



Home Health

Quality Reporting Program Provider Training



Percent of Patients with Pressure Ulcers That Are New or Worsened Covariates: M1028, M1060, and M1620

Presenter: Kathryn D. Roby, M.Ed., M.S., R.N., CHCE, CHAP/ACHC

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Objectives

Demonstrate a working knowledge of **M1028**. Active Diagnoses – Comorbidities and Co-existing Conditions; **M1060**. Height and Weight; and **M1620**. Bowel Incontinence Frequency.

- Describe the intent of **M1028**, **M1060**, and **M1620**.
- Interpret the response options for **M1028**, **M1060**, and **M1620**.
- Apply instructions in order to accurately respond to practice scenarios.
- Discuss how to resolve the common stumbling blocks encountered in coding these items.

Acronyms in This Presentation

- Assessment Submission and Processing (ASAP)
- Body Mass Index (BMI)
- Centers for Medicare & Medicaid Services (CMS)
- Diabetes Mellitus (DM)
- Discharge (DC)

Acronyms in This Presentation

- Follow-Up (FU)
- Home Health Agency (HHA)
- International Classification of Diseases (ICD)
- Outcome and Assessment Information Set (OASIS)
- Peripheral Arterial Disease (PAD)
- Peripheral Vascular Disease (PVD)
- Quality Measure (QM)

Acronyms in This Presentation

- Quality Improvement and Evaluation System (QIES)
- QIES Technical Support Office (QTSO)
- Registered Nurse (RN)
- Resumption of Care (ROC)
- Start of Care (SOC)
- Unknown (UK)



Terminology

- The terms “**Code**” or “**Coding**” used during this training refer to responding or scoring the Outcome and Assessment Information Set (OASIS) assessment items.
 - Not to be confused with the International Classification of Diseases (ICD)-10 coding.

Pressure Ulcer QM Covariates

The following OASIS items are risk adjustment covariates for the “Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened” Quality Measure (QM):

- **M1028.** Active Diagnoses – Comorbidities and Co-existing Conditions
- **M1060.** Height and Weight
- **M1620.** Bowel Incontinence Frequency
- **GG0170C.** Lying to Sitting on Side of Bed

OASIS-C2 New Items

- The following items are **new** to OASIS-C2, effective January 1, 2017.

Item:	Time Points Completed:
M1028. Active Diagnoses – Comorbidities and Co-existing Conditions	<ul style="list-style-type: none">• Start of Care (SOC)• Resumption of Care (ROC)
M1060. Height and Weight	<ul style="list-style-type: none">• SOC• ROC

OASIS-C2 Existing Item

- The following item has not been modified in OASIS-C2, effective January 1, 2017.

Item:	Time Points Completed:
M1620. Bowel Incontinence Frequency	<ul style="list-style-type: none">• SOC.• ROC.• Follow-up.• Discharge from agency, not to inpatient facility.

M1028.

Active Diagnoses

Comorbidities and Co-existing Conditions

M1028. Active Diagnoses

(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)

M1028 Item Intent

- Identifies whether two specific diagnoses are present and active.
- These diagnoses influence a patient's functional outcomes or increase a patient's risk for development or worsening of pressure ulcer(s).

M1028 Item Rationale

- Disease processes can have a significant adverse effect on an individual's health status and quality of life.
- Identifies active diagnoses that are associated with a patient's home health episode of care.

M1028 Time Points Completed

- SOC
- ROC
- **Not** assessed at Recertification, Transfer/Discharge



M1028 Steps for Assessment

1

- Identify Diagnoses.

2

- Determine Whether Diagnoses Are Active.

Step 1: Identify Diagnoses

Item Requires Documentation in the Medical Record by:

Physician

Nurse
Practitioner

Physician
Assistant

Clinical
Nurse
Specialist

Other
Authorized
Licensed
Staff, If
Allowable
Under State
Licensure
Laws

Step 1: Identify Diagnoses

Some Examples of Medical Record Sources

- Transfer documents.
- Physician progress notes.
- Recent history and physical.
- Discharge summary.
- Medication sheets.
- Physician orders.
- Consults and official diagnostic reports.
- Diagnosis/problem list(s).
- Other resources, as available.

Step 1: Identify Diagnoses

- Admission/SOC assessment may indicate symptoms associated with one of the listed conditions, but a documented diagnosis may not be present in available records.
 - If so, the clinician should contact the physician (or others, as listed on Slide 16) to ask if the patient has the diagnosis.
- Once a diagnosis has been identified, determine if the diagnosis is active.

Step 1: Identify Diagnoses

- 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 (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under State licensure laws) to ensure validity, follow-up, and coordination of care.

Step 1: Identify Diagnoses

- Diagnoses communicated verbally should be documented in the medical record by the physician (or other licensed staff if allowable under State licensure laws) to ensure follow-up and coordination of care.
- Only diagnoses confirmed and documented by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under State licensure laws) should be considered when coding this item.

Step 2: Determine Active Diagnoses

Determine If the Diagnosis is Active

- Active diagnoses are 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.

Step 2: Determine Active Diagnoses

Some Examples of Medical Record Sources

- Transfer documents.
- Physician progress notes.
- Recent history and physical.
- Discharge summary.
- Medication sheets.
- Physician orders.
- Consults and other official diagnostic reports.
- Diagnosis/problem list(s).
- Other resources, as available.

Step 2: Determine Active Diagnoses

- Only diagnoses confirmed by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under State licensure laws) that are active should be coded on the OASIS Data Set.

Step 2: Determine Active Diagnoses

What if information regarding active diagnoses is learned after the assessment completed date?

Step 2: Determine Active Diagnoses

What if information regarding active diagnoses is learned after the assessment completed date?

- The OASIS Data Set should not be revised to reflect this new information.
- The OASIS Data Set should reflect what was known and documented at the time of the assessment.

Step 2: Determine Active Diagnoses

What if it is discovered that a documented active diagnosis was not indicated on the OASIS Data Set?

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What if it is discovered that a documented active diagnosis was not indicated on the OASIS Data Set?

The OASIS Data Set should be revised in accordance with the instructions in the Survey and Certification Memo No. 15-18-HHA, *Outcome and Assessment Information Set (OASIS) transition to the Automated Submission and Processing System (ASAP) and OASIS Correction policy*, as well as the *OASIS Submission User's Guide*.

M1028 Response-Specific Instructions

Select Response 1, Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) if the patient has an active diagnosis of PVD or PAD.

(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)

M1028 Response-Specific Instructions

PVD or PAD is indicated by any of the following diagnosis codes that start with the first four characters of:

- I70.2 – Atherosclerosis of native arteries of the extremities.
- I70.3 – Atherosclerosis of bypass graft(s) of the extremities.
- I70.4 – Atherosclerosis of autologous vein bypass graft(s) of the extremities.
- I70.5 – Atherosclerosis of nonautologous biological bypass graft(s) of the extremities.
- I70.6 – Atherosclerosis of nonbiological bypass graft(s) of the extremities.
- I70.7 – Atherosclerosis of other type of bypass graft(s) of the extremities.
- I70.91 – Generalized atherosclerosis.
- I70.92 – Chronic total occlusion of artery of the extremities.

M1028 Response-Specific Instructions

PVD or PAD is indicated by the following diagnosis code that start with the first three characters of:

- I73. – Other peripheral vascular diseases.

M1028 Response-Specific Instructions

Select Response **2**, Diabetes Mellitus (DM) if the patient has an active diagnosis of 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 Mellitus (DM)

M1028 Response-Specific Instructions

DM is indicated by any of the following diagnosis codes that start with the first three characters of:

- E08. – Diabetes mellitus due to underlying condition.
- E09. – Drug or chemical induced diabetes mellitus.
- E10. – Type 1 diabetes mellitus.
- E11. – Type 2 diabetes mellitus.
- E13. – Other specific diabetes mellitus.

M1028 Response-Specific Instructions

- If the assessment is completed and it is determined that the patient does not have a diagnosis of diabetes, PVD, or PAD, **both boxes should be left unchecked.**
- Documentation or auditing strategies to ensure accurate completion of the comprehensive assessment are at the discretion of your organization.

M1028 Use of a Dash

- 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.
- This most often occurs when the patient is unexpectedly transferred, discharged, or dies before assessment of the item could be completed.
- The Centers for Medicare & Medicaid Services (CMS) expects **dash (–)** use to be a rare occurrence.

M1028 Tips

- There must be specific documentation in the medical record by a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized staff if allowable under State licensure laws) of the disease or condition being an active diagnosis.
 - For example: A physician documents at the time of assessment that the patient has inadequately controlled diabetes and requires adjustment of the medication regimen.

M1028 Tips

- Consider only the documented active diagnoses.
- A diagnosis should not be inferred by association with other conditions (e.g., “absence of hair on lower extremities” should not be inferred to mean PVD).

M1028.

Active Diagnoses

Practice Scenarios

Practice Scenario (1)

- Mr. J is admitted to home care services after surgery for a left total knee replacement. His medical record documents current active diagnoses of asthma and arthritis.
- The admitting clinician completes M1028. Active Diagnoses as noted below.

(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)

Practice Scenario (2)

- Mr. B has Type 2 Diabetes Mellitus (DM) and takes metformin and glypizide daily.
- His healthcare regimen also includes regular blood glucose monitoring, exercise, and a diabetic diet.
- The physician progress note documents an active diagnosis of both DM with peripheral neuropathy and Peripheral Vascular Disease (PVD).

Practice Scenario (3)

- Mrs. K underwent a below the knee amputation due to gangrene associated with PVD. She requires dressing changes to the stump and monitoring for wound healing.
- In addition, peripheral pulse monitoring is ordered. The nurse practitioner's progress note documents PVD and left below-the-knee amputation.

M1060. Height and Weight

M1060. Height and Weight

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

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inches

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

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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.)

M1060 Item Intent

- Support calculation of the patient's body mass index (BMI) using the patient's height and weight.

M1060 Item Rationale

- Diminished nutritional and hydration status can lead to debility that can adversely affect wound healing and increase risk for the development of pressure ulcers.
- Height and weight measurements (and BMI calculation) assist staff members in assessing the patient's nutrition and hydration status by providing a mechanism for monitoring stability of weight and BMI over a period of time. The measurement of height and weight for the calculation of BMI is one guide for determining nutritional status.
- Weight measurement is also used in the assessment of heart failure.

M1060 Time Points Completed

- SOC
- ROC



M1060A. Height Steps for Assessment

1. Measure height in accordance with the agency's policies and procedures, which should reflect current standards of practice (e.g., shoes off).
2. Measure and record height in inches.
3. When reporting height for a patient with bilateral lower extremity amputation, measure and record the patient's current height (i.e., height after bilateral amputation).

M1060A. Height Response-Specific Instructions

- Complete only if **M0100** equals **1**, Start of Care or **3**, Resumption of Care.
- Record the patient's height to the nearest whole inch.
- Use mathematical rounding.
 - Record a height of 62.5 inches as 63 inches.
 - Record a height of 62.4 inches as 62 inches.

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

6	3
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inches

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

M1060B. Weight Steps for Assessment

1. Weight should be measured in accordance with the agency's policies and procedures, which should reflect current standards of practice (e.g., shoes off).
2. Measure and record the patient's weight in pounds.
3. If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, enter the **dash (-)** value and document the rationale on the patient's medical record.

M1060B. Weight Response-Specific Instructions

- Complete only if **M0100** equals **1**, Start of Care or **3**, Resumption of Care.
- Use mathematical rounding.
 - Record a weight of 152.5 pounds as 153 pounds.
 - Record a weight of 152.4 pounds as 152 pounds.

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

1	5	3
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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.)

M1060 Use of a Dash

- 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.
- This most often occurs when the patient is unexpectedly transferred, discharged, or dies before assessment of the item could be completed.
- CMS expects **dash (–)** use to be a rare occurrence.

M1060 Practice Scenario (1)

- Mrs. G has congestive heart failure and advanced osteoporosis. She is at risk for pathological fractures.
- She is pain free at rest but experiences severe pain when she moves. Daily weights have been discontinued as part of her prescribed medical care due to pain management.

M1060 Practice Scenario (2)

- As part of the SOC comprehensive assessment, the registered nurse (R.N.) needs to obtain a height for Mr. B.
- Mr. B has had bilateral lower extremity amputations due to complications from diabetes. His legs are now uneven in length.
- Using a tape measure, the R.N. measures the patient's current height while the patient is lying in bed.
- She obtains two measurements: 64.4 inches and 60.8 inches.

M1060 Practice Scenario (3)

- During the SOC home visit, the R.N. completes the comprehensive assessment. The agency's policy states that a patient's weight is to be obtained with footwear removed.
- The R.N. assists the patient to remove his shoes and obtains his weight.
- The R.N. records the weight as 126.8 pounds.

M1060 Practice Scenario (4)

- On Day 20 of his home health quality episode, Mr. Y is transferred to acute care and remains hospitalized for 3 days. On Day 24, home health services resume.
- During the ROC assessment, the clinician attempts to weigh Mr. Y, but he is unable to stand on the scale due to shortness of breath.
- The clinician locates the following information:
 - From the most recent SOC assessment (24 days ago), Mr. Y has a documented weight of 175 pounds. This weight was obtained by a different clinician from the same agency.
 - Hospital medical records from his latest hospitalization indicate a recent weight of 177 pounds.

M1620. Bowel Incontinence Frequency

M1620 Item Intent

- Identifies how often the patient experiences bowel incontinence.
- Refers to the frequency of a symptom (bowel incontinence), not to the etiology (cause) of that symptom.
- Does not address treatment of incontinence or constipation (e.g., a bowel program).

M1620 Time Points Completed

- SOC.
- ROC.
- Follow-up (FU).
- Discharge (DC) from agency, not to inpatient facility.

M1620 Response-Specific Instructions

(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 [<i>Omit "UK" option on FU, DC</i>] |

M1620 Assessment Strategies

- Review the bowel elimination pattern as you take the health history.
- Observe the cleanliness around the toilet when you are in the bathroom.
- Note any visible evidence of soiled clothing.

M1620 Assessment Strategies

- Ask the patient if she/he has difficulty controlling stools, has problems with soiling clothing, uncontrollable diarrhea, etc.
- If applicable, query the aide about evidence of bowel incontinence at follow-up time points. This information can then be discussed with the patient.

Summary

- The QM for pressure ulcers that are new or worsened has multiple covariates for risk adjustment.
 - **M1028.** Active Diagnoses – Comorbidities and Co-existing Conditions
 - **M1060.** Height and Weight
 - **M1620.** Bowel Incontinence Frequency
 - **GG0170C.** Lying to Sitting on Side of Bed
- Items **M1028**, **M1060**, and **GG0170C** are new to OASIS-C2.
- No changes to Item **M1620**.

Action Plan

- Review/develop policies and procedures for height and weight and active diagnoses.
- Develop an education plan for clinicians for each new OASIS-C2 item.
 - Practice coding a variety of scenarios with staff.
- Annual Performance Improvement Plan.
 - Consider a review of items to ensure accuracy in data collection.

Resources

- OASIS Educational Coordinators:
 - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/downloads/OASISeducationalcoordinators.pdf>
- Quality Measures: Home Health Quality Reporting Program
 - HomeHealthQualityQuestions@cms.hhs.gov
- OASIS Items & Payment Policy: Home Health Policy Mailbox
 - HomehealthPolicy@cms.hhs.gov
- Data Submission & CASPER: QTSO Help Desk
 - Telephone: (800) 339-9313
 - Email: help@qtso.com
 - Website: <https://www.qtso.com/index.php>



Questions?