

# Dancin' with the C Diagnosis Updates

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## Objectives



- Identify *critical* OASIS-C & diagnosis code clarifications;
- Detail the *application* of these updates with common home health scenarios;
- Discuss the *wound item clarifications* since the posting of the revised OASIS-C WOCN Guidance;
- Share tips and strategies that will support your staff with these critical OASIS-C and code updates.
- **Take Aways:** Procedure Code Reference Guide  
Start of Care Audit Tool  
*Tools Provided During Program*

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## The Reality of OASIS-C

- **A Survivors Delight**
  - You do the record audit post every episode
  - You connect the dots on what's not done
  - You notify the state regarding CoP Compliance
  - You notify state regarding lack of timely physician orders
- **Medicare Delight**
  - Payment risk or alteration for episodes with delayed verbal orders
  - Payment risk for episodes with quality issues at transfer/discharge
- **Attorney Delight (or Nightmare).....**
  - Depends on your vantage point

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## OASIS-C Hot Spots

- **Early Trends for 2010** *Beyond Common Software Glitches*
  - **Diagnoses Items (M1010; 1012; 1016; 1020; 1022; 1024)**
  - **Wound Scores Inconsistent in the Field & documentation**
    - Pressure Ulcers (M1306 & M1308) & Diagnosis Codes
    - Surgical Wounds (M1342) & Diagnosis Codes
    - Wound & Open Lesion (M1350) & Diagnosis Codes
  - **Functional Scores Inconsistent on Home Visits**
    - Ambulation (M1860)
    - Transferring (M1850)
  - **Plan of Care Synopsis (M2250): Standardized Risk Tools**
  - **Transfer & Discharge Items: Heart Failure**
  - **Look Back Period (M2400)**
- **Where Do You Stand with These Early Hot Spots?**

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## OASIS-C: The Game Changer

- **Process and Quality Outcomes**
  - **2010 Changes**
    - Process and Quality Outcomes: Home Care Compare
    - CAHPS: [www.homehealthcahps.org](http://www.homehealthcahps.org)
    - P4P: Potential 2012
  - **HHQI Summit: [www.homehealthquality.org](http://www.homehealthquality.org)**
  - **Compliance & Risk Management**
- **Leadership Role**
  - **Data Based Decision-Making**
  - **Accountability**
  - **Staff support and feedback to refine OASIS-C practices**
- **2010 Goals: Where will you be in 2011?**

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## Home Health Opportunities

- **Clearly demonstrate Quality Process Outcomes not currently reflected on the OASIS-B**
  - Pain Management
  - Heart Failure
  - Diabetic Foot Care
- **Increased precision with assessment language**
- **Assessment review of focused high risk interventions (Falls; Integument; Depression)**
- **Evidence Best Practices already verified in the industry (Diabetic Foot Care; Pain)**
- **Refine care planning to enhance practice**

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## How Will Your New Report Card Look?

### You Fill In the Blanks for Your Agency

Quality Measures	Your Agency	National	State
Timely Care*	90%	85%	88%
Immunizations	%	%	%
Plan of Care to Mitigate Pain*	90%	82%	80%
Risk Assessment & Plan of Care for Pressure Ulcers*	90%	88%	78%
Diabetic Foot Care*	%	%	%
Heart Failure Follow Up*	90%	%	%
Depression Screen & Plan of Care*	%	%	%
Falls Risk & Plan of Care*	99%	94%	98%
Medication Assessment & Follow-up*	99%	99%	98%
Education on High Risk Drugs*	90 %	90%	%

\* Outcomes for P4P

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## Revised Diagnoses Items

- 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):**

<u>Inpatient Facility Diagnosis</u>	<u>ICD-9-CM Code</u>
a. _____	_____
b. _____	_____
c. _____	_____
d. _____	_____
e. _____	_____
f. _____	_____

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## M1010 Item Guidance

- Identifies diagnoses for which patient was receiving treatment in an inpatient facility within the past 14 days.**
  - Date of admission to home care is Day "0"; and the day immediately prior to the date of admission is Day 1.
- Include the list of diagnoses that required treatment during the inpatient stay and may or may not correspond with the hospital admitting diagnoses**
- The expanded list (from MO 190) allows for a more comprehensive picture of the patient's condition prior to the initiation or resumption of home care.**
- Data Sources**
  - Patient/caregiver interview
  - Physician
  - Referral information (H&P; progress notes; D/C summary)

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## New Procedure Diagnoses Items

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

<u>Inpatient Procedure</u>	<u>ICD-9-CM Code</u>
a. _____	_____. ____
b. _____	_____. ____
c. _____	_____. ____
d. _____	_____. ____

NA – Not applicable  
 UK - Unknown

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## M1012 Item Guidance

- Identifies medical procedures that the patient received during an inpatient stay within the past 14 days that are relevant to the home health plan of care.
- Include only those procedures that occurred during the inpatient stay that are relevant to the home health plan of care, based on the information available at the start or resumption of care.
- Do not include inpatient procedures that are not relevant to the home health plan of care.
  - Example: diagnostic procedure (CT scan); x-rays; MRI; other
- **Data Sources**
  - Patient/caregiver interview
  - Physician
  - Referral information (H&P; progress notes; D/C summary)

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## A Quick Quiz

- All Procedure Codes need to be verified with the physician
  - True
  - False
- You can only list surgical procedures that occurred in the last 14 days
  - True
  - False
- Medical procedures are not listed on the OASIS-C
  - True
  - False

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## Exploring Procedure Codes

- Consider additional codes as well
- What are common additional codes?
  - Details: number of vessels; unilateral vs bialteral
  - Biopsies
  - Other procedures (complications)
  - Application of adhesion barriers
- Where will you obtain the detail for these procedures?
- Do you need to adjust or revise processes to secure this information?
  - Intake & Liason Formats (expanded dx items)
- Why is this detail so important?

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## Common Case Scenarios

- Mrs. Smith had a radical mastectomy. What procedure codes would be most common with this surgical procedure?

Mr. Hanson has lung cancer, and was admitted for dehydration and electrolyte imbalance secondary to chemotherapy. What procedure codes would be used in this case?

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## More Case Scenarios

- Mr. Freer had a temporary colostomy due to colitis. What procedure codes would be most common with this surgery?
  
- Mr. Sims had a failed joint revision. What procedure codes would we use then? Any other common procedures that may occur with this event?

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## Common Home Health Codes

### ■ Cardiac Procedure Codes

#### □ Check specificity & Code also

- AAA 38.64
- Aortic Valve Replacement 35.22
- CABG 36.1x
- Cardiac catheterizations 36.22
- Angioplasty 36.09
- Endarectomy 38.1
- Pacemaker insertions 37.8x
- Tricuspid valve replacement 35.28

### ■ What Other Cardiac Procedure Codes are Common in Your Agency?

#### □ Print a 2009 Procedure Code List for Your Agency

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## More Common Procedure Codes

### ■ Orthopedic Codes

#### □ Check specificity & Check Code also

- Total knee replacement 81.54
- Revision of the knee 81.55
- Total hip replacement 81.51
- Hip revision 81.53
- ORIF 79.35

### ■ Other Common Home Health Procedure Codes

- Hernia Repair 53.00 – See details
- G-tube 46.32
- J tube 46.38
- Bowel resection 45.7x
- Peg replacement 43.11
- Colostomy closure 46.52

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## Other Common Procedure Codes

### ■ Insertion of Vascular Catheter 86.07

### ■ Venous Catheter-NEC 38.93

### ■ Venous catheter-renal dialysis 38.95

### ■ Ureteral catheter 59.8

#### □ Removal of Foley Catheter 97.64

### ■ Other Incision w/Drain & Subcutaneous Tissue 86.04

### ■ Non Excisional Wound Debridement Infect/Burn 86.28

### ■ Other Common Home Health Procedure Codes

- Lap Choley 51.23
- Lysis of Peritoneal adhesions 54.59
- Percutaneous abdominal drain 54.91
- Thoracentesis 34.91
- Infusion of electrolytes 99.18

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## Revised Diagnoses Items

- **M1016 Diagnosis Requiring Medical or Treatment 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):**

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

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## M1016 Item Guidance

- Identifies if any change has occurred to the patient's treatment regimen, health care services, or medications within the past 14 days.
  - Purpose: Help identify the patient's recent history by identifying new diagnoses or diagnoses that have exacerbated over the past 2 weeks.
  - Helps the clinician develop an appropriate plan of care, since patients who have recent changes in treatment plans have a higher risk of becoming unstable.
- 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.
- Data Sources
  - Patient/caregiver interview
  - Physician
  - Referral information (H&P; progress notes; D/C summary)

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## A Quick Quiz

- All diagnoses reported on the OASIS, including the Procedures, must be confirmed with the physician
  - True
  - False
- A patient had a joint replacement 28 days ago, but has just come home to home health from a SNF setting. We cannot list the joint replacement on the OASIS because it is over 14 days
  - True
  - False

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## Current Diagnoses Items

- M1020/1022/1024 Diagnoses, Symptom Control and Payment Diagnoses:
- The diagnoses are to be listed in the order that best reflects the seriousness of each condition and support the disciplines and services provided
- Symptom Control replaces Severity Index (0-4)
- The sequencing of the symptom control ratings may not match the sequencing of the diagnosis
- Do not assign symptom control ratings for V & E codes
- 1020 Primary Diagnosis
- 1022 Other Diagnoses
- 1024 Payment Diagnoses (OPTIONAL)

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## Dx Selection & Sequencing

- CMS expects HHA's to understand each patient's specific clinical status before selecting and assigning each diagnosis.
  - Each patient's overall medical condition and care needs must be comprehensively assessed **BEFORE** the HHA identifies and assigns each diagnosis for which the patient is receiving home care.
    - See Appendix D
- Primary Diagnosis (M1020)- the diagnosis most related to the patient's current plan of care, the most acute diagnosis and, therefore, the chief reason for providing home care.

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## Secondary Diagnoses



- Secondary Diagnoses M1022

*“All conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care.”*
- In general, M1022 should include not only conditions actively addressed in the patient's plan of care but also any co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.

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## One Case Scenario

- 87 year old male admitted post hospital discharge for pneumonia. COPD; CAD; Hypothyroidism; hyperlipidemia; oxygen. Remains on antibiotics. Clinical notes indicate patient has lost 30 pounds this past year. Dietician consult ordered.
- OASIS listed the following diagnoses
- Pneumonia
- COPD, exacerbated
- CAD
- Hypothyroidism
- Hyperlipidemia
- Oxygen use
- How would you Sequence These Diagnoses?

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## Consider This Option

### What's the Point Difference Here?

- 87 year old male admitted post hospital discharge for pneumonia. COPD; CAD; Hypothyroidism; hyperlipidemia; oxygen. Remains on antibiotics. Clinical notes indicate patient has lost 30 pounds this past year. Dietician consult ordered.
- M1020/1022                      M1020/1022
- ~~Pneumonia~~                      Pneumonia
- ~~Exacerbated COPD~~                      Exc. COPD
- ~~CAD~~                      CAD
- ~~Hypothyroidism~~                      Hypothyroidism
- ~~Hyperlipidemia~~                      Hyperlipidemia
- ~~Oxygen Use~~                      Abnormal weight loss
- C 2 to C3**                      Oxygen Use
- \$380.41**

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## Another Common Case Scenario

### What's the Point Difference Here?

- Patient admitted to home health post ORIF. Meds include Inhalers; Prednisone; Prilosec; Warfarin; Lasix; Oxycodone.
- M1020/M1022                      M1020/1022/1024
- ~~A/C ORIF~~                      A/C ORIF
- ~~Abnormal Gait~~                      Abnormal Gait
- ~~Osteoarthritis~~                      Osteoarthritis
- ~~Anticoagulant therapy~~                      **COPD**
- ~~Drug Monitoring~~                      **GERD**
- ~~Joint Replaced~~                      Drug monitoring
- Point Increase**                      Anticoagulant therapy
- C1 to C2 = \$380.41**

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## How About This Case?

### What's the Point Difference Here?

- Patient admitted post hospitalization for diverticulitis, pain, and weakness. Rehab only for balance, gait, fall preventions, muscle strengthening. **Clinical note and meds indicate HTN.**

<del>■ <b>M1020/M1022</b></del>	<b>M1020/1022/1024</b>
<del>Admission for Therapy</del>	Admission for Therapy
<del>Diverticulitis</del>	Diverticulitis
<del>Muscle weakness</del>	Muscle weakness
<del>Arthritis</del>	Arthritis
<del>Pain</del>	Pain

**Point Increase**  
C1 to C2 = \$380.41

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## One More Case

### What's the Point Difference Here?

- 81 year old female admitted for therapy only post tears of medial and lateral cartilage. Medications include: Starlix; Skelaxin; Torsemide; Trazadone; Nitrostat; Ecotrin; Simvastatin; Xopenes HFA Inhaler; Benzonitrate; & 8 more meds

<del>■ <b>M1020/M1022</b></del>	<b>M1020/1022/1024</b>
<del>Admission for PT Only</del>	Admission for PT only
<del>Osteoarthritis</del>	Osteoarthritis
<del>Medial &amp; lateral tears</del>	Medial & lateral tears

**Point Increase**  
C1 to C2 = \$380.41

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## Integument Items

- M1300 through M1350 (WOCN.org)
  - Updated WOCN OASIS-C Guidance 12/2009
- **RBC Limited Wound Reference Guide: (Updated w/ WOCN)**
- Eleven items apply to Pressure Ulcers (M1300 – M1324)
- M1308 Matrix: Current number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage
- **Healed Stage 3 & Stage 4 will continue to be documented**
  - In grid format
- M1310-1314 Pressure Ulcer Length, Width and Depth
  - Harmonize with MDS Tool & NQF Pressure Ulcer Framework
  - For Stage III or IV with largest surface dimension
- M1322 Current Stage 1 Pressure Ulcers
- **CMS Tracks to Discharge: Where do pressure ulcers originate?**

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## Unhealed Pressure Ulcers

- M1306 Does the patient have at least one Unhealed Pressure Ulcer at Stage II or Higher or designated as “unstageable”?

0 – No

1 - Yes

- Score Stage II or higher only
- Stage 3 & 4 can never be considered “fully healed”, but can be considered closed when they are fully granulated and the wound surface is covered with new epithelial tissue
- Unhealed = non-epithelialized

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## M1306: A Gateway OASIS-C Item

- If you do not answer this item accurately, you will not access the case mix items (Medicare PPS)
- Consider this
  - All Stage 2 pressure ulcers and higher are considered non healing for Item M1306
  - Even closed Stage 3 & 4 Pressure ulcers are considered non healing by this integument item
- Stage II
  - Stage II do NOT granulate and newly epithelialized Stage II are NOT counted (NOT reported-already healed)
  - Stage II Pressure ulcers can only be scored as not healing (on Status of pressure ulcers)

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## Stage II Pressure Ulcers: Review

- Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister



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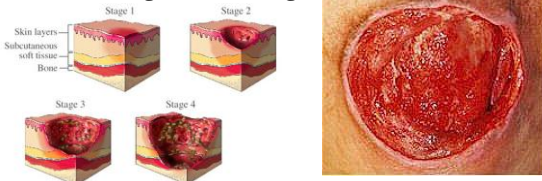
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### Stage III Pressure Ulcers: Review

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are **not** exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.



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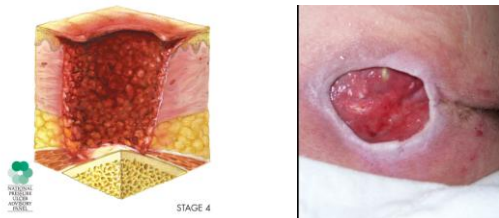
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### Stage IV Pressure Ulcers: Review

- Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.



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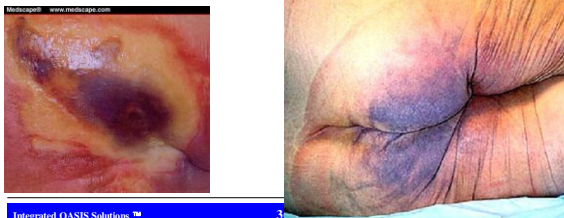
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### Unstageable Pressure Ulcers: Review

- D.1 Due to non-removable dressing
- D.2 Due to coverage of wound bed by slough and/or eschar
- D.3 Suspected deep tissue injury in evolution



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## Additional Integument Revisions

- M1308 Current Number of Unhealed (non epithelialized) Pressure Ulcers at Each Stage
  - a. Stage II **Column 1:** SOC/ROC/ F/U & D/C
  - b. Stage III **Column 2:** FU & D/C
  - c. Stage IV
  - d. 1 Unstageable: Known or likely but not stageable due to non-removable dressing or device
  - d.2 Unstageable: Known or likely but not stageable due to coverage of wound bed by slough and/or eschar
  - d. 3 Unstageable: Suspected deep tissue injury in evolution
- **Stage 1 NOT addressed (or report) in this item**

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## M1308 Wound Tips

- **M1308 addresses only Stage II, III and IV as well as unstageable pressure ulcers**
  - **Column 1** is always scored for *what you are assessing at the time of this specific OASIS*
    - What is visualized and/or assessed in the home at
    - SOC/ROC/FU & D/C
  - **Column 2** is *assessing if there was a lesion at that specific site at the time of the previous OASIS*
    - **Is performed only at a Follow-up or Discharge OASIS**
    - **Only completed if there is a 1 or higher in Column 1**
  - Many software programs will provide Skip
- Patterns & Alerts**

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## One Recert Scenario

- Patient has 1 DTI and 1 Stage II pressure ulcer on admission. On discharge, the patient's Stage II Pressure Ulcer is healed. But the DTI is now a Stage III Pressure Ulcer. **Answer M1308 for this Recert OASIS.**
  - Column 1 = \_\_\_\_\_ Column 2 = \_\_\_\_\_
- **Column 1** (Number of currently Present)
  - What's scored in Column 1? \_\_\_\_\_
- **Column 2** (Number of those listed in Column 1 that were present on admission (most recent SOC/ROC))
  - What's scored on Column 2? \_\_\_\_\_

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## Another Case Scenario

- Patient has 2 Stage II pressure ulcers and one closed Stage III on admission. On discharge, the patient's Stage II Pressure Ulcers are healed. Answer M1308 for this Discharge OASIS.
  - Column 1 = \_\_\_\_\_ Column 2 = \_\_\_\_\_
- Column 1 (Number of currently Present)
  - What's scored in Column 1? \_\_\_\_\_
- Column 2 (Number of those listed in Column 1 that were present on admission (most recent SOC/ROC))
  - What's scored on Column 2? \_\_\_\_\_

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## Try This Scenario on M1308 Grid

- Patient has no pressure ulcers on admission, but develops 2 Stage II's during the first episode which is present at the time of recertification (Follow-up)
  - Column 1 = \_\_\_\_\_ Column 2 = \_\_\_\_\_
- Column 1 (Number of currently Present)
  - \_\_\_\_\_
- Column 2 (Number of those listed in Column 1 that were present on admission (most recent SOC/ROC))
  - \_\_\_\_\_
- What Does This Grid Tell CMS?
  - Stage II's developed during this episode of care
  - May be reported as an Avoidable Event if not healed by D/C

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## More New Integument Items

- M1320: Status of Most Problematic (Observable) Pressure Ulcer
  - 0 – Newly Epithelialized
  - 1 – Fully Granulating
  - 2 – Early/partial granulation
  - 3 – Not healing
  - NA – No observable pressure ulcer
- Identifies the degree of closure visible in the most problematic observable pressure ulcer, Stage II or higher
- Most problematic (professional judgment)
  - Largest; most advanced stage; difficult to treat; difficult to relieve pressure

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## Pressure Ulcer Stage & Status Link

- OASIS-C Guidance indicates that Stage 1 & Stage II Pressure ulcers are always non healing status
- DTT's are also always non healing status
- Closed State III & IV Pressure ulcers are always Newly Epithelialized
- Stage III & IV Pressure ulcers may granulate
  - Status may change from non healing to early partial to fully granulating with progression thru the healing process
- A Stage II Pressure Ulcer may be more problematic than a closed Stage IV.

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## M1324: Stage of Most Problematic

- M1324 Stage of Most Problematic (Observable) Pressure Ulcer
  - 1 – Stage I
  - 2 – Stage II
  - 3 – Stage III
  - 4 – Stage IV

NA – No observable pressure ulcer
- **Reverse Staging is not appropriate**
- Closed Stage III or IV continues to be regarded as a Stage III or a Stage IV Pressure Ulcer
- An unhealed lower Stage pressure ulcer (1 or 2) may be the most problematic to be reported in this item

*Case Mix Item*

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## A Pressure Ulcer OASIS Review

- A pressure ulcer that is surgically debrided remains a pressure ulcer
- A pressure ulcer that has been skin grafted remains a pressure ulcer
- A pressure ulcer with a muscle flap is **NO** longer a pressure ulcer – now a surgical wound
- If a pressure ulcer is I&D'd and a drain is placed – then it becomes a surgical wound
- **Remember: You can only code the same site once**
- Also Code Closed (Stage III or IV) Pressure Ulcers

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## Pressure Ulcer Code Tips

- Pressure ulcers are the only ulcers that are staged on the code sequence. Do NOT code other ulcer stages (stasis; diabetic)
- When a patient has bilateral pressure ulcers of the same stage, only one code for the site and one code for the stage is listed
- When a patient has bilateral pressure ulcers of the same site with a different stage, then code one site with multiple codes for the 2 different stages
- Now Also Code: Closed pressure ulcers
  - Stage III & IV (NEVER Fully Heal)

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## Coding Pressure Ulcers

*Are these case mix codes?*

- 707.0x indicates pressure ulcer
- 5<sup>th</sup> digit indicates location on body
- Infected pressure ulcers are still coded 707.0x

### Considerations

- Seriousness of diagnosis
  - Impact on Plan of Care
  - Sequence impact
  - Challenge: Accurately represent clinical complexity
- Be sure that the OASIS M1308 matches codes

*Only ulcers staged on the OASIS M1308*

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## More on Pressure Ulcer Codes

- Pressure ulcers will be coded for site and stage
  - Code first 707.0x for Site
  - Then code 707.2x for Stage
- Stage codes are always secondary codes
  - Matches M1308 (Column 1)
  - 707.20: unspecified stage (do NOT use in home care)
  - 707.21: Stage 1
  - 707.22: Stage 2
  - 707.23: Stage 3
  - 707.24: Stage 4
  - 707.25: Unstageable (eschar or slough)

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## More Case Scenarios

- Patient admitted for 2 Stage 2 pressure ulcers, one on each elbow. Admitted post hospitalization for exacerbation for COPD.
- M1020: 491.21: COPD, exacerbation
- M1022: 707.01: Pressure ulcer, elbow
- M1022: 707.22: Stage 2 Pressure ulcer
- Patient admitted for two pressure ulcers on sacrum. One is a Stage 3 and one is a Stage 2.
- M1020: 707.03 Pressure ulcer, lower back, coccyx
- M1022: 707.23 Stage 3
- M1022: 707.22 Stage 2

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## Another Case Scenario

- Diabetic patient referred to home health for a Stage 3 pressure ulcer on the left heel. Also has 1 closed Stage IV on her coccyx. Debilitated patient with CHF; COPD.
- M1020: 707.07: Pressure ulcer, heel
- M1022: 707.23: Pressure ulcer Stage 3
- M1022: 250.00: DM
- M1022: 428.0: CHF
- M1022: 496: COPD
- M1022: 707.03 Pressure ulcer, coccyx
- Other: 707.25 Pressure ulcer status: Unstageable

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## How About This Case Scenario?

- Mrs. Story has been on your care for the past 2 episodes. During her 3<sup>rd</sup> episode she has an outpatient procedure for a skin graft for a Stage 3 pressure ulcer on buttock.
- Let's complete the OASIS-C Wound M items
- M1020: V58.77 (A/C Surgery Integument)  
M1024: Blank
- M1022: 707.05 Pressure ulcer buttock
- M1022: 707.25 Unstageable pressure ulcer

**What about M1306-M1324 ?**

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## Review: Case Scenarios

- Patient has one closed Stage III pressure ulcer on discharge. What is the healing status of this pressure ulcer?
  - Newly epithelialized
  - Fully granulating
  - Early partial granulation
  - Non healing
- Mrs. Eddy has one Stage 1 pressure ulcer on discharge. What is the healing status of this ulcer?
  - Newly epithelialized
  - Fully granulating
  - Early partial granulation
  - Non healing

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## Updated WOCN Guide (12/09)

- Definitions that apply to pressure ulcers, stasis ulcers & surgical wounds
  - Unhealed = absence of the skin's original integrity
  - Non-epithelialized = absence of regenerated epidermis across wound surface
  - Healing = Dynamic process involving synthesis of new tissue for repair of skin and soft tissue defects
- Did not clarify key questions
  - Stasis ulcers can NEVER be scored as Newly epithelialized
- Utilize RBC Wound Guide as a field reference
  - Definitions & Practical Score Guide (3 Pages)

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## M1340: Surgical Wound

- M1340: Does this patient have a Surgical Wound?
  - 0 – No
  - 1 – Yes, patient has at least one (observable) surgical wound
  - 2 – Surgical wound known but not observable due to non-removable dressing
- Presence of a wound resulting from surgery
  - Debridement is NOT a surgical wound
  - Muscle flap, skin advancement or rotational flap is a surgical wound
  - Ostomies are excluded from this item (unless “take-down”)
- If complete epithelialization present for over 30 days, then the surgical wound is no longer included in this item

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## M1342: Status of Surgical Wound

- **M1342: Status of Most Problematic (Observable) Surgical Wound**
  - 0 – Newly epithelialized
  - 1 – Fully granulating
  - 2 – Early/partial granulation
  - 3 – Not healing
- **Identifies the degree of healing in the most problematic, observable surgical wound**
- **Score “0” for implanted venous access devices and infusion devices when the insertion site is healed**
  - Epithelialization is regeneration of the epidermis across a wound surface (resurfacing)

*Case Mix Item*

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## M1342: Status of Surgical Wound

- **Identifies the degree of healing in the most problematic, observable surgical wound**
- **The most problematic may be the**
  - Largest
  - Most resistant to treatment
  - An infected surgical wound
- **For purposes of the OASIS then: Utilize the WOCN Guidelines (See RBC Limited Updated Wound Guide)**
  - A surgical wound closed by primary intention (sutures; staples; cement) is described as a surgical wound until reepithelialization has been present for approximately 30 days
  - After 30 days, it is described as a scar (NOT a surgical wound)
- **Epithelialization is**
  - Regeneration of the epidermis across a wound surface

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## Surgical Wound Dx Coding

- **ICD-9-CM Code Guidelines**
  - Requires physician documentation to assign non healing or infected surgical wound
- **OASIS-C Item Response (M1342)**
  - Based on WOCN Guidelines & Clinical Assessment
- **Code Guidelines Define Complicated Surgical Wounds**
  - **Diagnosis Codes**
    - Complication may include a dehiscence or an infection
    - Common surgical wound complication diagnosis codes:
    - 998.83 – non-healing surgical wound
    - 998.59 – post op infection
    - 998.31 - disruption of internal surgical wound
    - 998.32 – disruption of external surgical wound
    - 996.xx – complications of surgery

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## One Case Scenario

- Patient admitted home health post cholecystectomy with t- tube. AKA; DM; CHF; HTN
- **Considerations**
- M1020: V58.75 Aftercare for GI surgery
- M1022: 250.00 DM
- M1022: 428.0 CHF
- M1022: 401.9 HTN
- M1022: V58.31 Surgical dressing changes
- M1022: V49.76 AKA
- M1024: \_\_\_\_\_ How Would You Complete?
- *How do we score M1324: Status of Surgical Wound?*

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## Another Case Scenario

- Patient admitted home health post hospitalization for a cholecystectomy. Wound dehiscd and infected with MRSA. Wound care and IV antibiotics.
- M1020: 998.31 Disruption of internal surgical wound
- M1022: 998.59 Other postoperative infection
- M1022: 041.12 MRSA
- M1022: V58.81 Fitting and adjustment of vascular catheter
- M1022: V58.62: Long term antibiotics

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## M1350: Skin Lesion or Open Wound

- **M1350:** Does this patient have a Skin Lesion or Open Wound excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency?  
0 - No  
1 - Yes
- Identifies the presence or absence of a skin lesion or open wound **NOT** already addressed in previous items that is receiving clinical assessment or intervention from the home health agency
  - Diabetic ulcers; cellulitis; trauma wounds; some ostomies
- **Plan of Care** addresses intervention

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## More on Skin Lesion or Open Wound

- **A lesion is a broad term for pathologically altered tissue**
  - Sores; rashes; skin tears; burns; ulcers
  - Excludes bowel ostomies (**Includes ALL other ostomies**)
  - Includes diabetic ulcers; cellulitis; ulcers; trauma wounds; abscesses; skin tears; other
- **Plan of Care must address intervention**
  - Clinical assessment *and*
  - **Intervention (includes education and/or treatments)**
  - **Other clinical documentation will indicate assessment and ongoing interventions, including teaching**
- **Does not include tattoos, piercings**

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## Home Health Case Mix Ostomies

- **Case Mix Ostomies**
  - Active agency interventions
  - Place in top six diagnosis items (M1020/1022)
  - Do **NOT** list a case mix diagnosis in M1024 (Case Mix Payer item) across from case mix ostomies
- **Tracheostomy: V55.0**
- **Cystostomy: V55.5**
- **Other Artificial Opening of the Urinary Tract: V55.6**
  - These three V codes **cannot have another case mix diagnosis placed in M1024 (Case Mix Payer Item)**
  - **Remember: V & E Codes cannot be placed in M1024**

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## More Quick Quiz

- **If I score M1350 as “Yes” the Plan of Care (485) must have orders for dressing changes.**
  - True
  - False
- **Assessment and education are interventions that support a “Yes” score on M1350.**
  - True
  - False
- **Wounds are coded by etiology.**
  - True
  - False

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## Top Therapy Diagnoses

- **Aftercare for Fractures: V54.xx**
  - Traumatic fractures: V54.1x
  - Pathologic fractures: V54.2x
- **Aftercare for Joint Replacements: V54.81-V54.89**
  - List joint replaced also: V43.xx
- **Care post neurological (stroke) event: 438.xx**
- **Care involving rehab procedures: V57.xx**
- **Disease specific care, neuromuscular focus**
- **Symptoms involving nervous & musculoskeletal: 781.2**
- **Aftercare for surgery: V58.xx**

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## ADL's & IADL Changes

- Includes Current ability to safely perform the specified activity
  - Current ability to tend safely to personal hygiene needs
- Score revisions increase items to **increase precision** in answers
  - Ambulation scores differentiates two-handed device from a one-handed device
- Provides greater specificity to enhance care planning
- Enhance consistency & outcomes
- **Old Habits Die Hard in the Field**
  - Joint Field Visits to Ensure Application of Revised Items

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## M 1850: Transferring

- **M1850 Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.**
  - 0 – Able to independently transfer
  - 1 – Able to transfer with minimal human assistance or with use of an assistive device
  - 2 – Able to bear weight and pivot during the transfer process but unable to transfer self
  - 3 – Unable to transfer self and is unable to bear weight or pivot when transferred by another person
  - 4 – Bedfast, unable to transfer but is able to turn and position self in bed
  - 5 – Bedfast, unable to transfer and is unable to turn and position self

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## Case Scenario

- Mrs. Sceney needs a little boost to move from supine to a sitting position at the side of the bed, and also needs cueing and reminding on how to use the walker to transfer from bed to chair. How do you score Mrs. Sceney on Transferring (M1850) on this discharge OASIS?

- 0 – Able to independently transfer
- 1 – Able to transfer with minimal human assistance or with use of an assistive device
- 2 – Able to bear weight and pivot during the transfer process but unable to transfer self
- 3 – Unable to transfer self and is unable to bear weight or pivot when transferred by another person
- 4 – Bedfast, unable to transfer but is able to turn and position self in bed
- 5 – Bedfast, unable to transfer and is unable to turn and position self

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## Refined Ambulation Item

- **M1860 Ambulation/Locomotion:** Ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of services

- 0 – Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e. needs no human assistance or assistive device).
- 1 – With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and climb stairs with or without railings
- 2 – Requires use of a two-handed device (e.g. walker or crutches) to walk alone on as level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces
- 3 – Able to walk only with the supervision or assistance of another person at all times
- 4; 5; 6 See Item definitions

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## Another Ambulation Scenario

- Mr. McCall refuses to use his walker outside his home, and occasionally forgets to use it when ambulating inside his home. How would you score M1860, Ambulation/Locomotion?

- **M1860 Ambulation/Locomotion:** Ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of services

- 0 – Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e. needs no human assistance or assistive device).
- 1 – With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and climb stairs with or without railings
- 2 – Requires use of a two-handed device (e.g. walker or crutches) to walk alone on as level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces
- 3 – Able to walk only with the supervision or assistance of another person at all times
- 4; 5; 6 See Item definitions

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## Case Scenario: Ambulation Item

- On discharge, Mr. Tulley progressed from walking with a walker to a cane, only requiring stand-by assistance when he climbs the stairs. What would you score M1860, Ambulation/Locomotion?
- M1860 Ambulation/Locomotion:** Ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of services
  - 0 – Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e. needs no human assistance or assistive device).
  - 1 – With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and climb stairs with or without railings
  - 2 – Requires use of a two-handed device (e.g. walker or crutches) to walk alone on as level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces
  - 3 – Able to walk only with the supervision or assistance of another person at all times
  - 4; 5; 6 See Item definitions

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## The Great Gait Debate

- Pending further clarification from AHA Coding Clinic**
- Home health struggles to code consistently**
- Gait Problems: 781.2** – the symptom code is located under **Musculoskeletal and Neurologic Symptoms**
- Is an acceptable diagnosis that avoids reporting a condition that no longer exists; or more intensive services for gait issues related to neurological conditions such as MS, Parkinson's, ALS, Myasthenia, Spondylosis
- Use of 781.2 must follow documentation and POC
- Gaits are coded by etiology**
  - What is the cause of the gait issue?

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## More on Gait Abnormality

- What is the etiology of the abnormal gait?**
- Gait abnormality: 781.2** is used when a residual effect from a neurological problem exists; may follow MS, Alzheimer's, Parkinson's, ALS, Spondylosis and some corrective ortho surgery
- Falls of unknown etiology**
- Consider**
  - Is the focus of care the treatment of abnormal gait?
  - Is abnormal gait integral to the condition?
  - Is the therapist providing multiple aspects of the disease, condition or post op care?

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## Case Scenario

- Patient admitted to home health post hospitalization for exacerbation of Parkinson's. HTN, CAD, history of recent falls. SNV for assessment, nutritional and medication management. PT for gait training, & assistive device.

<ul style="list-style-type: none"> <li>▪ <del>M1020/M1022</del></li> </ul>	<ul style="list-style-type: none"> <li>▪ <del>M1020/1022/1024</del></li> </ul>
332.0 Parkinson's	332.0 Parkinson's disease
V15.88	<b>781.2 Abnormal gait</b>
401.9 HTN	401.9 HTN
414.00 CAD	414.00 CAD
	V15.88 Hx Falls

**Abnormal gait not integral to Parkinson's disease**

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## Case Scenario

### What's the Point Difference Here?

- Patient admitted to home health post hip replacement. SVN for PT/INR & dressing changes. PT for gait training, home safety, muscle strengthening and assistive device. HTN.

<ul style="list-style-type: none"> <li>▪ <del>M1020/M1022</del></li> </ul>	<ul style="list-style-type: none"> <li>▪ <del>M1020/1022/1024</del></li> </ul>
V54.81 A/C Joint replacement	V54.81 A/C Joint Replacement
<b>781.2 Abnormal gait</b>	401.9 HTN
V58.31 Surgical dressing changes	V43.64 Hip joint replaced
V58.83 L/T Use of Anticoags	V58.83 Enctr. drug monitoring
V58.61 L/T Use of Anticoags	V58.61 L/T use of anticoags
	V58.31 Surgical drsng changes

**Abnormal gait integral to orthopedic Aftercare and/or joint replacement of the lower body**

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## Case Scenario

- Patient admitted to home health due to recent history of falls. CHF, HTN, CAD. SNV for assessment and medication management. PT for gait training, & assistive device.

<ul style="list-style-type: none"> <li>▪ <del>M1020/1022</del></li> </ul>	<ul style="list-style-type: none"> <li>▪ <del>M1020/1022/1024</del></li> </ul>
V15.88 Hx Falls	<b>781.2 Abnormal gait</b>
781.2 Abnormal gait	428.0 CHF
428.0 CHF	401.9 HTN
401.9 HTN	414.00 CAD
414.00 CAD	V15.88 Hx Falls

**Abnormal gait may be used for falls of unknown etiology**

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## Difficulty in Walking

- 719.7 is located in Chapter 13: Diseases of Musculoskeletal System
- Infers a relationship with joint disorders as the etiology of the difficulty in walking
- Chronic condition with no repair of bone or joint
- Often utilized with folks with osteoarthritis w/o joint replacement or surgical intervention
- Stiffness; effusion, synovitis, loose bodies
- Must follow physician documentation and clinical record

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## Muscle Weakness – 728.87

- Can be generalized muscle weakness or one weakness of one muscle group – Unspecified disorder of muscle, ligament or fascia  
Means muscle groups have lost *measurable* “power”
- Documentation must be specific as to muscle strength and goal progression
- Code 780.79 – weakness, fatigue, lack of strength, lethargy, loss of energy - asthenia

Are your therapists specific regarding muscle strength?

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## Generalized Weakness – 780.79

- Generalized weakness is malaise, fatigue or tiredness as one would have with the flu or chronic illness.
- Medical patients with a loss of function due to short period of hospitalization, with no spontaneous recovery
- 780.79 indicates generalized weakness without specific documentation of muscle weakness
- Does not medically justify patients for therapy
  - Consider using medical diagnosis
    - Exacerbation CHF

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## A Common Scenario

- Patient admitted to home health for due to severe OA of bilateral knees. Frequent falls. Not a candidate for surgical intervention.
- M1020: \_\_\_\_\_
- M1022: 715.36 OA, localized, not specified whether primary or secondary, lower leg
- M1022: Other co-morbidities
- M1022: V15.88: History of falls

What about abnormal gait?

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## Another Case Scenario

- Patient admitted to home health post hospitalization for CHF. SNV for disease & medication management. HTN; anemia; CKD. PT for safety evaluation, HEP, muscle strengthening. High risk for falls.
  - M1020: 428.0 CHF
  - M1022: 285.9 Anemia
  - M1022: 403.90 HTN
  - M1022: 585.9 CKD, unspecified
  - M1022: V15.88 High risk or hx of falls
- Weakness integral to anemia**

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## A Quick Quiz

- Abnormal gait is integral to orthopedic surgery of the lower extremities.
  - True
  - False
- All diagnoses on the POC (485) need to be confirmed with the physician.
  - True
  - False
- Acute stroke diagnoses are case mix.
  - True
  - False

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## Plan of Care Items: Page 21

**(M2250) Plan of Care Synopsis:** (Check only one box in each row.) Does the physician-ordered plan of care include the following:

Plan / Intervention	No	Yes	Not Applicable
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient is not diabetic or is bilateral amputee
c. Falls prevention interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No pain identified
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient is not assessed to be at risk for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient has no pressure ulcers with need for moist wound healing

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## M2250: Plan of Care Synopsis

- **Best Practices to be Reported on Home Care Compare**
- **Response Considerations**
  - **Yes indicates communication with physician regarding the Plan of Care**
  - Collaboration with disciplines regarding appropriate Plan of Care items is acceptable
  - Plan of care interventions may be pharmacological and/or non pharmacological
- **Depression**
  - **Diagnosis or screened for symptoms of depression**
  - Medication monitoring; medication effectiveness; medication teaching; referrals (MSW or community referrals)
- **Ulcer Treatments**
  - **Mark Yes** if physician orders moist wound healing dressings **OR** NA if such orders have been requested from the physician with no agreement for orders **OR** no pressure ulcers with need for treatment

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## More on Plan of Care Synopsis

- **If Diabetic Foot Care is scored “Yes” then:**
  - Diabetes will be listed as a pertinent diagnoses (M1020/1022)
    - 250.xx
    - 249.xx
  - Diabetic Foot Care will be listed on the Plan of Care (485)
- **If Moist Wound Healing Products scored “Yes” on M2250 then:**
  - Pressure ulcers diagnoses (2 diagnoses) will be listed as pertinent diagnoses
    - Site
    - Stage
  - Wound care will be listed on the Plan of Care
  - Wound items (M1300- M1350) will be consistent with diagnoses items
- **If depression is a diagnosis on the pertinent diagnosis, and M2250 is scored “Yes” then:**
  - **Plan of Care will indicate interventions for depression**

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## Common M2250 Errors

- Plan of Care Synopsis M2250 indicates “Yes” but
  - Orders not in clinical record for specific intervention **OR**
  - Clinical record does not indicate patient has a specific risk or disease process
    - Examples: Diabetes; Risk for Pressure ulcers; Risk for Falls; Pain; Depression and/or a positive screen on the depression tool; Current Pressure ulcers
- If the provider does not include these Best Practices in the Plan of Care (485) and/or orders, then the provider will not receive credit for performing these Best Practices
  - Fall Prevention Interventions; Teach diabetic foot care

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## OASIS-C Review: M2250

- 1. This item indicates the Plan of Care Synopsis at the completion of the OASIS-C assessment. Many of the areas in M2250 follow evidence based practices. Use of fall prevention interventions, instruction on proper foot care for diabetic patients, pressure ulcer prevention education, and ongoing pain assessment/monitoring are all good clinical practices that routinely implement without specific physician orders. Are we now required to obtain physician’s orders for these general care practices?
- If your agency wants credit for conducting this fall prevention intervention (Marking “yes” on M2250), you must have an order for fall prevention interventions.
- Source: OASIS Q & A: Question 24 (1/2010)

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## Heart Failure Defined

- HF is NOT a disease
  - Complex clinical syndrome resulting from
    - Structural or functional cardiac disorders
  - Impaired ability of ventricle to fill with or eject blood
- HF is preferred over CHF
  - All HF patients do NOT have volume overload
- Chief Symptoms of HF
  - Dyspnea
  - Fatigue
- Variations in Symptom Manifestation
  - Edema
  - Exercise intolerance



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## Heart Failure (Transfer & D/C)

- **M1500 Symptoms of Heart Failure:** If the patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

0 – No (*Go to M1732 at TRN; Go to M1600 at DC*)

1 – Yes

2 – Not assessed (*Go to M1732 at TRN; Go to M1600 at DC*)

NA – Patient does not have diagnosis of HF

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## Heart Failure Code Tips

- Heart Failure is **NOT** interchangeable with CHF
- Heart Failure does **NOT** indicate pulmonary or systemic congestion
  - Query physician when necessary
- **CHF includes right heart failure secondary to left heart failure**
  - Do **NOT** list CHF (428.0) with Left HF (428.1x)
    - Redundant coding (CHF takes precedence)
- Do **NOT** list pulmonary edema (514) **with** CHF
  - Unless physician indicates PE due to other condition
- **List ALL types of heart failure**
  - **Diastolic HF (428.30) with CHF (428.0)**

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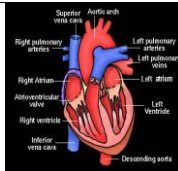
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## Related HF Clinical Documentation

- **Intake Referral Data May Include**

- Cardiac Failure
- CHF
- Failing Heart
- Cor Pulmonale
- Cardiomyopathy



- **Other Common Related Conditions**

- Ischemic Heart Disease
- Hypertensive Heart Disease/Cardiomyopathy
- Alcoholic Cardiomyopathy
- Hypertrophic Cardiomyopathy
- Pulmonary Hypertension

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## Heart Failure Specificity

- |                               |                            |
|-------------------------------|----------------------------|
| ■ <b>Left Sided HF</b>        | ■ <b>Right Sided HF</b>    |
| ■ Dyspnea                     | ■ Dependent edema          |
| ■ Orthopnea                   | ■ Weight gain              |
| ■ Paroxymal nocturnal dyspnea | ■ Anorexia                 |
| ■ Tachycardia                 | ■ Abdominal distention     |
| ■ Crackles                    | ■ Hepatomegaly             |
| ■ Gallop heart sounds (S3 S4) | ■ Jugular vein distention  |
| ■ Enlarged PMI                | ■ Parasternal life (heave) |

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## Common Heart Failure Diagnoses

- **Ensure clinicians are up to date on Heart Failure Diagnoses**
  - Heart Failure is more than CHF (428.0)
  - Right Heart Failure secondary to left heart failure (428.0)
  - Left heart failure (includes acute PE) 428.1x
  - Systolic heart failure (428.2x)
  - Diastolic heart failure (428.3x)
  - Combined systolic and diastolic heart failure (428.4x)
  - Chronic cardiopulmonary disease (Cor Pulmonale: chronic) NOS (416.9)
- **Do clinicians understand the signs and symptoms of heart failure and how this diagnosis may impact patient outcomes and treatment plan?**
  - Agency policy for cardiac assessments
  - What about Therapy only cases?
  - What happens if a heart failure patient is discharged from nursing to therapy only for discharge later in the episode?

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## OASIS-C Q & A Update: M1500

- **1. If an OASIS assessment does not report heart failure, how do I answer M1500 & M1510 at the time of transfer?**
  - If Heart Failure is not in any of the OASIS diagnoses items, including M1010 (Inpatient Diagnoses), M1016 (Diagnoses Causing a Change in Treatment) or M1020/1022/1024 (Primary/Secondary/Case Mix Payment) answer NA and skip M1510.
  - If the patient is diagnosed during the episode, and does not have an OASIS assessment to indicate this diagnosis, then answer NA and skip M1510.
- **Source: OASIS-C Final Guidance**
  - Item Intent
  - Response- Specific Instructions
  - OASIS Q & A's: Category 4: Q21 (10/2009)

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## More on Heart Failure (Transfer/ D/C)

- **M1510 Heart Failure Follow-up:** If the patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? (Mark all that apply)
  - 0 – No action taken
  - 1 – Patient’s physician (or other primary care practitioner) contacted the same day
  - 2 – Patient advised to get emergency treatment (e.g. call 911 or go to emergency room)
  - 3 – Implement physician-ordered patient-specific established parameters for treatment
  - 4 – Patient education or other clinical interventions
  - 5- Obtained change in care plan orders e.g. increased monitoring by agency, change in visit frequency, telehealth, etc.)

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## OASIS-C Q & A Update: M1510

- **1.** In M1510 where we are reporting the actions taken in response to heart failure symptoms, are we allowed to consider interventions that take place over the phone when answering this item or must we only consider the interventions that occur face to face during a home visit? Many agencies use telehealth and may not be making face-to-face visits but adequately intervening in cases of increased weight gain, etc. ?
  - Interventions provided via the telephone or other telehealth methods utilized to address heart failure symptoms could be reported on M1510, Heart Failure Follow-up.
- **Source: OASIS-C Final Guidance**
  - Response- Specific Instructions
  - OASIS Q & A's: Category 4: Q9 (1/2010)

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## The Discharge Process

- **Completion of the Discharge OASIS requires a review of the previous OASIS & the care provided during this episode**
  - How will discharging clinicians complete this OASIS?
  - What tracking tools or processes are available to quickly respond to these items?
- **Does your agency have a Pre-Discharge Protocol to identify further care interventions prior to discharge?**
  - Risk Interventions (Fall; Integument)
  - Quality Interventions (Pain; Depression; Medications)

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## Intervention Items: “Look Back”

**(M2400) Intervention Synopsis:** (Check only one box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Falls prevention interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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## Common M2400 Errors

- **Discharge indicates the Plan of Care and interventions were performed during this episode of care but**
  - Orders not in clinical record for specific intervention OR
  - Pertinent diagnoses do not reflect related issues OR
  - Clinical notes (or OASIS) do not indicate the intervention was performed
    - **Examples:** Diabetic foot care; Pressure ulcer prevention; Pain monitoring and mitigation; Fall Prevention; Depression monitoring and/or interventions
- **If the provider does not include these Best Practices in the Plan of Care (485) and/or orders, then the provider will not receive credit for performing these Best Practices**

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## Common Agency Risks

- **Not listing pertinent dx indicated in new OASIS-C items (M1010; 1012; 1016; 1020; 1022; 1024)**
- **Upcoding – reversing the order of diagnoses to increase reimbursement**
- **Lack of supporting physician documentation for accurate primary and secondary diagnoses and code assignment (Billable diagnoses)**
- **Lack of substantiating clinician documentation in the OASIS assessment to support the selection and sequencing of primary and secondary diagnoses**
- **Not following ICD-9-CM code convention**

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## Resource Web Site



- **CMS OASIS Web Page**
  - [www.cms.hhs.gov/oasis](http://www.cms.hhs.gov/oasis)
- **Home Health PPS**
  - [www.cms.hhs.gov/HomeHealthPPS/](http://www.cms.hhs.gov/HomeHealthPPS/)
- **Wound Ostomy Continence Nurse Society (WOCN)**
  - [www.wocn.org](http://www.wocn.org)
- **National Pressure Ulcer Advisory Panel (NPUAP)**
  - [www.npuap.org](http://www.npuap.org)
- **www.ahima.org**
  - AHIMA (American Health Information Management Association)

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**(M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:**  
 (Enter "0" if none; excludes Stage I pressure ulcers)

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
a. <b>Stage II:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	___	___
b. <b>Stage III:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	___	___
c. <b>Stage IV:</b> Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	___	___
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	___	___
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	___	___
d.3 Unstageable: Suspected deep tissue injury in evolution.	___	___

**Directions for M1310, M1312, and M1314:** If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

**(M1310) Pressure Ulcer Length:** Longest length "head-to-toe" | \_\_ | \_\_ | . | \_\_ | (cm)

**(M1312) Pressure Ulcer Width:** Width of the same pressure ulcer; greatest width perpendicular to the length  
 | \_\_ | \_\_ | . | \_\_ | (cm)

**(M1314) Pressure Ulcer Depth:** Depth of the same pressure ulcer; from visible surface to the deepest area  
 | \_\_ | \_\_ | . | \_\_ | (cm)

**(M1320) Status of Most Problematic (Observable) Pressure Ulcer:**

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable pressure ulcer