

OASIS ITEM
<p>(M1000) From which of the following Inpatient Facilities was the patient discharged within the past 14 days? (Mark all that apply.)</p> <p><input type="checkbox"/> 1 - Long-term nursing facility (NF)</p> <p><input type="checkbox"/> 2 - Skilled nursing facility (SNF / TCU)</p> <p><input type="checkbox"/> 3 - Short-stay acute hospital (IPP S)</p> <p><input type="checkbox"/> 4 - Long-term care hospital (LTCH)</p> <p><input type="checkbox"/> 5 - Inpatient rehabilitation hospital or unit (IRF)</p> <p><input type="checkbox"/> 6 - Psychiatric hospital or unit</p> <p><input type="checkbox"/> 7 - Other (specify) _____</p> <p><input type="checkbox"/> NA - Patient was not discharged from an inpatient facility [Go to M1016]</p>
ITEM INTENT
<p>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.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care</p> <p>Resumption of care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> Mark all that apply. For example, patient may have been discharged from both a hospital <u>and</u> 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 14 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 Yes;
 - 2) While in the skilled nursing facility was the patient receiving skilled care under the Medicare Part A benefit? If Yes; and
 - 3) Was the patient receiving skilled care under the Medicare Part A benefit during the 14 days prior to admission to home health care? Yes.
- 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 individuals with intellectual disabilities (ICF/IID) 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
<p>(M1005) Inpatient Discharge Date (most recent):</p> <p>____/____/____ month / day / year</p> <p><input type="checkbox"/> UK - Unknown</p>
ITEM INTENT
Identifies the date of the <u>most recent</u> 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
<p>Start of care</p> <p>Resumption of care</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> The term “past 14 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” (for example, May 4, 2014 = 05/04/2014). Enter all four digits of the year.
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> 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																						
<p>(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):</p> <table border="0"> <thead> <tr> <th></th> <th><u>Inpatient Facility Diagnosis</u></th> <th><u>ICD-9-CM Code</u></th> </tr> </thead> <tbody> <tr> <td>a.</td> <td>_____</td> <td>_____. ____</td> </tr> <tr> <td>b.</td> <td>_____</td> <td>_____. ____</td> </tr> <tr> <td>c.</td> <td>_____</td> <td>_____. ____</td> </tr> <tr> <td>d.</td> <td>_____</td> <td>_____. ____</td> </tr> <tr> <td>e.</td> <td>_____</td> <td>_____. ____</td> </tr> <tr> <td>f.</td> <td>_____</td> <td>_____. ____</td> </tr> </tbody> </table>			<u>Inpatient Facility Diagnosis</u>	<u>ICD-9-CM Code</u>	a.	_____	_____. ____	b.	_____	_____. ____	c.	_____	_____. ____	d.	_____	_____. ____	e.	_____	_____. ____	f.	_____	_____. ____
	<u>Inpatient Facility Diagnosis</u>	<u>ICD-9-CM Code</u>																				
a.	_____	_____. ____																				
b.	_____	_____. ____																				
c.	_____	_____. ____																				
d.	_____	_____. ____																				
e.	_____	_____. ____																				
f.	_____	_____. ____																				
ITEM INTENT																						
<p>Identifies diagnosis(es) for which patient was actively receiving treatment in an inpatient facility within the last 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.</p>																						
TIME POINTS ITEM(S) COMPLETED																						
<p>Start of care</p> <p>Resumption of care</p>																						
RESPONSE—SPECIFIC INSTRUCTIONS																						
<ul style="list-style-type: none"> • “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 “last 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 <u>not</u> 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																						
<ul style="list-style-type: none"> • 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

(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):

<u>Changed Medical Regimen Diagnosis</u>	<u>ICD-9-CM Code</u>
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.

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 List of Codes and Descriptions and Official Guidelines for Coding and Reporting should be the source for coding guidance.

OASIS ITEM
<p>(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 <u>prior to</u> the inpatient stay or change in medical or treatment regimen. (Mark all that apply.)</p> <p> <input type="checkbox"/> 1 - Urinary incontinence <input type="checkbox"/> 2 - Indwelling/suprapubic catheter <input type="checkbox"/> 3 - Intractable pain <input type="checkbox"/> 4 - Impaired decision-making <input type="checkbox"/> 5 - Disruptive or socially inappropriate behavior <input type="checkbox"/> 6 - Memory loss to the extent that supervision required <input type="checkbox"/> 7 - None of the above <input type="checkbox"/> NA - No inpatient facility discharge <u>and</u> no change in medical or treatment regimen in past 14 days <input type="checkbox"/> UK - Unknown </p>
ITEM INTENT
Identifies existence of condition(s) <u>prior to</u> medical regimen change or inpatient stay within past 14 days.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> 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 <u>prior to</u> the inpatient stay or change in medical or treatment regimen. Select Response “NA” if no inpatient facility discharge <u>and</u> 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 <u>prior to</u> the inpatient stay or change in medical or treatment regimen. The term “past 14 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
<ul style="list-style-type: none"> Patient/caregiver interview Physician Referral information (for example, 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-C M 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-C M 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-C M 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). See OASIS-C Guidance Manual.

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-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M 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-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

OASIS Item Guidance
Patient History & Diagnoses

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
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	(V-codes are allowed)	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
a. _____	a. (_____.____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	a. _____ (_____.____)	a. _____ (_____.____)
(M1022) Other Diagnoses	(V- or E-codes are allowed)	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
b. _____	b. (_____.____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	b. _____ (_____.____)	b. _____ (_____.____)
c. _____	c. (_____.____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	c. _____ (_____.____)	c. _____ (_____.____)
d. _____	d. (_____.____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	d. _____ (_____.____)	d. _____ (_____.____)
e. _____	e. (_____.____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	e. _____ (_____.____)	e. _____ (_____.____)
f. _____	f. (_____.____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	f. _____ (_____.____)	f. _____ (_____.____)

ITEM INTENT

M1020: Primary Diagnosis - the intent of this item is to accurately report and code the patient's primary home health diagnosis and document the degree of symptom control for that diagnosis. The patient's primary home health diagnosis is defined as the chief reason the patient is receiving home care and the diagnosis most related to the current home health Plan of Care.

M1022: Secondary Diagnoses - the intent of this item is to accurately report and code the patient's secondary home health diagnoses and document the degree of symptom control for each diagnosis. Secondary diagnoses are comorbid conditions that exist at the time of the assessment, that are actively addressed in the patient's Plan of Care, or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis.

M1024 Payment Diagnosis - OPTIONAL: the intent of this item is to allow the reporting of fractures for which the patient is receiving aftercare, when a V-code for aftercare of fracture is reported as a primary or secondary diagnosis in Columns 1 and 2. It also provides the agency with the option of documenting an underlying condition, if a V-code is reported as a primary or secondary diagnosis in Columns 1 and 2, and the underlying condition is no longer active.

TIME POINTS ITEM(S) COMPLETED

Start of care
Resumption of care
Follow-up

RESPONSE-SPECIFIC INSTRUCTIONS

- HHA clinicians and coders must comply with the ICD-9-CM Official Guidelines for Coding and Reporting when assigning primary and secondary diagnoses to the OASIS items M1020 and M1022. See Chapter 5 for link.
 - The ICD-9-CM is a morbidity classification published by the United States for classifying diagnoses and reason for care in all health care settings. The ICD-9-CM is based on the ICD-9, the international classification of disease published by the World Health Organization (WHO).
 - The ICD-9-CM Official Guidelines for Coding and Reporting were developed by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself and should be used as a companion document to the official version of the ICD-9-CM List of Codes and Descriptions.
 - Adherence to the ICD-9-CM Official Guidelines for Coding and Reporting when assigning ICD-9-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). Each agency must ensure that diagnoses and ICD-9-CM codes reported in the OASIS data set meet these guidelines.
- Identifying the patient's Primary and Secondary Home Health Diagnoses
 - The assessing clinician is expected to complete the patient's comprehensive assessment and understand the patient's overall medical condition and care needs before selecting and assigning diagnoses.
 - The determination of the patient's primary and secondary home health diagnoses must be made by the assessing clinician based on the findings of the assessment, information in the medical record, and input from the physician.
 - As noted in the Item Intent, the patient's primary diagnosis is defined as the chief reason the patient is receiving home care and the diagnosis most related to the current home health Plan of Care. The primary diagnosis may or may not relate to the patient's most recent hospital stay, but must relate to the skilled services (skilled nursing, physical therapy, occupational therapy, and speech language pathology) rendered by the HHA.
 - As noted in the Item Intent, the secondary diagnoses include coexisting conditions actively addressed in the patient's Plan of Care, and any comorbid conditions having the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. The secondary diagnoses may or may not be related to a patient's recent hospital stay, but must have the potential to impact the skilled services provided by the HHA.
 - Diagnoses may change during the course of the home health stay due to a change in the patient's health status or a change in the focus of home health care. At each required OASIS time point, the clinician must assess the patient's clinical status and determine the primary and secondary diagnoses based on patient status and treatment plan at the time of the assessment.
 - Only current medical diagnoses should be reported as primary or secondary diagnoses in M1020 and M1022. Diagnoses should be excluded if they are resolved or do not have the potential to impact the skilled services provided by the HHA. An example of a resolved condition is cholecystitis following a cholecystectomy.
 - In addition to following the ICD-9-CM Official Guidelines for Coding and Reporting, selection of home health diagnoses must be performed in compliance with Medicare's rules and regulations for coverage and payment to ensure provider compliance with Section 1862(a)(1)(A) of the Social Security Act. Section 1862(a)(1)(A) excludes provider services from Medicare coverage and payment that "are not reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1020/M1022/M1024)

- Reporting Primary and Secondary Diagnoses in M1020 and M1022
 - At each required OASIS time point, the assessing clinician should enter the patient's current primary and secondary diagnoses in Column 1 of M1020 and M1022. Complete Column 1 from top to bottom, leaving any blank entries at the bottom.
 - 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."
- Reporting ICD-9-CM Diagnosis Codes in Column 2 of M1020 and M1022
 - The assessing clinician can enter the actual numeric ICD-9-CM codes for each diagnosis listed in Column 1 and 2 of M1020 and M1022, once the assessment is completed and the diagnosis is entered in Column 1. Alternatively, a coding specialist in the agency may enter the actual numeric ICD-9-CM codes in Column 2, as long as the assessing clinician has determined the primary and secondary diagnoses in Column 1.
 - The correct process for selecting an ICD-9-CM code using the Alphabetic Index and the Tabular List is described in the ICD-9-CM Official Guidelines for Coding and Reporting. Follow the official conventions and instructions provided within the ICD-9-CM List of Codes and Descriptions and the Official Guidelines to code each row in Column 2.
 - Each ICD-9-CM code must be entered at its highest level of specificity (diagnosis codes only - no surgical or procedure codes allowed).
 - ICD-9-CM coding guidelines do not allow external cause codes (ICD-9-CM codes beginning with E) to be reported in M1020 (Primary Diagnosis) but they may be reported in M1022 (Secondary Diagnoses).
 - ICD-9-CM coding guidelines do not allow fracture diagnoses codes to be reported as a primary or secondary diagnosis in a home health setting. For patients receiving aftercare for fractures, enter the appropriate V-code in M1020 or M1022, and enter the fracture code in M1024 on the corresponding row.
 - When a V-code is reported in Column 2, the code for the underlying condition may also be entered in Column 2, as long as it is a current on-going condition that has a potential to impact the skilled services provided by the HHA (and ICD-9-CM guidelines permit coding as a primary or secondary diagnosis in the home health setting). See the ICD-9-CM Official Guidelines for Coding and Reporting for complete instructions on code assignment and sequencing related to the use of V-codes and use of multiple coding for a single condition (such as manifestation/etiology pairs).
- Reporting the Symptom Control Rating in Column 2 of M1020 and M1022
 - At each required time point, the assessing clinician should record the symptom control ratings for each primary and secondary diagnosis in column 2 of M1020 and M1022. Do not assign symptom control ratings for V- or E-codes.
 - 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.
 - Choose one value that represents the degree of symptom control appropriate for each diagnosis using the scale provided in the M1020/M1022 instructions.

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

- M1024 Payment Diagnoses (OPTIONAL)
 - As noted above, if a V-code for aftercare of a fracture is reported in Column 2, then the acute fracture code may be reported in Column 3, since ICD-9 -CM Official Guidelines for Coding and Reporting do not permit coding of acute fracture codes as a primary or secondary diagnosis in the home health setting.
 - If a V-code is reported in Column 2 and the underlying condition for the V-code is resolved, then the resolved condition may be reported in Columns 3 and 4 at the agency's discretion. Non-fracture diagnosis codes reported in Columns 3 and 4 do not impact payment.
 - If a diagnosis is reported in Columns 3 and 4, the instructions that accompany items M1020/M1022/M1024 should be followed to code each row in Column 3 and/or 4. If a diagnosis and ICD-9-CM code are entered in Columns 3 and 4, it must be placed in the same row as the corresponding V-code. Note that V-codes and external cause codes (ICD-9-CM codes beginning with E) may not be reported in M1024.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Physician orders
- Referral information
- Current medication list
- The current ICD-9-CM List of Codes and Descriptions and the ICD-9-CM Official Guidelines for Coding and Reporting should be the source for coding (see Chapter 5 for link).
- For degree of symptom control, data sources may include patient/caregiver interview, physician, physical assessment, and review of past health history.

OASIS ITEM		
<p>(M1030) Therapies the patient receives <u>at home</u>: (Mark all that apply.)</p> <p> <input type="checkbox"/> 1 - Intravenous or infusion therapy (excludes TPN) <input type="checkbox"/> 2 - Parenteral nutrition (TPN or lipids) <input type="checkbox"/> 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal) <input type="checkbox"/> 4 - None of the above </p>		
ITEM INTENT		
<p>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.</p>		
TIME POINTS ITEM(S) COMPLETED		
<p>Start of care Resumption of care Follow-up</p>		
RESPONSE—SPECIFIC INSTRUCTIONS		
<ul style="list-style-type: none"> 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 (for example, 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 (for example, site is observed only or dressing changes are provided), do <u>not</u> 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 (for example, 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 <u>not</u> apply. A flush of a feeding tube does <u>not</u> provide nutrition. 		
DATA SOURCES / RESOURCES		
<table border="0"> <tbody> <tr> <td> <ul style="list-style-type: none"> Patient/caregiver interview Physician orders Referral information </td> <td> <ul style="list-style-type: none"> Review of past health history Physical assessment </td> </tr> </tbody> </table>	<ul style="list-style-type: none"> Patient/caregiver interview Physician orders Referral information 	<ul style="list-style-type: none"> Review of past health history Physical assessment
<ul style="list-style-type: none"> Patient/caregiver interview Physician orders Referral information 	<ul style="list-style-type: none"> Review of past health history Physical assessment 	

OASIS ITEM
<p>(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months) <input type="checkbox"/> 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months <input type="checkbox"/> 3 - Multiple hospitalizations (2 or more) in the past 6 months <input type="checkbox"/> 4 - Multiple emergency department visits (2 or more) in the past 6 months <input type="checkbox"/> 5 - Decline in mental, emotional, or behavioral status in the past 3 months <input type="checkbox"/> 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months <input type="checkbox"/> 7 - Currently taking 5 or more medications <input type="checkbox"/> 8 - Currently reports exhaustion <input type="checkbox"/> 9 - Other risk(s) not listed in 1 - 8 <input type="checkbox"/> 10 - None of the above
ITEM INTENT
Identifies patient characteristics that may indicate the patient is at risk for hospitalization.
TIME POINTS ITEM(S) COMPLETED
Start of care Resumption of care
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> • Select all Responses 1-9 that apply. • If Response 10 is selected, none of the other responses should be selected. • Response 1 includes witnessed and reported (unwitnessed) falls. • In Response 5, decline in mental, emotional, or behavioral status refers to significant changes occurring within the past 3 months that may impact the patient's ability to remain safely in the home and increase the likelihood of hospitalization. • In Response 7, medications includes OTC medications. • Response 9 - Other risk(s), may be selected if the assessing clinician finds characteristics other than those listed in Responses 1-8 that may indicate risk for hospitalization (for example, slower movements during sit to stand and walking).
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> • Patient/caregiver interview • Physician • Review of health history • Referral information • Physical assessment

OASIS ITEM
<p>(M1034) Overall Status: Which description best fits the patient's overall status? (Check one)</p> <p><input type="checkbox"/> 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).</p> <p><input type="checkbox"/> 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).</p> <p><input type="checkbox"/> 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.</p> <p><input type="checkbox"/> 3 - The patient has serious progressive conditions that could lead to death within a year.</p> <p><input type="checkbox"/> UK - The patient's situation is unknown or unclear.</p>
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
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • Patient/caregiver interview • Physician • Review of health history • Referral information • Physical assessment • Advance Directive

OASIS ITEM
<p>(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome: (Mark all that apply.)</p> <p> <input type="checkbox"/> 1 - Smoking <input type="checkbox"/> 2 - Obesity <input type="checkbox"/> 3 - Alcohol dependency <input type="checkbox"/> 4 - Drug dependency <input type="checkbox"/> 5 - None of the above <input type="checkbox"/> UK - Unknown </p>
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
<ul style="list-style-type: none"> • 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 (for example, 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
<ul style="list-style-type: none"> • 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
<p>(M1041) Influenza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?</p> <p><input type="checkbox"/> 0 - No <i>[Go to M1051]</i></p> <p><input type="checkbox"/> 1 - Yes</p>
ITEM INTENT
Identifies whether the patient was receiving services from the home health agency during the time period for which influenza vaccine data are collected (October 1 and March 31).
TIME POINTS ITEM(S) COMPLETED
<p>Transfer to inpatient facility</p> <p>Discharge from agency – not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> 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 was receiving home health agency services on or between October 1 through March 31. If no part of the care episode (from SOC/ROC to Transfer or Discharge) occurred during the time period from October 1 and March 31, mark "No."
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> Clinical record and calendar

OASIS ITEM
<p>(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?</p> <p><input type="checkbox"/> 1 - Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)</p> <p><input type="checkbox"/> 2 - Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)</p> <p><input type="checkbox"/> 3 - Yes; received from another health care provider (for example: physician, pharmacist)</p> <p><input type="checkbox"/> 4 - No; patient offered and declined</p> <p><input type="checkbox"/> 5 - No; patient assessed and determined to have medical contraindication(s)</p> <p><input type="checkbox"/> 6 - No; not indicated - patient does not meet age/condition guidelines for influenza vaccine</p> <p><input type="checkbox"/> 7 - No; inability to obtain vaccine due to declared shortage</p> <p><input type="checkbox"/> 8 - No; patient did not receive the vaccine due to reasons other than those listed in Responses 4 - 7.</p>
ITEM INTENT
<p>For a patient with any part of the home health episode (SOC/ROC to Transfer/Discharge) occurring between October 1 and March 31, identifies whether the patient received an influenza vaccine for this year's flu season, and if not, the reason why. This item meets National Quality Forum (NQF) standards for harmonization of influenza measures across care settings.</p>
TIME POINTS ITEM(S) COMPLETED
<p>Transfer to an inpatient facility Discharge from agency - not to an inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> Complete if Response 1 for M1041 is selected. Select only one response. Select Response 1 if your agency provided the influenza vaccine to the patient during this episode of care (SOC/ROC to Transfer/Discharge). Select Response 2 if your agency provided the flu vaccine for this year's flu season prior to this home health episode, (for example, 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). <ul style="list-style-type: none"> 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. Select Response 3 if the patient or caregiver reports (or there is documentation in the clinical 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. Responses 1 or 2 or 3 may be selected even if the flu vaccine for this year's influenza season was provided prior to October 1 (that is, flu vaccine was made available early). Select Response 4 if the patient and/or healthcare proxy (for example, someone with power of attorney) refused the vaccine. Note: It is not required that the agency offered the vaccine. Select Response 4 only if the patient was offered the vaccine and he/she refused. Select Response 5 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 M1046)

- Select Response 6 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 7 only in the event that the vaccine is unavailable due to a CDC-declared shortage.
- Select Response 8 only if the patient did not receive the vaccine due to a reason other than Responses 4-7.

DATA SOURCES / RESOURCES

- Clinical record
- Patient/caregiver interview
- Physician or other health care provider
- A link to CDC Guidelines can be found in Chapter 5 of this manual.

OASIS ITEM
<p>(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?</p> <p><input type="checkbox"/> 0 - No</p> <p><input type="checkbox"/> 1 - Yes [<i>Go to M1500 at TRN; Go to M1230 at DC</i>]</p>
ITEM INTENT
Identifies whether the patient has ever received the pneumonia vaccine.
TIME POINTS ITEM(S) COMPLETED
Transfer to an inpatient facility Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> Select Response 1 if the patient has ever received the pneumococcal vaccine.
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> Clinical record Patient/caregiver interview

OASIS ITEM
<p>(M1056) Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:</p> <p> <input type="checkbox"/> 1 - Offered and declined <input type="checkbox"/> 2 - Assessed and determined to have medical contraindication(s) <input type="checkbox"/> 3 - Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine <input type="checkbox"/> 4 - None of the above </p>
ITEM INTENT
Explains why the patient has never received the pneumococcal vaccination.
TIME POINTS ITEM(S) COMPLETED
Transfer to an inpatient facility Discharge from agency - not to an inpatient facility
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> • Response 1 should be selected if the patient and/or healthcare proxy (for example, someone with power of attorney) refused the vaccine. • Response 2 should be selected if pneumococcal vaccine 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 3 if CDC age/condition guidelines indicate that pneumococcal vaccination is not indicated for this patient. Age/condition guidelines are updated as needed by the CDC. Detailed information regarding current pneumococcal vaccination 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. • Response 4 should be selected only if the patient was not provided the vaccine due to a reason other than Responses 1 - 3.
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> • Patient/caregiver interview • Physician • Clinical Record • A link to CDC Guidelines for pneumococcal vaccine administration can be found in Chapter 5 of this manual.