OASIS-C2 – Get the Facts

Presented by: Anita Werner, RN, HCS-D, COS-C
Senior Compliance Consultant

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OASIS C2 IS FINALIZED!

- OASIS data set and manual are available:
  - Originally posted 6-27, but OASIS manual revision posted 6-30.
- Effective on January 1, 2017.

FORMATTING CHANGES

Many Items now have a response entry box rather than a line ____ or a check 🍀
FORMATTING CHANGES

Multiple check box items were changed to a single box when responses are mutually exclusive.

REVISED NUMBERING

- M1501 (M1500) Symptoms in Heart Failure Patients.
- M1511 (M1510) Heart Failure Follow-up.
- M2016 (M2015) Pt/Cg Drug Education Intervention.
- M2301 (M2300) Emergent Care.
- M2401 (M2400) Intervention Synopsis.

REVISED LOOK-BACK PERIOD

New instruction for the “look-back” period on five items collected at Transfer and Discharge.

OASIS-C2

“At the time of or any time since the most recent SOC/ROC assessment”

OASIS-C1

“At the time of or any time since the previous OASIS assessment”
REVISED LOOK-BACK PERIOD

- M1501 – Symptoms in Heart Failure.
- M1511 – Heart Failure Follow-up.
- M2016 – Patient/Caregiver Drug Education.
- M2301 – Emergent Care.
- M2401 – Intervention Synopsis.

IMPACT ACT REVISIONS

IMPACT Act: Improving Medicare Post-Acute Care Transformation Act of 2014:
- Requires providers to standardize and submit patient assessment and quality data (LTCHs, IRFs, SNFs, and HHAs).
- Goals:
  - Improve quality in all post-acute settings;
  - Improve transition between care settings; and
  - Compare care and outcomes in different post-acute care settings.

IMPACT ACT REVISIONS

Arabic numbers rather than roman numerals to indicate pressure ulcer stages.
**IMPACT ACT REVISIONS**

Numbering revised on two Integumentary and three medication items:
- Added “1” to the former Item number to standardized with other post-acute care settings.
- M1311: Current number of unhealed pressure ulcers at Each Stage.
- M1313: Worsening in pressure ulcer status since SOC/ROC.
- M2001: Drug Regimen Review.
- M2003: Medication Follow-up.

• Three additional standardized OASIS items.
• Included due to their potential significant impact upon pressure ulcer development and worsening:
  - M1028: Active Diagnosis of PVD, PAD, or DM.
  - M1060: Height and Weight.
  - GG0170c: Mobility – Lying to sitting on the edge of the bed.

**M1028: ACTIVE DIAGNOSIS OF PVD, PAD, OR DM**

(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 Melliits (DM)

PVD or PAD related diagnoses codes:
- I70.2xx through I70.7xx Atherosclerosis of the Native Arteries and/or Bypass Grafts.
- I70.91 Generalized Atherosclerosis of the Extremities.
- I70.92 Chronic Total Occlusion of Artery of the Extremities.
- I73.xx Other Peripheral Vascular Disease.
M1028: ACTIVE DIAGNOSIS OF PVD, PAD, OR DM

Diagnoses must be documented as “active” by physician (or NP, PA, CNS, etc.).
- Can be directly stated or may be inferred as active by statements related to med management, treatment changes, need for nurse monitoring, and med management by nursing.
- How does the plan of care reflect your response?

DM related diagnoses codes:
- E08.xxx Diabetes Mellitus Due to Underlying Condition.
- E09.xxx Drug or Chemical Induced Diabetes Mellitus.
- E10.xxx Type I Diabetes Mellitus.
- E11.xxx Type II Diabetes Mellitus.
- E13.xxx Other Specific Diabetes Mellitus.

M1028: ACTIVE DIAGNOSIS OF PVD, PAD, OR DM

Diagnoses must be confirmed by physician (or NP, PA, CNS, etc.) and documented.
- Document confirmation of diagnosis by physician if not found in referral information.
M1060: HEIGHT AND WEIGHT

- Collected at SOC and ROC.
- Included to allow for calculation of BMI:
  - Risk adjustment when BMI $\geq 12.0$ and $\leq 19.0$

**BMI FORMULA**

$$\text{BMI} = \frac{703 \times \text{weight (lb)}}{\text{height (in$^2$)}}$$

- Enter actual, current height for patient's with bilateral lower extremity amputation.
- Round to the nearest inch or pound.
- A dash (--) is an acceptable entry in rare situations when:
  - Patient unexpectedly transfers, discharges, or expires.
  - Patient cannot be weighed due to extreme pain, immobility, risk of pathological fractures.

- Review agency policy for consistency in measurements using best practices.
- Include as a part of intake referral data.
GG0170C: MOBILITY – LYING TO SITTING ON EDGE OF THE BED

- Completed at SOC and ROC.
- Included to reflect impact of impaired mobility on risk of worsening of current pressure ulcers or development of new pressure ulcers.
- Notice reversal of scale!!!
  - 06 = Independent.
  - 05 through 02 = Help from another person.
  - 01 = Dependent.
GG0170C: MOBILITY – LYING TO SITTING ON EDGE OF THE BED

• Allow patient 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.

• May complete with or without an assistive device.

• When patient’s performance is unsafe or of poor quality, score according to amount of assistance provided.

GG0170C: MOBILITY – LYING TO SITTING ON EDGE OF THE BED

• When performance varies, report the usual status rather than their most independent or most dependent status.

• Codes provided for use when not attempted:
  – 07 = Patient refused.
  – 09 = Not Applicable.
  – 88 = Not attempted due to medical condition or safety concerns.
  – Dash (-) = Could not be assessed due to unexpected transfer, discharge, or death. Only used in rare circumstances.

GG0170C: MOBILITY – LYING TO SITTING ON EDGE OF THE BED

Codes used when activity is completed:

– 06 = Independent: No cueing or assistance of any kind.
– 05 = Setup or cleanup assistance: Only prior to/after activity.
– 04 = Supervision or Touching: Includes cueing; intermittent or continual assistance.
– 03 = Partial/moderate assistance: Helper provides less than ½ the assistance.
– 02 = Substantial/maximal assistance: Helper provides more than ½ the assistance.
– 01 = Dependent: Helper provides all the effort, or assistance of two or more helpers is required to complete the activity.
GG0170C: MOBILITY – LYING TO SITTING ON EDGE OF THE BED

• Acceptable Discharge Goal responses:
  – 01 through 06 when a discharge goal can be established.
  – Dash (-) may be entered in rare circumstances such as unexpected patient transfer, discharge, or death.
• Collaborate with Patient/Caregiver to set goal:
  – Consider whether the patient is likely to improve, remain stable, or decline based upon assessment findings and patient/caregiver indication of prior level of function.
• Does the plan of care reflect your goal setting? Are therapy services needed?

MEDICATION ITEM REVISIONS

• OASIS-C1
  – M2000: Does a complete drug regimen review indicate potentially significant medication issues (for example, adverse drug reactions, ineffective drug therapy, significant side effects, drug interactions, duplicate therapy, omissions, dosage errors, or non-compliance [non-adherence])?

• OASIS-C2
  – M2001: Did a complete drug regimen review identify potential clinically significant medication issues?

M2001: DRUG REGIMEN REVIEW

Enter Code

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No – No issues found during review [Go to M2010]</td>
</tr>
<tr>
<td>1</td>
<td>Yes – Issues found during review</td>
</tr>
<tr>
<td>9</td>
<td>NA – Patient is not taking any medications [Go to M2004]</td>
</tr>
</tbody>
</table>

• Complete a medication reconciliation including all prescribed & OTC meds by any route to identify, and if possible, prevent potential clinically significant medication issues.
• Potential clinically significant medication issue: requires physician or physician designee notification by midnight of the next calendar day.
M2001: DRUG REGIMEN REVIEW

Potential or actual clinically significant medication issues can include:

– Adverse reaction.
– Ineffective drug therapy.
– Side effects.
– Drug interactions.
– Duplicate therapy.
– Omissions.
– Dosage errors.
– Non-adherence.

M2001: DRUG REGIMEN REVIEW

• Be careful - response numbers have changed!
  – OASIS-C1:  1= No problems found.
  – OASIS-C2:  1= Issues found.

• 0 – No issues found during review:
  – Referral medication list matches patient’s medications in the home.
  – Diagnoses/symptoms are adequately controlled.
  – All meds are in the home.
  – Plan for taking all meds safely at the right time.
  – No S/S of adverse reactions.

M2001: DRUG REGIMEN REVIEW

1 – Yes – Issues found during review:
  – Referral list doesn’t match meds on hand.
  – Disease/symptoms inadequately controlled.
  – Symptoms of potential adverse reaction.
  – Meds not obtained or patient indicating they probably won’t take the meds.
  – Patient seems confused about when/how to take meds indicating a high risk for med errors.
  – Taking multiple non-prescribed OTCs/herbals that could interact with prescribed medications.
  – Complex medication plan with multiple prescribers and/or obtained from multiple pharmacies so the risk of drug interactions is high.
M2001: Drug Regimen Review

- N/A – Patient not taking any medications.

- Dash (-) – For use in rare occurrences such as when the patient is transferred, discharged, or dies unexpectedly before the item could be completed.

- If issues identified don’t require this immediate attention it’s not considered a potential or actual clinically significant med issue.

- Q&A 160.4 and example in M2001: If an issue is identified and resolved by the time the assessment is completed it does not have to be reported.

M2003: Medication Follow-up

- Was the physician or physician designee contacted at SOC/ROC for issues that in your judgment required notification by midnight of the next calendar day?

- If multiple issues are identified, all must be communicated by midnight of the next calendar day to enter response of 1-Yes.

- 1-Yes – Two-way communication AND completion of the prescribed actions must have occurred by midnight of the next calendar day:
  - Enter 1-Yes if physician’s direction takes longer than the time frame; for example, “monitor BP this weekend and address with PCP on Monday.”
  - Enter 1-Yes if physician responds, but no new orders or instructions are given.

- If multiple issues are identified, all must be communicated by midnight of the next calendar day and all prescribed actions must have been completed to enter response. 1-Yes.
**M2003: Medication Follow-Up**

- 0-No – Enter 0 if the physician was not contacted, did not return a call, if all identified issues weren’t reported, or if all prescribed actions weren’t completed.

- Dash (-) – Use only in rare circumstances where a patient unexpectedly transfers, discharges, or expires. CMS prefers clinicians complete the item to the best of their ability.

**M2005: Medication Intervention**

<table>
<thead>
<tr>
<th>Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/intentional actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
</tbody>
</table>

- Completed at Transfer & Discharge, and now also completed for a Death At Home. An issue identified at the last SOC/ROC would be captured both on the SOC/ROC and on the TF, D/C, or Death at Home.

- Was the physician or physician designee contacted for issues that in your judgment required notification by midnight of the next calendar day for all issues since the most recent SOC/ROC?

**M2016: Patient/Caregiver Drug Education Intervention**

<table>
<thead>
<tr>
<th>Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health-care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
</tbody>
</table>

New guidance:

- Drug education interventions should address all medications the patient is taking, prescribed and OTC, by any route.

- Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider.
M1306: UNHEALED PRESSURE ULCER STAGE 2 OR HIGHER OR UNSTAGEABLE

Multiple revisions to Response-Specific Instructions.

Agencies may adopt the NPUAP (National Pressure Ulcer Advisory Panel) guidelines for clinical practice and documentation. Default to CMS OASIS Instructions if discrepancies exist between NPUAP guidelines and the OASIS scoring instructions.

M1306: UNHEALED PRESSURE ULCER STAGE 2 OR HIGHER OR UNSTAGEABLE

Stage 3 and Stage 4 pressure ulcers:

- "Once the pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered to be closed, and will continue to remodel and increase in tensile strength."
- "For the purposes of scoring the OASIS, the wound is considered healed at this point, and should no longer be reported as an unhealed pressure ulcer."

Agencies should be aware 'healed' site is at higher risk to open because tensile strength is only 80% of normal skin.

M1306: UNHEALED PRESSURE ULCER STAGE 2 OR HIGHER OR UNSTAGEABLE

Added instruction that "healed" vs. "unhealed" can refer to whether the ulcer is "closed" vs. "open":

- Stage 1 and Suspected DTI may be closed, but should not be considered healed.
- Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar/slough, would not be considered healed.

Enter 1-Yes when pressure ulcers are known to be present but can’t be observed due to a dressing or device. Noted documentation is required that a pressure ulcer exists under the dressing or device. "Suspected" ulcers without documentation would not be reflected.
**M1307: OLDEST STAGE 2 PRESSURE ULCER PRESENT AT DISCHARGE**

Enter response 2 if the oldest Stage 2 pressure ulcer wasn't present at the most recent SOC/ROC.

If no pressure ulcer existed at the SOC/ROC, then a Stage 1 developed and progressed to Stage 2 by discharge, enter Response 2 and record the date the ulcer was first identified as a Stage 2 ulcer.

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**M1311: CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE (PART 1)**

**A1. Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with red/pink wound bed, without slough. May also be present as an intact or open/purulent blister.

Number of Stage 2 pressure ulcers

(F 0 at PUCD; Go to M1313(A))

**A2. Number of 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 2:** Full thickness tissue loss. Nondistinctive tissue loss, viable soft tissue, tendon, or muscle. May include undermining and tunneling.

Number of Stage 2 pressure ulcers

(F 0 at PUCD; Go to M1311(C)

**C1. Stage 4:** Full thickness tissue loss with exposed bone, tendon, or muscle. May include undermining and tunneling.

Number of Stage 4 pressure ulcers

(E 0 and PUCD; Go to M1314(C))

**C2. Number of 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.

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**M1311: CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE (PART 2)**

**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

(E 0 and PUCD; Go to M1317(E))

**D2. Number of stageable 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

(E 0 and PUCD; Go to M1317(E))

**E2. Number of stageable 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 to muscle.

Number of unstageable pressure ulcers with suspected deep tissue injury in evolution

(E 0 and PUCD; Go to M1311(C))

**F2. Number of stageable 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]
M1311: CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE

Item Intent: Identifies the number of Stage 2 or higher pressure ulcers at each stage present at the time of assessment. Stage 1 pressure ulcers and ulcers that have healed are not reported.

- Closed Stage 3 and Stage 4 pressure ulcers are no longer reflected in M1311 (M1308).

M1311: CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE

- When a pressure ulcer stage worsens before the assessment is completed (5-day or 48-hour window), report the ulcer at its initial stage.
- For each pressure ulcer, determine whether the pressure ulcer was present at the time of the most recent SOC/ROC, and did not form during this home health quality episode (SOC to Follow-up or Discharge or ROC to Follow-up or Discharge).
- A2, B2, C2, D2, E2, F2 are completed only at Follow-up and Discharge.

M1311: CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE

- For each pressure ulcer, determine whether the pressure ulcer was present at the time of the most recent SOC/ROC, and did not form during this home health quality episode (SOC to Follow-up or Discharge or ROC to Follow-up or Discharge).
- A2, B2, C2, D2, E2, F2 are completed only at Follow-up and Discharge.
### M1311: CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE

- When any bone, tendon, muscle, or joint capsule (Stage 4 structures) are visible, report as a Stage 4 regardless of the presence or absence of slough and/or eschar in the wound bed.

  *NEW*

- A pressure ulcer treated with a skin graft should not be reported as a pressure ulcer and until the graft edges completely heal, should be reported as a surgical wound on M1340.

  *Previously captured as unstageable due to a dressing or device*

### M1311: CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device:</td>
</tr>
<tr>
<td></td>
<td>- “Known” refers to documentation being available that an ulcer is present under the dressing/device.</td>
</tr>
<tr>
<td></td>
<td>- Removed the wording &quot;or that the care provider suspects may be present based on clinical assessment findings (patient reports discomfort or history of past ulcer in the same area).</td>
</tr>
</tbody>
</table>

### M1311: CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE

Seeking additional guidance on instruction:

- If the pressure ulcer was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge assessment, it’s "Present on Admission" stage should be considered the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, do not report the higher stage ulcer as being "present at SOC/ROC when completing the discharge assessment."
M1313: WORSENING IN PRESSURE ULCER STATUS SINCE SOC/ROC

Expanded Response:

Specific Instructions:
– “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.

Then, for each current stage, count the number of pressure ulcers that are new or have increased in numerical stage since the last SOC/ROC was completed. This allows a more accurate assessment than simply comparing total counts at Discharge and most recent SOC/ROC.

New Instruction:
– Row d: Unstageable due to non-removable dressing:
  Enter the number of current pressure ulcers at Discharge that are unstageable due to a non-removable dressing, that were not present at the most recent SOC/ROC.
– Row e: Unstageable due to coverage of wound bed by slough and/or eschar:
  • Capture if Stage 1 or 2 at the most recent SOC/ROC.
  • DO NOT capture if Stage 3 or 4 at the most recent SOC/ROC.
M1313: WORSENING IN PRESSURE ULCER STATUS SINCE SOC/ROC

• New Instruction:
  – Row f: Unstageable-Suspected deep tissue injury in evolution: Capture if a Stage 1 or 2 at the most recent SOC/ROC.

• Expanded Instruction:
  – If the pressure ulcer was unstageable for any reason at the most recent SOC/ROC, do not consider it worsened if at some point between SOC/ROC and Discharge it became stageable and remained at that same stage at Discharge. If the stage worsened after initial staging, the ulcer is captured because the wound has worsened.

• New Instruction:
  – Ulcers previously staged, then became unstageable, but debrided and can now be staged again should be captured based upon the stage before and after becoming unstageable.
  – A dash (-) may be used in rare occurrences when the item can’t be assessed due to unexpected transfer, discharge, or death.

• Remember, closed Stage 3 and closed Stage 4 pressure ulcers are not captured in OASIS-C2 unless the wound were to break down and reopen.

M1313 REPORTING ALGORITHM

Important reference for completing M1313!
M1313 REPORTING ALGORITHM

<table>
<thead>
<tr>
<th>Current stage of discharge</th>
<th>Unable to remove 100% of wound</th>
<th>Prior stage at most recent 100% wound</th>
<th>Status of wound or reopening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 4 of Discharge</td>
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<td></td>
<td></td>
<td></td>
<td>Step 1</td>
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<td>Step 2</td>
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<td></td>
<td></td>
<td></td>
<td>Step 3</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Unstageable with documented</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Unstageable with documented</td>
</tr>
<tr>
<td>Stage 5 of Discharge</td>
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<td>Not present</td>
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<td>Step 1</td>
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<td></td>
<td>Unstageable</td>
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<tr>
<td>Stage 6 of Discharge</td>
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<td>Not present</td>
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<td></td>
<td>Step 1</td>
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<td>Step 2</td>
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M1313 REPORTING ALGORITHM

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<th>Current stage of discharge</th>
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<th>Prior stage at most recent 100% wound</th>
<th>Status of wound or reopening</th>
</tr>
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<tbody>
<tr>
<td>Stage 1 of Discharge</td>
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<td>Not present</td>
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<td></td>
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<td></td>
<td>Step 1</td>
</tr>
<tr>
<td>Stage 2 of Discharge</td>
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<td></td>
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<td></td>
<td>Step 1</td>
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<td>Step 2</td>
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<tr>
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<td>Step 2</td>
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<tr>
<td>Stage 4 of Discharge</td>
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<td>Step 1</td>
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<td>Step 2</td>
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<tr>
<td>Stage 5 of Discharge</td>
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<td>Step 2</td>
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<tr>
<td>Stage 6 of Discharge</td>
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<td>Step 1</td>
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<td></td>
<td></td>
<td></td>
<td>Step 2</td>
</tr>
</tbody>
</table>

M1320 & M1324 – STATUS AND STAGE OF MOST PROBLEMATIC PRESSURE ULCER

Remember – No closed Stage 3 or Stage 4 pressure ulcers are captured in these items unless they have broken down and reopened.
M1340 – DOES THIS PATIENT HAVE A SURGICAL WOUND

- New Guidance: If a pressure ulcer is surgically closed with a flap or graft it is no longer reported as a pressure ulcer. It should be reported as a surgical wound until healed, even if the flap or graft fails.
- OASIS responses may not coincide with coding placed on the plan of care.

M1017 – DIAGNOSES REQUIRING MEDICAL OR TREATMENT REGIMEN CHANGE WITHIN PAST 14 DAYS

Expanded Instruction
- A diagnosis reported in M1011-Inpatient Diagnoses may also be reported in M1017 if within the 14 days prior to the SOC/ROC date:
  - The condition was new or exacerbated; AND
  - The condition required changes in the treatment regimen; AND
  - The patient was discharged from an inpatient facility where the condition was actively treated.

M1046 – INFLUENZA VACCINE RECEIVED

Expanded Instruction:
- When clinician is unable to determine if the patient received the influenza vaccine Response 8 is the correct response.
**M1051 – PNEUMOCOCCAL VACCINE RECEIVED**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
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</tr>
<tr>
<td>1</td>
<td>Yes (Go to M1501 at TRN; Go to M1250 at DC)</td>
</tr>
</tbody>
</table>

Expanded Instruction:
– When clinician is unable to determine if the patient received the pneumococcal vaccine
  Response 0-No is the correct response.

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**COUNTING “THE LAST 14 DAYS”**

- M1600 – Has the patient been treated for a UTI in the last 14 days?
- M1710 – When Confused within the last 14 days?
- M1720 – When Anxious within the last 14 days?

New Clarification: At discharge, the 14 day period is counted based on the M0090-Date Assessment Completed. The M0090 date is “Day 0” and 14 days are counted backwards with the day prior to M0090 being “Day 1.”

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**M1840 – TOILET TRANSFERRING**

New Guidance: In the absence of a toilet in the home:
– Determine if the patient could use a bedside commode or bedpan/urinal as defined in the responses.
– Enter Response 4-Totally Dependent if this equipment is not in the home to allow assessment.
PLANNING FOR 2017

- Do intake/referral forms capture needed information?
  - Specificity in diabetes and vascular disease diagnoses.
  - Most recent height and weight.
- Do policies reflect standardized assessment?
  - Obtaining height and weight.
  - Drug regimen review, follow-up, and education.
- Do agency tracking tools accurately capture events “at the time of or since the previous SOC/ROC”.

Do your plans of care reflect best practices?
- Interventions related to pressure ulcer prevention on the plan of care:
  - Patient specific measures: Nutrition, pressure-relieving devices, incontinence management, positioning measures, etc.
- Interventions related to PAD/PVD on the plan of care.
- Interventions related to Diabetes on the plan of care.

Questions???
info@fazzi.com
www.fazzi.com

THANK YOU!

Fazzi
BE INVINCIBLE