OASIS ITEM

(M1000) From which of the following **Inpatient Facilities** was the patient discharged within the past 14 days? **(Mark all that apply.)**

- ☐ 1 - Long-term nursing facility (NF)
- ☐ 2 - Skilled nursing facility (SNF/TCU)
- ☐ 3 - Short-stay acute hospital (IPPS)
- ☐ 4 - Long-term care hospital (LTCH)
- ☐ 5 - Inpatient rehabilitation hospital or unit (IRF)
- ☐ 6 - Psychiatric hospital or unit
- ☐ 7 - Other (specify) _____
- ☐ NA - Patient was not discharged from an inpatient facility **[*Go to M1021*]**

ITEM INTENT

- 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 date. 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.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- Mark all that apply. For example, patient may have been discharged from both a hospital and 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 date. This means that for purposes of counting the 14-day period, the Start of Care date is day 0 and the day immediately prior to the Start of Care date 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.
- Determine responses to the questions below. If all three of the criteria below apply, select Response 2:

  - Was the patient discharged from a Medicare-certified skilled nursing facility? If yes;
  - While in the skilled nursing facility was the patient receiving skilled care under the Medicare Part A benefit? If yes; and

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1000)

- Was the patient receiving skilled care under the Medicare Part A benefit during the 14 days prior to the home health care Start of Care date? 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

(M1005) Inpatient Discharge Date (most recent):

☐☐ / ☐☐ / ☐☐☐☐
month day year

☐ UK - Unknown

ITEM INTENT

- Identifies the date of the most recent discharge from an inpatient facility (within past 14 days). (Past 14 days encompasses the two-week period immediately preceding the Start/Resumption of Care date.)

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- The term “past 14 days” is the two-week period immediately preceding the Start/Resumption of Care date. This means that for purposes of counting the 14-day period, the Start of Care date is day 0 and the day immediately prior to the Start of Care date 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, 2019 = 05/04/2019). Enter all four digits of the year.

DATA SOURCES/RESOURCES

- 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

(M1021/1023) **Diagnoses and Symptom Control:** List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-CM code at the level of highest specificity in Column 2 (diagnosis codes only – no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses.

Code each row according to the following directions for each column.

Column 1: Enter the description of the diagnosis. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 2: Enter the ICD-10-CM code for the condition described in Column 1 – no surgical or procedure codes allowed. Codes must be entered at the level of highest specificity and ICD-10-CM coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-CM codes beginning with V, W, X, or Y) may not be reported in M1021 (Primary Diagnosis) but may be reported in M1023 (Secondary Diagnoses). Also note that when a Z-code is reported in Column 2, the code for the underlying condition can often be entered in Column 2, as long as it is an active on-going condition impacting home health care.

Rate the degree of symptom control for the condition listed in Column 1. Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code. Choose one value that represents the degree of symptom control appropriate for each diagnosis 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 the rating for symptom control in Column 2 should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide.

OASIS ITEM

(M1021) Primary Diagnosis & (M1023) Other Diagnoses	
Column 1	**Column 2**
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses
Description	ICD-10-CM / Symptom Control Rating
(M1021) Primary Diagnosis a. _____	**V, W, X, Y codes NOT allowed** a. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
(M1023) Other Diagnoses b. _____	**All ICD-10–CM codes allowed** b. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
c. _____	c. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
d. _____	d. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
e. _____	e. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4
f. _____	f. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4

ITEM INTENT

- M1021: 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.
- M1023: 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.

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-10-CM Official Guidelines for Coding and Reporting when assigning primary and secondary diagnoses to the OASIS items M1021 and M1023. See Chapter 5 for link.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEMS M1021/1023)

- The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for care in all health care settings. The ICD-10-CM is based on the ICD-10, the international classification of disease published by the World Health Organization (WHO).
- The ICD-10-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-10-CM itself and should be used as a companion document to the official version of the ICD-10-CM List of Codes and Descriptions.
- Adherence to the ICD-10-CM Official Guidelines for Coding and Reporting when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). It is expected that each agency will ensure that diagnoses and ICD-10-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 and may elicit input from other agency staff that have had direct in-person contact with the patient, or have had some other means of gathering information to contribute to the OASIS data collection.
  - 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. 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.
  - When determining secondary diagnoses, the assessing clinician should consider diagnoses that are actively addressed in the Plan of Care as well as diagnoses that affect the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.
  - 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 M1021 and M1023. 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-10-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 ITEMS M1021/1023)

- Reporting Primary and Secondary Diagnoses in M1021 and M1023
  - At each required OASIS time point, the assessing clinician should enter the patient's current primary and secondary diagnoses in Column 1 of M1021 and M1023. 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-10-CM Codes in Column 2 of M1021 and M1023
  - The assessing clinician can enter the actual numeric ICD-10-CM codes for each diagnosis listed in Column 1 and 2 of M1021 and M1023, 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-10-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-10-CM code using the Alphabetic Index and the Tabular List is described in the ICD-10-CM Official Guidelines for Coding and Reporting. Follow the official conventions and instructions provided within the ICD-10-CM List of Codes and Descriptions and the Official Guidelines to code each row in Column 2.
  - Each ICD-10-CM code must be entered at its highest level of specificity (diagnosis codes only – no surgical or procedure codes allowed).
  - ICD-10-CM does not allow external cause codes (ICD-10-CM codes beginning with V, W, X, or Y) to be reported in M1021 (Primary Diagnosis) but they may be reported in M1023 (Secondary Diagnoses).
  - Also note that when a Z-code is reported in Column 2, the code for the underlying condition may 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. See the ICD-10-CM Official Guidelines for Coding and Reporting for complete instructions on code assignment and sequencing related to the use of Z-codes and use of multiple coding for a single condition (such as manifestation/etiology pairs).

- Reporting the Symptom Control Rating in Column 2 of M1021 and M1023.
  - At each required time point, the assessing clinician should record the symptom control ratings for each primary and secondary diagnosis in column 2 of M1021 and M1023.
  - 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 M1021/M1023 instructions.

- Refer to the ICD-10-CM Official Guidelines for Coding and Reporting for instructions on multiple coding for a single condition (such as manifestation/etiology pairs).

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Physician
- Physician orders
- Referral information
- Current medication list
- The current ICD-10-CM List of Codes and Descriptions and the ICD-10-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

(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)
- ☐ 3 - None of the above

Item Intent

This item 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).

Time Points Item(s) Completed

Start of care

Resumption of care

Response-Specific Instructions

1. **Identify diagnoses**: The diseases and conditions in this item require a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) documented diagnosis at the time of assessment.

   - Clinical record sources for physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) diagnoses include, but are not limited to, transfer documents, physician progress notes, recent history and physical, discharge summary, physician orders, and consults.

     - Available documentation may be limited at admission/start of care. Admission/start of care assessment may indicate symptoms associated with one of this item's listed conditions while a documented diagnosis is not present in available records. The clinician should contact the physician (or other, as listed above) to ask if the patient has the diagnosis. Once a diagnosis has been identified, determine if the diagnosis is active.

     - Although open communication regarding diagnostic information between the physician and other clinical staff is important, it is also essential that diagnoses communicated verbally be documented in the clinical record by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other licensed staff if allowable under state licensure laws) to ensure follow-up and coordination of care.

   - Diagnostic information, including past medical and surgical history obtained from family members and close contacts, must also be documented in the clinical record by the

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEMS M1028)

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.

- 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.

2. **Determine whether diagnoses are active:** Once a diagnosis is identified, determine whether the diagnosis is active.

- If information regarding active diagnoses is learned after the end of the assessment time frame, 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.

- If, however, it comes to light after the data set is submitted that a documented active diagnosis was present but not indicated on the OASIS data set, the Home Health Agency should modify the OASIS data set in accordance with the instructions in the Survey and Certification Memo #15-18-HHA, Outcome and Assessment Information Set (OASIS) transition to the Automated Submission and Processing System (ASAP) and OASIS Correction policy.

  - A copy of this memo is located on CMS.gov under Provider Enrollment and Certification/Quality Safety & Oversight – General Information/Policy & Memos to States and Regions. For additional details, please reference the OASIS Submission User's Guide and Training site (QTSO site).

DEFINITION

ACTIVE DIAGNOSES

- 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 or do not affect the patient's current functional, cognitive, or mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.

Coding Instructions

Code 1, Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD), if the patient has an active diagnosis of Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD), indicated by any of the following diagnosis codes:

Codes that start with the first 4 characters of:

- **I70.2**, Atherosclerosis of native arteries of the extremities
- **I70.3**, Atherosclerosis of unspecified type of bypass graft(s) of the extremities
- **I70.4**, Atherosclerosis of autologous vein bypass graft(s) of the extremities

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEMS M1028)

- **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

Codes that start with the first 3 characters of:

- **I73**, Other peripheral vascular diseases

Code 2, Diabetes Mellitus (DM), if the patient has an active diagnosis of Diabetes Mellitus (DM) indicated by any of the following diagnosis codes:

Codes that start with the first 3 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 **specified** diabetes mellitus

Code 3, None of the Above, if the patient does not have any of the active diagnoses listed above.

- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

Coding Tips

The following tips may assist staff in determining whether a disease or condition should be coded as an active diagnosis.

- The physician (nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) may specifically indicate that a diagnosis is active.
- If there is documentation in the clinical record that a patient has diabetes mellitus, Select Response 2, Diabetes Mellitus (DM). If there is only documentation in the clinical record of a complication such as nephropathy or neuropathy and there is no documentation that the patient has diabetes, it should not be assumed the complication is associated with diabetes, and Response 2, Diabetes Mellitus, should not be checked.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEMS M1028)

- The physician (nurse practitioner, physician assistant, clinical nurse specialist or other authorized licensed staff if allowable under state licensure laws) for example, documents at the time of assessment that the patient has inadequately controlled diabetes and requires adjustment of the medication regimen. This would be sufficient documentation of an active diagnosis and would require no additional confirmation because the physician documented the diagnosis and also confirmed that the medication regimen needed to be modified.

Examples

1. Active Diagnosis of Diabetes Mellitus

Mr. A is prescribed insulin for diabetes mellitus. He requires regular blood glucose monitoring to determine whether blood glucose goals are achieved by the current medication regimen. The physician progress note documents diabetes mellitus.

Coding: M1028, Active Diagnoses, would be coded 2, Diabetes Mellitus.

Rationale: This would be considered an active diagnosis because the physician progress note documents the diabetes mellitus diagnosis, and because there is ongoing medication management and glucose monitoring.

2. None of the Above

During the SOC/ROC assessment, Mrs. K told Nurse J, RN that she has had diabetes for 20 years. Nurse J reviewed the transfer documents from the acute care facility and all clinical records on the patient but was unable find a documented diagnosis of Diabetes Mellitus by physician, nurse practitioner, physician assistant or authorized licensed staff member in their state. There is no documented diagnosis of PVD or PAD.

Coding: M1028, Active Diagnoses, would be coded 3, None of the Above.

Rationale: This would be considered a "none of the above" response because the nurse was unable to find the diagnosis of diabetes at the time of assessment, documented by a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws). And, there is no documented diagnosis of PVD or PAD.

Data Sources/Resources

Transfer documents

Clinical Records

Referrals

OASIS ITEM

(M1030) Therapies the patient receives at home: **(Mark all that apply.)**

- ☐ 1 - Intravenous or infusion therapy (excludes TPN)
- ☐ 2 - Parenteral nutrition (TPN or lipids)
- ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 - None of the above

ITEM INTENT

- 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.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up

RESPONSE-SPECIFIC INSTRUCTIONS

- 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 not 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 not apply. A flush of a feeding tube does not provide nutrition.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Physician orders
- Referral information
- Physical assessment
- Review of past health history

OASIS ITEM

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

- ☐ 1 - History of falls (2 or more falls – or any fall with an injury – in the past 12 months)
- ☐ 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ☐ 3 - Multiple hospitalizations (2 or more) in the past 6 months
- ☐ 4 - Multiple emergency department visits (2 or more) in the past 6 months
- ☐ 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- ☐ 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ☐ 7 - Currently taking 5 or more medications
- ☐ 8 - Currently reports exhaustion
- ☐ 9 - Other risk(s) not listed in 1 - 8
- ☐ 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

- 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 include 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

- Patient/caregiver interview
- Physician
- Review of health history
- Referral information
- Physical assessment

OASIS ITEM

(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?
Enter Code ☐	0 No *[Go to M1051]* 1 Yes

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

- Transfer to an inpatient facility
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- 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, enter the response for “No.”

DATA SOURCES/RESOURCES

- Clinical record and calendar

OASIS ITEM

(M1046)	**Influenza Vaccine Received:** Did the patient receive the influenza vaccine for this year's flu season?
Enter Code ☐	1 Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge) 2 Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge) 3 Yes; received from another health care provider (for example, physician, pharmacist) 4 No; patient offered and declined 5 No; patient assessed and determined to have medical contraindication(s) 6 No; not indicated – patient does not meet age/condition guidelines for influenza vaccine 7 No; inability to obtain vaccine due to declared shortage 8 No; patient did not receive the vaccine due to reasons other than those listed in responses 4–7

ITEM INTENT

- 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.

TIME POINTS ITEM(S) COMPLETED

- Transfer to an inpatient facility
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Complete if Response 1 – Yes is entered for M1041. Enter only one response.
- Enter Response 1 if your agency provided the influenza vaccine to the patient during this episode of care (SOC/ROC to Transfer/Discharge).
- Enter 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).
  - You may enter 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.
- Enter 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.
- Response 1, 2, or 3 may be entered 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).
- Enter 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. Enter Response 4 only if the patient was offered the vaccine and he/she refused.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1046)

- Enter Response 5 if the influenza vaccine is contraindicated for medical reasons. Refer to the Centers for Disease Control and Prevention (CDC) website for information on contraindications for the influenza vaccine (See link in Chapter 5).
- Enter 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. It is the agency's responsibility to make current guidelines available to clinicians.
- Enter Response 7 only in the event that the vaccine is unavailable due to a CDC-declared shortage.
- Enter Response 8 only if the patient did not receive the vaccine due to a reason other than Responses 4–7, including situations where the assessing clinician is unable to determine whether the patient received the influenza vaccination.

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

(M1051)	**Pneumococcal Vaccine:** Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?
Enter Code ☐	0 No 1 Yes *[Go to M2005 at TRN; Go to M1242 at DC]*

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

- Enter Response 1 if the patient has ever received the pneumococcal vaccine.
- Enter Response 0 if the patient has never received the pneumococcal vaccine, or if the assessing clinician is unable to determine whether the patient has ever received the pneumococcal vaccine.

DATA SOURCES/RESOURCES

- Clinical record
- Patient/caregiver interview

OASIS ITEM

(M1056)	**Reason Pneumococcal Vaccine not received:** If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:
Enter Code ☐	1 Offered and declined 2 Assessed and determined to have medical contraindication(s) 3 Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine 4 None of the above

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

- Enter Response 1 if the patient and/or healthcare proxy (for example, someone with power of attorney) refused the vaccine.
- Enter Response 2 if pneumococcal vaccine administration is medically contraindicated for this patient. Refer to the Centers for Disease Control and Prevention (CDC) website for information on contraindications for the pneumococcal vaccination (See link in Chapter 5).
- Enter 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.
- Enter Response 4 only if the agency did not provide the vaccine due to a reason other than Responses 1-3 including situations where the assessing clinician is unable to determine whether the patient has ever received the pneumococcal vaccine.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Physician
- Clinical Record
- A link to CDC Guidelines for pneumococcal vaccine administration can be found in Chapter 5 of this manual

OASIS Item

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

☐☐ inches	a. Height (in inches). Record most recent height measure since the most recent SOC/ROC
☐☐☐ pounds	b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

Item Intent

These items support calculation of the patient's body mass index (BMI) using the patient's height and weight.

Time Points Item(s) Completed

Start of care

Resumption of care

Response-Specific Instructions

Coding Instructions

- **M1060 – a, Height**
  - Measure height in accordance with the agency's policies and procedures.
  - Measure and record the patient's height to the nearest whole inch.
  - Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches, and a height of 62.4 inches would be rounded to 62 inches.
  - Only enter a height that has been directly measured by agency staff. Do not enter a height that is self-reported or derived from documentation from another provider setting.

- **M1060 – b, Weight**
  - Weight should be measured in accordance with the agency's policies and procedures.
  - Measure and record the patient's weight in pounds.
  - Use mathematical rounding (e.g., if weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs., round down to the nearest whole pound). For example, a weight of 152.5 lbs. would be rounded to 153 lbs. and a weight of 152.4 lbs. would be rounded to 152 lbs.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEMS M1060)

- If agency staff weighs the patient multiple times during the assessment period, use the first weight.
- Only enter a weight that has been directly measured by agency staff. Do not enter a weight that is self-reported or derived from documentation from another provider setting.

- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

Coding Tips

- 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).
- If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, the use of a dash (–) is appropriate. Document the rationale on the patient's medical record.
- When there is an unsuccessful attempt to measure a patient's height or weight, at SOC/ROC, and there is a documented agency-obtained height or weight from one or more previous home health visits, an agency-obtained height or weight from a documented visit conducted within the previous 30-day window may be used to complete M1060 for this SOC/ROC assessment. Whenever possible, a current height and weight should be obtained by the agency as part of the SOC/ROC assessment.