and the hospital discharge summary.
  - The physician . . . may document at the time of assessment that the patient's condition is inadequately controlled and needs monitoring or adjustment of the medication regimen. (For example: diabetes)

(M1028) Guidance

- If patient does not have an active diagnosis of PVD, PAD, or diabetes within the assessment timeframe, leave boxes in M1028 unchecked. *(CMS Q&A #46.2, 10/16)*
- Use a dash (-) if information is not available or could not be assessed. *(CMS Q&A #46.1, 10/16)*
- When a patient has diabetic peripheral vascular disease (PVD) or peripheral artery disease (PAD), both the diabetes item (2) and the PAD/PVD (1) items are checked in item M1028, Active Diagnoses.

(November 2016 HHQRP Training Q&A #33 published 2/2017)

(M1028) Examples of Active Diagnoses

Your patient underwent a below the knee amputation due to gangrene associated with peripheral vascular disease. She requires dressing changes to the stump and monitoring for wound healing. In addition, peripheral pulse monitoring is ordered. The physician's progress note documents peripheral vascular disease and a left below the knee amputation.

(M1028) Examples of Active Diagnoses

Your patient underwent a below the knee amputation due to gangrene associated with peripheral vascular disease. She requires dressing changes to the stump and monitoring for wound healing. In addition, peripheral pulse monitoring is ordered. The physician's progress note documents peripheral vascular disease and a left below the knee amputation.

- **Response 1:** Peripheral vascular disease would be checked.
- **Rationale:** This would be considered an active diagnosis because the physician's progress note documents the peripheral vascular disease diagnosis, with peripheral pulse monitoring and recent below the knee amputation, with dressing changes and wound status monitoring.

- **Note:** Additional scenarios may be found in the *OASIS-C2 Guidance Manual, Chapter 3, M1028, 12/16.*

Coding Scenario

- The patient has multiple diagnoses that will be addressed in the POC: CHF, A-fib, COPD, anemia, hemiplegia as late effect of CVA, Parkinson's disease, peripheral vascular disease. The clinician sequences these diagnoses as follows:
  - M1021a: Heart failure, unspecified
  - M1023b: Atrial fibrillation
  - M1023c: COPD, unspecified
  - M1023d: Anemia
  - M1023e: Right-sided hemiplegia as a late effect of CVA
  - M1023f: Parkinson's disease
  - Other pertinent diagnoses: Peripheral vascular disease, unspecified

Can the clinician check Response 1 (PVD) on M1028?

Coding Scenario

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  - M1023d: Anemia
  - M1023e: Right-sided hemiplegia as a late effect of CVA
  - M1023f: Parkinson's disease
  - Other pertinent diagnoses: Peripheral vascular disease, unspecified
- Can the clinician check Response 1 (PVD) on M1028?

  Yes, if the PVD is addressed on the POC even if it is not listed in M1023b – M1023f. *(CMS Q&A #46.5, 10/16)*

(M1060): *New in OASIS-C2*

Covariate

(M1060) Height and Weight—While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up

☐☐ inches — a. Height (in inches). Record most recent height measure since the most recent SOC/ROC

☐☐☐ pounds — b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.).

- Height and weight support calculation of body mass index (BMI). – a risk co-variant for Worsening of Pressure Ulcer IMPACT measure. (BMI < 19 impacts risk adjustment)
- Data collection by self-report or from paperwork from another provider setting is not acceptable. *(CMS Q&A #62.9, 10/16)*
- If a patient cannot be weighed/measured, enter the dash value (-) and document the rationale on the patient's medical record.

(M1060) Assessing Height

- Follow agency policy/procedure and standard of practice (i.e., shoes off).
- Record height to full inches - use mathematical rounding:
  - For example: Height of 62.5 inches would be rounded to 63 inches, and a height of 62.4 inches would be rounded to 62 inches.
- Height for patient with bilateral lower extremity amputation:
  - Current height (i.e., height after bilateral amputation).
- A dash (–) is valid response. *(OASIS-C2 Convention)*
  - Indicates no information is available and/or an item could not be assessed.
  - For example: Patient unexpectedly transferred, discharged or dies before the assessment of the item could be completed.

M1060: Scenario

- Ms. K was admitted to your agency on January 6th. She weighed 120 lbs. at SOC. On January 12, the patient sustained a fall, fracturing her pelvis. Her weight on admission to the hospital was 125 lbs. She was readmitted to your agency on February 3rd for physical and occupational therapy and pain management.
- At ROC the patient was experiencing significant pain and could not stand to be weighed within the timeframe of the ROC.
- How should the clinician complete M1060 Weight?

  a. 120 lbs. b. 125 lbs. c. Dash (-)

M1060: Scenario

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- At ROC the patient was experiencing significant pain and could not stand to be weighed within the timeframe of the ROC.
- How should the clinician complete M1060 Weight?

  a. 120 lbs. b. 125 lbs. c. Dash (-)

Answer: 120 lbs. - based on weight within last 30 days (same agency/provider *(**Source:** HHQRP Provider Training 11/2016)*

(M1620)

(M1620) Bowel Incontinence Frequency:		
Enter Code ☐	0	Very rarely or never has bowel incontinence
	1	Less than once weekly
	2	One to three times weekly
	3	Four to six times weekly
	4	On a daily basis
	5	More often than once daily
	NA	Patient has ostomy for bowel elimination
	UK	Unknown ***[Omit "UK" option on FU, DC]***

- Covariate risk adjuster for Quality Measure: New or Worsened Pressure Ulcers (responses 2 – 5).
- Item impacts HHRG score and NRS reimbursement.
- What is the timeframe under consideration?

M1620 Scenario

- **Question:** At the SOC assessment no bowel incontinence is reported for the past 7 days. At a repeat visit on day #4, the patient has experienced 3 episodes of bowel incontinence since the SOC. Can the clinician amend M1620 reflect this additional assessment information?
- **Answer: Yes**
  - The SOC comprehensive assessment must be completed within 5 days after the SOC date (M0030).
  - The assessing clinician may elect to re-assess bowel incontinence within the allowed timeframe and change her/his original response.
  - The M0090 date should also be changed to reflect the date the assessment was completed/updated.

(GG0170C) Mobility
Lying to Sitting on Side of Bed

Covariate

- **Item Intent:** Identify the patient's need for assistance with the mobility task of moving from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
  - No other activities are measured
- **Time Points:** Collected at SOC/ROC only – not at DC
- **Co-variate (risk adjustment factor):** New or Worsening Pressure Ulcers Quality Measure. No other measures.
- Combination item (2 components):
  - 1. SOC/ROC Performance - only component that impacts risk adjustment
  - 2. Discharge Goal

(GG0170C) Mobility

Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.

Coding:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activity may be completed with or without assistive devices.

06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper.

05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

04 **Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01 **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07 **Patient refused**

09 **Not applicable**

88 Not attempted due to **medical condition or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓Enter Response in Boxes↓		
☐☐	☐☐	**Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

(GG0170C) SOC/ROC Assessment Steps

- Activity in GG0170C: Lying to Sitting on Side of Bed
  - The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
- Use direct observation and/or patient/CG/family report.
- Have patient perform independently if safe to do so or with CG assistance if needed to be safe. Respond according to level of assistance needed.
- May use assistive device to be safe to complete task. Use of device should not impact score adversely.
- If performance varies, report patient's **usual** performance **not most independent** performance.

(GG0170C) Performance Levels

Response	Assistance
06	Independent with or w/out a device – no human assistance.
05	CG sets up or cleans up only, does not assist during activity.
04	**CG supervision, touching, verbal cueing assistance (intermittently or continuously).**
03	**CG provides < ½ effort - lift s, holds, supports trunk/limbs.**
02	**CG provides > ½ effort - lifts, holds, supports trunk/limbs.**
01	**Dependent. CG must provide ALL of effort or 2 or more CGs are needed for patient to complete activity.**
07	**Patient refused**
09	**Not applicable**
88	**Not attempted due to medical condition or safety concerns**
Responses 01-04, 07, 09, 88 impact risk adjustment for Worsening PU.	

(GG0170C) Scoring SOC/ROC Performance

- Report patient's usual status at SOC/ROC using 6-point scale (01 – 06) **OR**,
- If the patient does not attempt the activity and a caregiver does not complete the activity for the patient, report the reason the activity was not attempted.
- Use one of three "activity was not attempted" codes:
  - **07**, Patient refused
  - **09**, Not applicable, patient did not perform this activity prior to the current illness, exacerbation, or injury
  - **88**, Not attempted due to medical or safety concerns
- If no information is available or assessment is not possible for reasons other than above, enter a dash ("–") for 1-SOC/ROC Performance. Dash response does not impact risk adjustment.

(GG0170C) Scoring Discharge Goal

- Report the Discharge Goal using the 6-point scale. Do not use 07, 09, or 88 to report D/C Goal.
- Assessing clinician, in conjunction with patient and family input, can establish the discharge goal.
- If the assessing clinician does not establish a discharge goal, enter a dash (-) for the Discharge Goal.
  - Indicates that no information is available or could not be assessed.
- Discharge Goal score does not impact risk adjustment.

Selecting a Discharge Goal

- In general:
  - If the patient is expected to make progress, the Discharge Goal would be higher than the SOC/ROC response.
  - If the patient is not expected to make progress but would be expected to maintain the SOC/ROC functional level, the Discharge Goal would be the same as the SOC/ROC score.
  - If the patient is expected to decline rapidly but skilled therapy services may slow decline of function, the Discharge Goal would be lower than the SOC/ROC score.

(GG0170C) Scoring Example

- The patient states he wishes he could get out of bed himself rather than depending on his wife to help. At the SOC the patient requires his wife to do most of the effort.
- Based on the patient's prior functional status, his current diagnoses, the expected length of stay, and his motivation to improve, the clinician expects that by discharge, the patient would likely only require assistance helping his legs off the bed to complete the supine to sitting task.
  - **SOC/ROC Performance = 02, Substantial/maximal assistance**
  - **Discharge Goal = 03 Partial/moderate assistance**

See additional GG0170C examples in Chapter 3, OASIS-C2 Guidance Manual

GG0170C: *"What If?"*

Remember: *The assessing clinician must exercise clinical judgment in reporting the help a patient needs to complete the lying to sitting transfer.*

What if . . .

- Patient's preferred (or necessary) sleeping surface is a recliner or a mattress on the floor?
- Patient's feet do not reach the floor when sitting on side of bed?

GG0170C: "What If?" Scenarios

What if . . .

- Patient's preferred (or necessary) sleeping surface is a recliner or a mattress on the floor?
  - Assess the patient's need for assistance using that sleeping surface
- Patient's feet do not reach the floor when sitting on side of bed?
  - If patient performs activity independently – score 06 (Independent)
  - For safety, if patient needs help to lower bed or place stool under feet prior to transfer – score 05 (Setup or clean-up assistance

(CMS Q&A #151.21, 10/16)

GG0170C: "What If?" (cont.)

(Source: CMS Home Health Provider Training Q&As, November 2016)

- Patient's preferred sleeping surface is an electric powered recliner?
- Patient was bed bound prior to SOC/ROC?
- Patient's bed bound status is new or temporary?

GG0170C: "What If?" (cont.)

(Source: CMS Home Health Provider Training Q&As, November 2016)

- Patient's preferred sleeping surface is an electric powered recliner?
  - If the patient pushes a button to reach a sitting position, select 06 (Independent).
- Patient was bed bound prior to SOC/ROC?
  - Performance level at SOC/ROC = 09 (Not applicable)
  - If not expected to improve, a dash (-) is appropriate to report Discharge Goal.
- Patient's bed bound status is new or temporary?
  - Performance level at SOC/ROC = 88 (Not attempted due to medical condition)
  - Use 01 - 06 as Discharge Goal if patient is expected to improve.

Pressure Ulcer "Rules of the Road"

- Outcomes depend on clinicians' knowledge of OASIS pressure ulcer guidelines and the accuracy of responses to the pressure ulcer items.
- Must understand pressure ulcer item guidance and instructions in OASIS-C2:
  - Definitions
  - Terminology
  - Changes in practice standards

NPUAP Guidance and OASIS

- Agencies may adopt the NPUAP guidelines in their clinical practice and documentation.
- Since CMS has adapted the NPUAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPUAP.
- When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&As, providers should rely on the CMS OASIS instructions.

(OASIS Guidance Manual, Chapter 3, M1306, 12/17)

Updated Pressure Ulcer Definition and Terminology

(OASIS Guidance Manual, Chapter 3, M1306, 12/17)

- Pressure ulcers are defined as localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
- If pressure is not the primary cause of the lesion, do not report the wound as a pressure ulcer.
  - For example: Blister of the heel due to rubbing of a new shoe on the heel.
- Use of "healed" vs. "unhealed" terminology can refer to whether the ulcer is "closed" vs. "open".

Reverse Staging of Pressure Ulcers

- Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals.
  - For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Clinical standards require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has healed.

(OASIS Guidance Manual, Chapter 3, M1307, 12/16)

M1311 Replaced M1308 in OASIS-C2

- M1311 continues to count number of Stage 2 or higher pressure ulcers at all time points and exclude all Stage 1 ulcers.
- But M1311 introduced:
  - New/revised terminology regarding "healed" and "unhealed" vs. "closed' and "open" *(first introduced in M1306).*
  - Concept of "Present on Admission".
  - New guidance on assessing and reporting pressure ulcers treated with grafts.
  - New 2-line format to count ulcers and respond to item.
- Clinician must know OASIS-C2 pressure ulcers guidance to respond accurately to M1311 and M1313.

General Pressure Ulcer Guidance

(OASIS-C2 Guidance Manual, M1306 and M1311, 12/17)

- **Unstageable Pressure Ulcers**
  - Are never considered healed.
  - Include:
    - Suspected Deep Tissue Injuries (DTIs):
      - Present as purple or maroon localized area of discolored, intact skin or blood-filled blister.
      - May be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler to touch than surrounding skin.
    - "Known" (documented in record) pressure ulcers covered with a nonremovable dressing.
    - Pressure ulcers where eschar or slough is obscuring visualization of bone, muscle, tendon, joint capsule (Stage 4 structures).

Stage 2 Pressure Ulcers

(OASIS-C2 Guidance Manual, M1306 and M1311, 12/16)

- Characterized by partial thickness loss of dermis.
- Present as:
  - Shallow, open ulcer with red-pink wound bed without slough **OR**
  - Intact or open/ruptured blister
    - Includes blisters due to shearing, but not those due to friction only
- Heal through the process of regeneration of epidermis across the wound surface ("re-epithelialization").
- Do not granulate.
- Are reported as unhealed until they have epithelialized.

Stage 3 Pressure Ulcers

(OASIS-C2 Guidance Manual, M1306 and M1311, 12/16)

- Characterized by full thickness tissue loss:
  - No visible bone, tendon or muscle.
  - Subcutaneous fat may be visible.
  - Slough may be present but does not obscure depth of tissue loss.
  - Tunneling or undermining may be present.
- Heal through a process of granulation, contraction, and re-epithelialization.
- Are considered **closed** when the wound surfaces have fully granulated and are completely covered with new epithelial tissue. ***New!***
- When closed, are considered **healed** and should no longer be reported as an unhealed pressure ulcer. ***New!***

Stage 4 Pressure Ulcers

(OASIS-C2 Guidance Manual, M1306 and M1311, 12/16)

- Characterized by full thickness tissue loss.
  - Bone, tendon and/or muscle is/are exposed.
  - Subcutaneous fat may be visible.
  - Slough / eschar may be present on some parts of the wound bed.
  - Tunneling or undermining may be present.
- Are considered **closed** when the wound surfaces have fully granulated and are completely covered with new epithelial tissue. ***New!***
- When closed, are considered **healed** and should no longer be reported as an unhealed pressure ulcer. ***New!***

M1311: New Two-Line Format

- Line 1 (completed at all time points)

  Number of current pressure ulcers at each stage

  A1 (Stage 2); B1 (Stage 3); C1 (Stage 4); D1 (Unstageable d/t non-removable dressing; E1 (Unstageable d/t eschar/slough); F1 (Unstageable w/suspected DTI)

- Line 2 (completed at F/U and D/C only)

  Number of these ulcers that were present at most recent SOC/ROC

  A2 (Stage 2); B2 (Stage 3); C2 (Stage 4); D2 (Unstageable d/t non-removable dressing; E2 (Unstageable d/t eschar/slough); F2 (Unstageable w/suspected DTI)

Note: *Responses are easier when using the electronic format.*

(M1311)

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1] **A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ↓ ☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1] **B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ↓ ☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 at FU/DC Go to M1311D1] **C2. Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ↓ ☐

(M1311) cont. . .

D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 at FU/DC Go to M1311E1] **D2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ↓ ☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 at FU/DC Go to M1311F1] **E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ↓ ☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)] **F2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ↓ ☐
[*Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC*]	

Additional M1311 Guidance: Grafts

New!

- A pressure ulcer treated with a skin graft (defined as transplantation of skin to another site) should not be reported as a pressure ulcer in M1311.
  - Report as a surgical wound in M1340/M342 until the graft edges heal completely. *(OASIS-C2 Guidance Manual, M1311, 12/16)*
- A muscle flap, skin advancement flap, or rotational flap graft performed to surgically replace a pressure ulcer is not a pressure ulcer. It is a surgical wound. Do not report the surgical wound in M1311.
  - A muscle flap, advancement flap, or rotational flap is defined as full thickness skin and subcutaneous tissue partially attached to the body by a narrow strip of tissue so that it retains its blood supply).

M1311 Q&A Guidance: Grafts

New Q&A Info

- Pressure ulcer treated with muscle flap graft:
  - Muscle flap graft that treated a Stage 3 pressure ulcer has been healed for a year. It begins to break down due to pressure → record wound as a new pressure ulcer. *(CMS Q&A #94, 10/16)*
  - Muscle flap graft that did not heal completely begins to break down → record as nonhealing surgical wound. *(CMS Q&A #94.1, 10/16)*
- Stage 4 pressure ulcer treated with a skin graft heals. Six months later, area breaks down again due to pressure.
  - A Stage 4 pressure ulcer treated with a skin graft should be treated as a surgical wound. If the new graft heals, is epithelialized for at least 30 days and then a pressure ulcer develops at the same site, the lesion should be reported as a Stage 4 pressure ulcer, because the original underlying tissue never re-forms in the same way. *(CMS HHQRP Training, written CMS Q&A response to attendee questions, Ann Spenard, May 4, 2017)*

Present on Admission = Present at SOC/ROC*

- "Present on Admission" means the pressure ulcer was present at the time of the most recent SOC/ROC, and did not form during this home health quality episode.
- If a pressure ulcer was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge assessment, its "Present on Admission" stage should be considered the stage at which it first becomes numerically stageable.
  - If the ulcer subsequently increases in numerical stage, do not report the higher stage ulcer as being "present at SOC/ROC" when completing the Discharge assessment.

(OASIS-C2 Guidance Manual, M1311, 12/16)

Present on Admission = Present at SOC/ROC*

Per CMS, the general standard of practice for patients starting or resuming care is that patient assessments are completed beginning as close to the actual time of the SOC/ROC (5-day/48-hr. window) as possible. *(OASIS-C2 Guidance Manual, M1311, 12/16)*

- If a pressure ulcer that is identified on the SOC date increases in numerical stage (worsens) within the assessment time frame, the initial stage of the pressure ulcer would be reported in M1311 at the SOC.
- **For example:** At SOC on 8/1, patient has a Stage 2 pressure ulcer and no other pressure ulcers. At a routine visit on 8/3, the pressure ulcer has worsened to a Stage 3. Report the Stage 2 on M1311, A1.

***Note:** Guidance for reporting the stage of the pressure ulcer at the SOC/ROC differs from other OASIS guidance on completion of an item within the 5-day or 2-day window.

(M1311) Scenario

- Patient was admitted with a Stage 3 pressure ulcer on her right hip at the SOC. She has no other pressure ulcers. At follow-up, the patient's ulcer was assessed as unstageable due to eschar and slough. The patient was discharged 3 weeks later because she was moving in with her daughter who lives in another state. At discharge, the ulcer on the right hip is assessed as a Stage 3. There is a new Stage 2 ulcer on her left hip. How should M1311 be answered at SOC, Follow-up, and Discharge?

(M1311) Scenario

- Patient was admitted with a Stage 3 pressure ulcer on her right hip at the SOC. She has no other pressure ulcers. At follow-up, the patient's ulcer was assessed as unstageable due to eschar and slough. The patient was discharged 3 weeks later because she was moving in with her daughter who lives in another state. At discharge, the ulcer on the right hip is assessed as a Stage 3. There is a new Stage 2 ulcer on her left hip. How should M1311 be answered at SOC, Follow-up, and Discharge?
  - **SOC/M1311:** B1 = 1 (Stage 3), Line 2 does not apply
  - **Follow-up/M1311:** B1 = 0, E1 = 1 (Unstageable d/t slough)
    B2 = 0, E2 = 0 (Unstageable d/t slough)
  - **Discharge/M1311:** A1 = 1 (Stage 2), B1 = 1 (Stage 3)
    A2 = 0 B2 = 1 (Stage 3)

? How many pressure ulcers worsened?

(M1313)

Impact

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:	
Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.	
	Enter Number
a. Stage 2	
b. Stage 3	
c. Stage 4	
Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.	
	Enter Number
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	
f. Unstageable – Suspected deep tissue injury in evolution.	

(M1313) Guidance

- Count the number of current pressure ulcers that are new or have increased in numerical stage since the last SOC/ROC was completed.
- Compare the current stage at Discharge to past stages to determine whether any pressure ulcer currently present is new or at an increased numerical stage (worsened) when compared to the most recent SOC/ROC.
- A pressure ulcer increased in numerical stage from SOC (or ROC) to Discharge, is considered worsened.
- For pressure ulcers that are currently Stage 2, 3, and 4, "worsening" refers to a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 at the time of discharge in comparison to the most recent SOC/ROC assessment.

(M1313) Guidance

New!

- A dash (–) value is a valid response for this item. A dash (–) value indicates that no information is available, and/or an item could not be assessed.
- Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals.
- Pressure ulcers that are Unstageable at Discharge due to a dressing/device, such as a cast that cannot be removed to assess the skin underneath cannot be reported as new or worsened unless no pressure ulcer existed at that site at the most recent SOC/ROC.

(M1313) Guidance

New!

- Once a pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered healed, and should no longer be reported as an unhealed pressure ulcer.

New!

- If a pressure ulcer was unstageable for any reason at the most recent SOC/ROC, do not consider it new or worsened if at some point between SOC/ROC and Discharge it became stageable and remained at that same stage at Discharge.

(M1313) Guidance

New!

- If the pressure ulcer was unstageable at SOC/ROC, then was stageable on a routine visit and/or Follow-Up assessment, and by Discharge the pressure ulcer had increased in numerical stage since the routine visit and/or Follow-Up assessment, it should be considered worsened at Discharge.

New!

- If a previously stageable pressure ulcer becomes unstageable, then was debrided sufficiently to be restaged by Discharge, compare its stage before and after it was deemed unstageable. If the pressure ulcer's stage has increased in numerical staging, report this as worsened.

(M1313) Reporting Algorithm

CURRENT STAGE *at Discharge*	*Look back to most recent SOC/ROC*	PRIOR STAGE *at most recent SOC/ROC*		*REPORT AS NEW OR WORSENED?*
a. Stage 2 *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	**▪ Not present ▪ Stage 1 ▪ Covered with a non-removable dressing/device, then documented as a Stage 1 at any home visit or Follow-Up assessment(s)**	⇨	**YES**
		▪ Stage 2	→	NO
		▪ Stage 3 ▪ Stage 4	→	NA (Stage 3 or 4 could not become a Stage 2)
		▪ Covered with a non-removable dressing/device and remains Unstageable until assessed as a Stage 2 at Discharge	→	NO
b. Stage 3 *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	**▪ Not present ▪ Stage 1 ▪ Stage 2 ▪ Unstageable with documented Stage 1 and/or 2 at any home visit or Follow-Up assessment(s)**	⇨	**YES**
		▪ Stage 3	→	NO
		▪ Stage 4	→	NA (Stage 4 could not become a Stage 3)
		▪ Unstageable until assessed as a Stage 3 at Discharge	→	NO

(M1313) Reporting Algorithm

CURRENT STAGE *at Discharge*	*Look back to most recent SOC/ROC*	PRIOR STAGE *at most recent SOC/ROC*	REPORT AS NEW OR WORSENED?
c. Stage 4 *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	▪ **Not present** ▪ **Stage 1** ▪ **Stage 2** ▪ **Stage 3** ▪ **Unstageable with documented Stage 1, 2, and/or 3 at any home visit or Follow-Up assessment(s)**	**YES**
		▪ Stage 4 ▪ Unstageable until assessed as a Stage 4 at Discharge	NO
d. Unstageable due to non-removable dressing *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	▪ **Not present**	**YES**
		▪ Stage 1 ▪ Stage 2 ▪ Stage 3 ▪ Stage 4 ▪ Unstageable	NO

(M1313) Reporting Algorithm

CURRENT STAGE *at Discharge*	*Look back to most recent SOC/ROC*	PRIOR STAGE *at most recent SOC/ROC*	REPORT AS NEW OR WORSENED?
e. Unstageable due to slough and/or eschar *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	▪ **Not present** ▪ **Stage 1** ▪ **Stage 2**	**YES**
		▪ Stage 3 ▪ Stage 4 ▪ Unstageable	NO
f. Unstageable – suspected deep tissue injury *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	▪ **Not present** ▪ **Stage 1** ▪ **Stage 2**	**YES**
		▪ Stage 3 ▪ Stage 4 ▪ Unstageable due to slough and/or eschar	NA (Full thickness pressure ulcer could not become a sDTI)
		▪ Unstageable – Suspected DTI or due to a non-removable dressing/device	NO

M1311 / M1313 Example (Part 1)

- Patient had a Stage 2 pressure ulcer on her left hip at SOC. How do you complete M1311 at SOC?
- After two weeks in home health, she was transferred to acute care for 3 days due to pneumonia. At the ROC assessment, the pressure ulcer on her left hip had deteriorated to a Stage 3 and she had a new Stage 1 pressure ulcer on her right hip. Complete M1311 for ROC.

M1311 / M1313 Example (Part 1)

- Patient had a Stage 2 pressure ulcer on her left hip at SOC. How do you complete M1311 at SOC?
  - **M1311:** A1(Stage 2) = 1 (Line 2 does not apply)
- After two weeks in home health, she was transferred to acute care for 3 days due to pneumonia. At the ROC assessment, the pressure ulcer on her left hip had deteriorated to a Stage 3 and she had a new Stage 1 pressure ulcer on her right hip. Complete M1311 for ROC.
  - **M1311:** B1(Stage 3) = 1
    Line 2 completed at F/U and D/C only
    Stage 1 pressure ulcers are excluded from M1311

M1311 / M1313 Example (Part 2)

- At Discharge, the Stage 3 pressure ulcer on her left hip was 80% granulated and the Stage 1 pressure on the right hip had evolved to a Stage 2 pressure ulcer. Complete M1311 and M1313.

M1311 / M1313 Example (Part 2)

- At Discharge, the Stage 3 pressure ulcer on her left hip was 80% granulated and the Stage 1 pressure on the right hip had evolved to a Stage 2 pressure ulcer. Complete M1311 and M1313.
  - **M1311 Line 1:** A1(Stage 2) = 1, B1(Stage 3) = 1
  - **M1311 Line 2:** A2(Stage 2) = 0, B2(Stage 3) = 1
    Line 2 is always completed at F/U and D/C
  - **M1313:**
    - **M1313a = 1 -** Stage 2 ulcer worsened
      (Stage 1 ulcer at ROC became Stage 2)
    - **M1313b = 0 -** Stage 3 ulcer at ROC remained a Stage 3 ulcer

M1311 Scenario

- A Stage 3 pressure ulcer is assessed on the right hip of the patient at SOC. A Stage 2 pressure ulcer is also present on the right malleolus. At discharge, the patient's Stage 3 ulcer on the right hip has fully epithelialized and the Stage 2 pressure ulcer on the right malleolus has healed. There is a new Stage 3 pressure ulcer on the patient's left hip. How should M1311 and M1313 be completed on the Discharge assessment.

M1311 Scenario

- A Stage 3 pressure ulcer is assessed on the right hip of the patient at SOC. A Stage 2 pressure ulcer is also present on the right malleolus. At discharge, the patient's Stage 3 ulcer on the right hip has fully epithelialized and the Stage 2 pressure ulcer on the right malleolus has healed. There is a new Stage 3 pressure ulcer on the patient's left hip. How should M1311 and M1313 be completed on the Discharge assessment.

  M1311- B1 = 1 Stage 3

  M1311- B2 = 0 Stage 3

  M1313b = 1 Stage 3

  (Source: CMS Home Health Provider Training, Q&As, 11/16)

(M1320)

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)		
Enter Code ☐	0	Newly epithelialized
	1	Fully granulating
	2	Early/partial granulation
	3	Not healing
	NA	No observable pressure ulcer

Do not use Response 0. Newly epithelialized (healed) ulcers should not be reported.

- Includes all Stage 2 or higher pressure ulcers that are not covered with a non-removable dressing.
- The presence of necrotic tissue does NOT make the pressure ulcer "NA – No observable pressure ulcer".
- A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base cannot be staged, but its healing status is either:
  - Response 2 – Early/Partial Granulation if necrotic or avascular tissue covers <25% of the wound bed, or
  - Response 3 - Not Healing, if the wound has ≥25% necrotic or avascular tissue.
- Enter "NA" for pressure ulcer sutured closed. *(CMS Q&A #98.2 10/16)*

(M1324)

(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)		
Enter Code ☐	1	Stage 1
	2	Stage 2
	3	Stage 3
	4	Stage 4
	NA	Patient has no pressure ulcers or no stageable pressure ulcers

New!

- Ulcers that have healed are not considered for this item.
- If a pressure ulcer is Stage 4 at SOC and is granulating at the Follow-up Assessment, the ulcer remains a Stage 4 ulcer.
- Enter "NA" if the patient has NO pressure ulcers or only has pressure ulcers that are Unstageable as defined above.

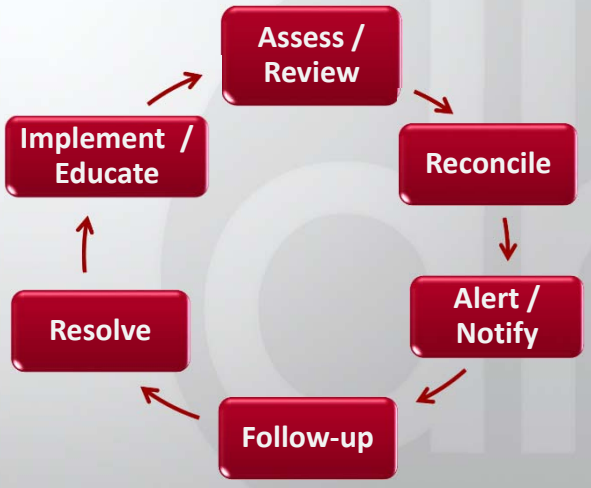
New IMPACT Quality Measure:

Medication Reconciliation

Drug Regimen Review Quality Measure

- Process measure applied across all post acute settings.
- Reports percentage of patient care episodes in which a drug regimen review was conducted at the time of the SOC/ROC and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout that care episode.
- Measure is NOT risk adjusted.
- No episodes are excluded from consideration.

Drug Regimen Review Process



Calculation of Drug Regimen Follow-up Process Measure

- OASIS-C2 Items included:
  - M2001
  - M2003
  - M2005

Higher score is better!

- If data are missing on any of the 3 items, the episode will not be included in the numerator used to calculate the measure (number of completed episodes meeting measure criteria) .
- The patient episode will continue to be counted in the denominator (total number of completed episodes).

(M2001) Drug Regimen Review

IMPACT

(M2001)	**Drug Regimen Review:** Did a complete drug regimen review identify potential clinically significant medication issues?
Enter Code ☐	0 No - No issues found during review *[Go to M2010]* 1 Yes - Issues found during review 9 NA - Patient is not taking any medications *[Go to M2040]*

- "Problems" are now issues.
- If elements of the drug regimen review were skipped (i.e., drug-to-drug interactions), a dash (–) should be reported, indicating the drug regimen review was not completed. *(CMS Q&A #160.5, 10/16)*
- Comprehensive assessment must be completed by one clinician (the assessing clinician). Collaboration is allowed with another clinician. M0090 date is date the 2 clinicians collaborate and complete the assessment.

(M2001) Drug Regimen Review

- **Includes:** Medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.
- A potentially clinically significant issue is one that warrants notification of the physician/physician-designee for orders or recommendations — by midnight of the next calendar day, at the latest.

Clinically Significant Medication Issues May Include

Adverse Drug Reaction	Duplicate Therapy
Ineffective Drug Therapy	Omissions
Side Effects	Dosage Errors (high or low)
Drug-Drug Interactions	Nonadherence
Drug-Food Interactions	

Clinically Significant Issues: Any of the circumstances listed above must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations — by midnight of the next calendar day, at the latest. Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue.

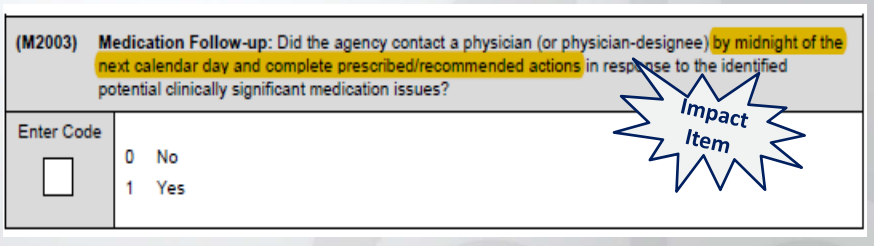
Is This a Clinically Significant Medication Issue? You Tell Me!

- Patient's BP is 95/60 after adding new hypertension medication to his drug regimen 2 days ago.
- Patient is taking Lasix 40 mg. at bedtime as ordered and complains about having to urinate frequently at night.
- Patient has an order to take 600 mg calcium daily. She ran out of the tablets yesterday and her daughter will pick up a new bottle tomorrow.
- Blood in the stool of a patient taking Coumadin.
- Prolonged clotting time of a patient taking Coumadin.

M2001: Response 0 (No issues found)

- Clinical judgment of assessing clinician that:
  - Patient has all medications prescribed.
  - Patient's list of discharge medications from the IP facility matches medications patient is taking in the home.
  - Diagnoses/symptoms for which patient is taking medications are adequately controlled.
  - Patient has a plan for safely taking medication at right time.
  - Patient is not showing signs/symptoms indicative of adverse drug reactions.

(M2003)



- Revision / Wording change to:
  - Clarify timing (12MN of next calendar day)
  - Emphasizes requirement to complete prescribed/recommended actions by 12MN of next calendar day
  - Recommended actions must also occur within the allowed timeframe for the SOC/ROC *(CMS Q&A #160.5.1, 10/16)*

M2003/M2005: Medication Reconciliation

- Physician notification alone is NOT medication reconciliation.
- In M2003/M2005, Medication follow-up and reconciliation **require**:
  - **2-way communication** with the physician or physician designee regarding the potentially significant medication issue **and**
  - **Completion of the prescribed / recommended actions** no later than 12 midnight of the next calendar day.

Definition: Physician Contact

- Contact with physician is defined as communication to the physician or physician-designee (made by telephone, voicemail, electronic means, fax, or any other means) that appropriately conveys the message of patient status.
- Communication can be directly to/from the physician or physician-designee, or indirectly through physician's office staff on behalf of the physician or physician-designee, in accordance with the legal scope of practice.

M2003: Response Guidance

- If the physician/physician-designee recommends an action that will take longer than the allowed time to complete, enter **Response 1 – Yes** as long as the agency has taken whatever recommended actions are possible to comply with by midnight of the next calendar day.
  - Includes when a weekend "on-call" physician unfamiliar with the patient directs agency to call the PCP on Monday for further orders. *(CMS Q&A #160.5, 10/16)*

M2003: Response Guidance

- When multiple potential clinically significant medication issues are identified at the SOC/ROC, all must be communicated to the physician/designee, with completion of ***ALL*** prescribed/recommended actions that are possible to comply with by midnight of the next calendar day in order to enter **Response 1 –Yes**.
  - If only one issue of two or more issues was communicated to the physician, then **Response 0 (No)** is the correct response.
  - If all prescribed actions that are possible to comply with by midnight of next calendar day are not met, then **Response 0 – No** is the correct response.

M2003: Response Guidance

- If the physician's/designee's **response** to notification of potentially significant issues is that there are no new orders or instructions related to the plan of care, then this completes the requirement for 2-way communication. Enter **Response 1 – Yes.** [Bullet #6 in M2003 should be amended.] *(email clarification from CMSOASISquestions, 8/22/2016)*
  - Document the physician's response in the record.
- If a potential clinically significant medication issue was identified, and the clinician attempted to communicate with the physician, but did not receive communication back from the physician/physician designee until after midnight of the next calendar day, enter **Response 0 – No.**

M2003 Scenario

- On day 5 after the SOC, the assessing clinician identified a medication issue and notified the physician who responded to her by midnight of the next calendar day (day 6) with a plan to resolve the problem. What is the appropriate response to M2003 (Medication Follow-up)?
  - Response 0 (No)
- If a medication issue is identified on day 5 after the SOC, the physician is contacted by midnight of the next calendar day and responds back with a plan to resolve the problem on day 6 after the SOC, this 2-way communication could not be captured at the SOC. *(CMS Q&A #160.5.1, 10/16)*
  - This guidance ensures compliance with CoP regarding completion of the comprehensive assessment at the SOC/ROC.

M2005

Impact

(M2005) **Medication Intervention:** Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?	
Enter Code ☐	0 No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

- Actions must be taken "**each time** clinically significant medication issues were identified . . ."
- "Since the SOC/ROC" means **at the time of or at any time since** the SOC/ROC.
- Completed at Transfer, Discharge, and Death at home.

M2001/M2003/M2005 Scenario

- A clinically significant medication issue is identified by the admitting RN at the SOC during the drug regimen review. The correct response to M2001 is:
  - **M2001 =**
- The RN contacted the MD's office on the day of admission and left a message related to the issue. The physician did not return the call until after midnight of the next calendar day.
  - **M2003 =**
- At discharge, the assessing clinicians determines there were no further medication issues since the SOC. The correct response to M2005 is:
  - **M2005 =**

M2001/M2003/M2005 Scenario

- A clinically significant medication issue is identified by the admitting RN at the SOC during the drug regimen review. The correct response to M2001 is:
  - **M2001 = 1 (Yes)**
- The RN contacted the MD's office on the day of admission and left a message related to the issue. The physician did not return the call until after midnight of the next calendar day. The correct response to M2003 is:
  - **M2003 = 0 (No)**
- At discharge, the assessing clinicians determines there were no further medication issues since the SOC. The correct response to M2005 is:
  - **M2005 = 0 (No)**

What Have We Learned About OASIS-C2?

- Parts of OASIS-C2 are easier than others.
- Pressure ulcers items will require some work to master.
- Identified the risk covariates for New and Worsening Pressure Ulcer measure – including M1620.
- Realized cross-setting measures are forcing compromise:
  - Reporting "present on admission" pressure ulcers at SOC/ROC
  - Reporting closed pressure ulcers
  - Redundancy of GG0170C (Mobility) and M1850 (Transfers)
- Are still learning how to use the dash (-).
- Still hoping for a consistent / reliable source for clarifying/resolving OASIS item issues as they arise.

The Big Take Away From Our Trip?

The future for OASIS and home health is change!

Enjoy the ride!!!

Web Site References

- **OASIS-C2 Guidance Manuals**
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html
- **CMS OASIS Q&As (OASIS-C1 and OASIS-C2)**
  https://www.qtso.com/hhatrain.html
- **CMS HHQRP Quality Training (Nov. 2016), Participant Q&As, published February 2017**
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.htm
- **CMS HHQRP Quality Training (May 2017), Participant Q&As, published on YouTube, June 14, 2017)**
  https://youtu.be/woLX9FzJY1o?t=2m40s.

Questions?

Submit a question:
Go to the chat pod located in the lower left corner of your screen. Type your question in the text box then click on the "Send" button.

Thank You!

Ann Rambusch, MSN, HCS-D, HCS-O, RN