Preparing for OASIS-C2

Highlights of item
& guidance changes

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Presented for: Wyoming Department of Health
September 30, 2016

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OASIS-C2 – WHAT'S NEW?

Standardization!

- Boxes instead of lines
- Single box format
- New items – M1028, M1060 and GG0170C
- Some items revised & numbered:
  - New Look back periods
  - Drug Regimen Review items
  - Pressure Ulcer items
- Dash (–) as a new valid response for some items
- New guidance regarding pressure ulcers & surgical wounds

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OASIS-C2 – WHAT'S NEW?
BOXES INSTEAD OF LINES

Standardization!

OASIS-C1

(M0032)	Resumption of Care Date: ___/___/_____ ☐ NA – Not Applicable (month/ day/ year)
(M0040)	Patient Name: _____ (First) _____ (MI) (Last) _____ (Suffix)

OASIS-C2

(M0032)	Resumption of Care Date: ☐☐/☐☐/☐☐ ☐ NA – Not Applicable (month day year)
(M0040)	Patient Name: ☐☐☐☐☐☐☐☐☐☐☐☐ ☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐ (First) (MI) (Last) (Suffix)

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OASIS-C2 – WHAT'S NEW?
SINGLE BOX ENTRY

Standardization!

OASIS-C1

(M1400)	When is the patient dyspneic or noticeably **Short of Breath**?
	☐ 0 – Patient is not short of breath
	☐ 1 – When walking more than 20 feet, climbing stairs
	☐ 2 – With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
	☐ 3 – With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation
	☐ 4 – At rest (during day or night)
(M1410)	**Respiratory Treatments** utilized at home: **(Mark all that apply.)**
	☐ 1 – Oxygen (intermittent or continuous)
	☐ 2 – Ventilator (continually or at night)
	☐ 3 – Continuous / Bi level positive airway pressure
	☐ 4 – None of the above

OASIS-C2

(M1400)	When is the patient dyspneic or noticeably **Short of Breath**?
Enter Code ☐	0 Patient is not short of breath
	1 When walking more than 20 feet, climbing stairs
	2 With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
	3 With minimal exertion (for example, while eating, talking or performing other ADLs) or with agitation
	4 At rest (during day or night)
(M1410)	**Respiratory Treatments** utilized at home: **(Mark all that apply.)**
☐	1 – Oxygen (intermittent or continuous)
☐	2 Ventilator (continually or at night)
☐	3 – Continuous / Bi-level positive airway pressure
☐	4 – None of the above

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M1028 ACTIVE DIAGNOSES (SOC/ROC)

(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)

NEW ITEM!

- Identify physician or physician-designee confirmed diagnoses that are **active** and associated with the patient's home health episode of care.
- **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 time of assessment.
- Do not include diagnoses that have been **resolved** or do not affect the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at time of assessment.
- Chapter 3 Guidance lists appropriate ICD-10 codes for identifying these diagnoses

M1028 ACTIVE DIAGNOSES (SOC/ROC)

(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)

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

- Codes that start with the first 4 characters of:
  - **I70.2** – Atherosclerosis of native arteries of the extremities
  - **I70.3** – Atherosclerosis of bypass graft(s) of the extremities
  - **I70.4** – Atherosclerosis of autologous vein bypass graft(s) of the extremities
  - **I70.5** – Atherosclerosis of nonautologous biological bypass graft(s) of the extremities
  - **I70.6** – Atherosclerosis of nonbiological bypass graft(s) of the extremities
  - **I70.7** – Atherosclerosis of other type of bypass graft(s) of the extremities
  - **I70.91** – Generalized atherosclerosis
  - **I70.92** – Chronic total occlusion of artery of the extremities
- Codes that start with the first 3 characters of:
  - **I73.** – Other peripheral vascular diseases

M1028 ACTIVE DIAGNOSES (SOC/ROC)

(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)

Select Response 2 - if an active diagnosis of Diabetes Mellitus (DM).

- 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 specific diabetes mellitus

- A **dash (–)** value is a valid response for this item.
  - A **dash (–)** value indicates that no information is available and /or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before the assessment of the item could be completed.
  - CMS expects dash use to be a rare occurrence.

M1060 HEIGHT AND WEIGHT (SOC/ROC)

(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.)

NEW ITEM!

- Measure height and weight in accordance with the **agency's policies and procedures**, which should reflect current standards of practice (shoes off, etc.)
- Measure and record **height in inches and weight in pounds**.
- Use mathematical **rounding** to the nearest whole inch.
- **A dash (-) value is a valid response** for this item. A dash (-) value indicates that no information is available and/or an item could not be assessed. CMS expects dash use to be a rare occurrence.
  - **If a patient cannot be weighed**, for example, because of extreme pain, immobility, or risk of pathological fractures, enter the dash value and document the rationale on the patient's medical record.

GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

NEW ITEM!

Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC

(GG0170C) Mobility

Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.

Coding:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activity may be completed with or without assistive devices.

06 Independent – Patient completes the activity by him/herself with no assistance from a helper.

05 Setup or clean-up assistance – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

04 Supervision or touching assistance – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

03 Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

02 Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01 Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07 **Patient refused**

09 **Not applicable**

88 Not attempted due to **medical condition or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal
↓Enter Codes in Boxes	
☐☐	☐☐

Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

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GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

- Assess functional status based on **direct observation and/or report by patient/ caregiver.**
- Patients should be allowed to perform activities as independently as possible, as long as they are safe.
- Activities may be completed **with or without assistive device(s).** Use of assistive device(s) to complete an activity should not affect the scoring of the activity.
- If the patient's **performance varies** during the assessment time frame, report the **patient's usual status**.

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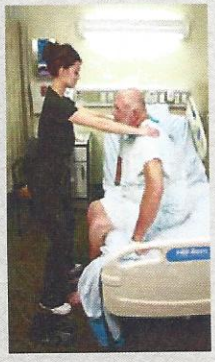
GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

- **SOC/ROC Performance,** report the patient's usual status at SOC/ROC using the **6-point scale** or, using one of the **three "activity was not attempted" codes,** report the reason the activity was not attempted.
- **Discharge Goal,** report the discharge goal using the 6-point scale. **Do not enter 07, 09, or 88 to report the discharge goal**. The assessing clinician, in conjunction with patient and family input, can establish the discharge goal.

GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

For GG0170C – SOC/ROC Performance, report the patient's usual status at SOC/ROC using the 6-point scale or, using one of the three "activity was not attempted" codes, report the reason the activity was not attempted.



06 – Independent	The patient completes the activity by him/herself with no human assistance.
05 – Setup or clean-up assistance	The caregiver SETS UP or CLEANS UP; patient completes activity. Caregiver assists only prior to or following the activity, but not during the activity. **For example**, the patient requires assistance putting on a shoulder sling prior to the transfer, or requires assistance removing the bedding from off his/her lower body to get out of bed.

GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

04 – Supervision or touching assistance	The caregiver must provide VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be required throughout the activity or intermittently. **For example**, the patient requires verbal cueing, coaxing, or general supervision for safety to complete activity; or patient may require only incidental help such as contact guard or steadying assist during the activity.
03 – Partial/moderate assistance	The caregiver must provide LESS THAN HALF the effort. Caregiver lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02 – Substantial/maximal assistance	The caregiver must provide MORE THAN HALF the effort. Caregiver lifts or holds trunk or limbs and provides more than half the effort.
01 – Dependent	The caregiver must provide ALL of the effort. Patient is unable to contribute any of the effort to complete the activity; or the assistance of two or more caregivers is required for the patient to complete the activity.

GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

If the patient **does not attempt** the activity **and a caregiver does not complete** the activity for the patient, report the reason the activity was not attempted.

"Activity Not Attempted" Codes

Enter 07 – Patient refused	The patient refused to complete the activity.
Enter 09 – Not Applicable	The patient did not perform this activity prior to the current illness, exacerbation, or injury.
Enter 88 – Not attempted due to medical condition or safety concerns	The activity was not attempted due to medical condition or safety concerns.
Enter a dash ("–")	No information is available or assessment is not possible for reason other than above.

GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

NEW ITEM!

Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC

(GG0170C) Mobility

Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.

Coding:

Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activity may be completed with or without assistive devices.

06 Independent – Patient completes the activity by him/herself with no assistance from a helper.

05 Setup or clean-up assistance – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.

04 Supervision or touching assistance – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.

03 Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

02 Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

01 Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07 **Patient refused**

09 **Not applicable**

88 Not attempted due to **medical condition or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal
↓Enter Codes in Boxes	
☐☐	☐☐

Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

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GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

For GG0170C – Discharge Goal

- The assessing clinician, in conjunction with patient and family input, can establish the discharge goal.

Expected Patient Progress	Discharge Goal
Expected to **make functional progress** by discharge	Report a Discharge Goal **higher (more independent)** than the SOC/ROC Performance response
Not expected to make progress during the home health episode, but is expected to **maintain his/her SOC functional level** - A medically complex patient	Report a Discharge Goal **the same as** the patient's SOC Performance response
Expected to **rapidly decline** and skilled therapy services may slow the decline of function - A patient with a progressive neurological condition	Report a Discharge Goal **lower (more dependent)** than the SOC/ROC Performance response
The assessing clinician does not establish a Discharge Goal for the patient's bed mobility task	Enter a **dash ("–")** for a Discharge Goal

M1501/M1511/M2016/M2301/M2401

(TRANSFER/DC)

New **"look back"** period…

WAS

" at the time of or since the most recent OASIS" — OASIS-C1

NOW is **"at the time of or since the most recent SOC/ROC"** — OASIS-C2

M1500 replaced by M1501

New **"look back"** period…
OASIS-C1 " at the time of or since the most recent OASIS"
OASIS-C2 **"at the time of or since the most recent SOC/ROC"**

OASIS-C1

(M1500)	**Symptoms in Heart Failure Patients:** If 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 the time of or at any time since the previous OASIS assessment?
	☐ 0 – No ***(Go to M2004 at TRN; Go to M1600 at DC)***
	☐ 1 – Yes
	☐ 2 – Not assessed ***(Go to M2004 at TRN; Go to M1600 at DC)***
	☐ NA – Patient does not have diagnosis of heart failure ***(Go to M2004 at TRN; Go to M1600 at DC)***

OASIS-C2

(M1501) Symptoms in Heart Failure Patients: If 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 the time of or at any time since the most recent SOC/ROC assessment?

Enter Code ☐

0 - No [***Go to M2005 at TRN; Go to M1600 at DC***]
1 - Yes
2 - Not assessed [***Go to M2005 at TRN; Go to M1600 at DC***]
NA - Patient does not have diagnosis of heart failure
[***Go to M2005 at TRN; Go to M1600 at DC***]

M1510 replaced by M1511

New **"look back"** period...
OASIS-C1 " at the time of or since the most recent OASIS"
OASIS-C2 **"at the time of or since the most recent SOC/ROC"**

OASIS-C1

(M1510) **Heart Failure Follow-up:** If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time 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 (for example, call 911 or go to emergency room)
- ☐ 3 – Implemented physician-ordered patient-specific established parameters for treatment
- ☐ 4 – Patient education or other clinical interventions
- ☐ 5 – Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

OASIS-C2

(M1511) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC 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 (for example, call 911 or go to emergency room)
- ☐ 3 - Implemented physician-ordered patient-specific established parameters for treatment
- ☐ 4 - Patient education or other clinical interventions
- ☐ 5 - Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

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M2015 replaced by M2016

New **"look back"** period...
OASIS-C1 " at the time of or since the most recent OASIS"
OASIS-C2 **"at the time of or since the most recent SOC/ROC"**

OASIS-C1

(M2015) **Patient/Caregiver Drug Education Intervention**: At the time of, or at any time since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA – Patient not taking any drugs

OASIS-C2

(M2016) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?

Enter Code ☐

0 - No
1 - Yes
NA - Patient not taking any drugs

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M2300 replaced by M2301

New **"look back"** period...
OASIS-C1 " at the time of or since the most recent OASIS"
OASIS-C2 **"at the time of or since the most recent SOC/ROC"**

OASIS-C1

(M2300)	**Emergent Care:** At the time of or at any time since the previous OASIS assessment has the patient utilized a hospital emergency department (includes holding/observation status)?
	☐ 0 - No **[*GotoM2400*]** ☐ 1 - Yes, used hospital emergency department WITHOUT hospital admission ☐ 2 - Yes, used hospital emergency department WITH hospital admission ☐ UK - Unknown **[*GotoM2400*]**

OASIS-C2

(M2301) Emergent Care: At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?

Enter Code ☐

0 - No **[*Go to M2401*]**
1 - Yes, used hospital emergency department WITHOUT hospital admission
2 - Yes, used hospital emergency department WITH hospital admission
UK - Unknown **[*Go to M2401*]**

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M2400 replaced by M2401

New **"look back"** period...
OASIS-C1 " at the time of or since the most recent OASIS"
OASIS-C2 **"at the time of or since the most recent SOC/ROC"**

OASIS-C1

(M2400)	**Intervention Synopsis:** (Check only **one** box in each row.) At the time of or at any time 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	☐0	☐1	☐NA Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b.	Falls prevention interventions	☐0	☐1	☐NA Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c.	Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐NA Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d.	Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e.	Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f.	Pressure ulcer treatment based on principles of moist wound healing	☐0	☐1	☐NA Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

OASIS-C2

(M2401) Intervention Synopsis: (Check only **one** box in each row.) At the time of or at any time since the most recent SOC/ROC 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	☐0	☐1	☐NA Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	☐0	☐1	☐NA Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐NA Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	☐0	☐1	☐NA Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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M2001/M2003 (SOC/ROC) /M2005 (TRF, DC, DEATH)

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?

Enter Code		
☐	0 No - No issues found during review	[*Go to M2010*]
	1 Yes - Issues found during review	
	9 NA - Patient is not taking any medications	[*Go to M2040*]

(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

Enter Code	
☐	0 - No
	1 - Yes

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

Enter Code	
☐	0 No
	1 Yes
	9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

M2001- Changed response options

M2003 & M2005- New wording: **"By midnight the next calendar day"**

"Yes" response requires identifying, contacting, and **completing** the prescribed/recommended actions.

M2005- The lookback period goes back to the **most recent SOC/ROC.**

Added to **Death at Home**

M2001 (SOC/ROC)

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?

Enter Code		
☐	0 No - No issues found during review	[*Go to M2010*]
	1 Yes - Issues found during review	
	9 NA - Patient is not taking any medications	[*Go to M2040*]

- The drug regimen review includes review of all medications a patient is currently using to identify potential clinically significant medication issues.
- Consider all meds, prescribed and OTC, administered by any route
  - Examples: Oral, topical, inhalant, pump, injection, intravenous, via enteral tube
- Definition of a **potential** or **existing** clinically significant medication issue:
  - An issue that in the **care provider's clinical judgment**, requires physician/physician-designee notification **by midnight of the next calendar day (at the latest).**
- Note that response options have changed from C1. There is no response option stating no Drug Regimen Review was completed.

M2001 (SOC/ROC)

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?		
Enter Code	0 No - No issues found during review	[*Go to M2010*]
	1 Yes - Issues found during review	
☐	9 NA - Patient is not taking any medications	[*Go to M2040*]

- Enter **"0"- No, no issues found during review** if, drug review was completed and in clinician's judgment, there were no clinically significant problems
- Enter **"1" Yes- Issues found during review** if, drug review was completed and in clinician's judgment, at least one potential clinically significant problem is identified
- Enter **"9" NA** - if not taking any medications
- **Potential** or **actual** clinically significant medication issues may include:
  - Adverse reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, nonadherence
- **To be clinically significant,** circumstances must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest.
  - Any circumstance that **does not require this immediate attention is not considered** a potential or actual clinically significant medication issue.

M2003 (SOC/ROC)

(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?	
Enter Code	0 - No
	1 - Yes
☐	

- Identifies if potential clinically significant medication issues identified through a medication review were addressed with the physician (or physician-designee) and prescribed/recommended actions completed by midnight of the next calendar day following their identification.

Contact with physician means:

- Communication to the physician or physician-designee
  - by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status
- Communication can be directly to/from the physician or physician-designee, or indirectly through physician's office staff on behalf of the physician or physician-designee, in accordance with the legal scope of practice.

M2003 (SOC/ROC)

(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?	
Enter Code ☐	0 - No 1 - Yes

Enter Response 0 – No

- If a potential clinically significant medication issue was identified, AND
  - Clinician attempted to communicate with the physician, BUT
  - **Did not** receive communication back from the physician/physician designee until after midnight of the next calendar day

M2003 (SOC/ROC)

(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?	
Enter Code ☐	0 - No 1 - Yes

Enter Response 0 – No

- If two potential clinically significant medication issues are identified at the SOC/ROC AND
  - Both are communicated to the physician/physician-designee timely, AND
  - Physician/physician-designee provides a recommended action for each issue
    - For example, patient education for one medication, and a new dosage for another AND
  - Both recommended actions COULD have been addressed by midnight of the next calendar day, BUT
  - **Only one** was addressed

M2003 (SOC/ROC)

(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

Enter Code ☐

0 - No
1 - Yes

Enter Response 1 – Yes

- Two-way communication occurred AND
- Completion of the prescribed/recommended actions occurred BY
- Midnight of the next calendar day after the potential clinically significant medication issue was identified AND
- above actions completed within the assessment time frame

M2003 (SOC/ROC)

(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

Enter Code ☐

0 - No
1 - Yes

ALSO Enter Response 1 – Yes if

- Physician/physician-designee recommends an action that will take longer than the allowed time to complete, as long as by midnight of the next calendar day the agency has taken whatever actions are possible to comply with the recommended action.
- **Examples**:
  - Physician instructs agency staff to continue to monitor the issue over the weekend and call if problem persists
  - Physician instructs the patient to address the concern with his PCP on a visit that is scheduled in two days

M2003 (SOC/ROC)

(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

Enter Code ☐

0 - No
1 - Yes

Enter Response 1 – Yes

- If the physician/physician-designee provides no new orders or instruction in response to timely reported potential clinically significant medication issue(s)
  - Indicates that the physician/physician-designee was contacted and prescribed/recommended actions were completed.
- When multiple potential clinically significant medication issues are identified at the SOC/ROC AND
  - ALL are communicated to the physician/physician-designee, WITH
  - Completion of ALL prescribed/recommended actions occurring by midnight of the next calendar day

M2003 (SOC/ROC)

(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

Enter Code ☐

0 - No
1 - Yes

A dash (–) value is a valid response for this item.

- Indicates that no information is available, and/or an item could not be assessed.
- Most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment could be completed.

CMS expects dash use to be a rare occurrence.

M2005 (TRF, DC, DEATH)

New **"look back"** period...
OASIS-C1 " at the time of or since the most recent OASIS"
OASIS-C2 **"at the time of or since the most recent SOC/ROC"**

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

Enter Code	
☐	0 No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

- New wording: **"By midnight the next calendar day"**
- "Yes" response requires identifying, contacting, and **completing** the prescribed/recommended actions.
- If the physician/physician-designee recommends an action that will take longer than the allowed time to complete, then Response 1 – Yes should be entered as long as by midnight of the next calendar day the agency has taken whatever actions are possible to comply with the recommended action.

M2005 (TRF, DC, DEATH)

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

Enter Code	
☐	0 No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

Similar to M2003 Medication Follow-up except:

- Time points: Transfer to inpatient facility, Discharge from agency - not to inpatient facility and **Death at home**
- Time under consideration: at the time of or any time since the SOC/ROC

- Identifies if any potential clinically significant medication issues (based on assessing clinician's clinical judgement) have been identified at the time of or at any time since the SOC/ROC, AND if so...
- If they were addressed with the physician or physician-designee, with prescribed/recommended actions completed by midnight of the next calendar day from identification.

M2005 (TRF, DC, DEATH)

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

Enter Code	
☐	0 No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

Enter Response 1 – Yes if at or since the SOC/ROC:

- The two-way communication AND
- Completion of the prescribed/recommended actions OCCURRED
- By midnight of the next calendar day
- EACH time a potential clinically significant issue was identified.

Enter Response 0 – No if a potential clinically significant medication issue was identified at or since the SOC/ROC and any of the above actions were not completed as required

M2005 (TRF, DC, DEATH)

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?

Enter Code	
☐	0 No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

- If the last OASIS assessment completed was the SOC or ROC, AND
  - A clinically significant medication issue was identified at that SOC or ROC visit and resolved with physician involvement by midnight of the next calendar day (before the SOC/ROC assessment was completed and within the assessment timeframe), THEN
  - The issue (and/or related physician/physician-designee communication) would be reported at both the SOC/ROC (on M2003) and again at Transfer, Death or Discharge (on M2005)
    - Since the time frame under consideration for M2005 is at the time of or at any time since SOC/ROC.

M2005 (TRF, DC, DEATH)

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?	
Enter Code ☐	0 No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

A dash (–) value is a valid response for this item.

- Indicates that no information is available, and/or an item could not be assessed.
- Most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment could be completed.
- CMS expects the use of the dash to be a rare occurrence.

PRESSURE ULCERS – NEW IN C2

- In April 2016, NPUAP announced updated terminology for the staging system (pressure "ulcer" changed to pressure "injury", removed "suspected" from sDTI, etc.)
- In OASIS-C2, CMS uses terminology ***adapted*** from NPUAP Pressure Ulcer Staging guidelines, which do not perfectly align with new 2016 NPUAP terminology.
- When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&As, providers should rely on the CMS OASIS instructions to complete OASIS.
- **PRESSURE ULCER DEFINITION** - Localized injury to skin and/or underlying tissue usually over a bony prominence, as a result of pressure.

Everyone Agrees!

PRESSURE ULCERS – NEW IN C2

Standardization!

- Patient assessments should be completed as close to the actual time of the SOC/ROC as possible.
  - Do not change assessment for an ulcer that increases in numerical stage (worsens) within the assessment time period

  Once a **Stage 2, 3, or 4** pressure ulcer is completely covered with new epithelial tissue, it is considered **healed** and no longer reported as a pressure ulcer.

GRAFT PROCEDURES:

- **A pressure ulcer treated with a skin graft is a surgical wound until the graft edges completely heal**

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M1308 replaced by 1311

(M1308) Current Number of Unhealed Pressure Ulcers at Each Stage or Unstageable: (Enter "0" if none; Excludes Stage I pressure ulcers and healed Stage II pressure ulcers)

Stage Descriptions—unhealed pressure ulcers	Number Currently Present
a. Stage II: 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. Stage III: 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. Stage IV: 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.	____

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter #
A1. Stage 2: 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 blister.	☐
Number of Stage 2 pressure ulcers [If 0 at FU/DC Go to M1311B1]	☐
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	☐
Number of Stage 3 pressure ulcers [If 0 at FU/DC Go to M1311C1]	☐
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	☐
Number of Stage 4 pressure ulcers [If 0 at FU/DC Go to M1311D1]	☐
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device	☐
Number of unstageable pressure ulcers due to non-removable dressing/device [If 0 at FU/DC Go to M1311E1	☐
D2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar	☐
Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar [If 0 at FU/DC Go to M1311F1]	☐
E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution	☐
Number of unstageable pressure ulcers with suspected deep tissue injury in evolution [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)]	☐
F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	
[Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC]	

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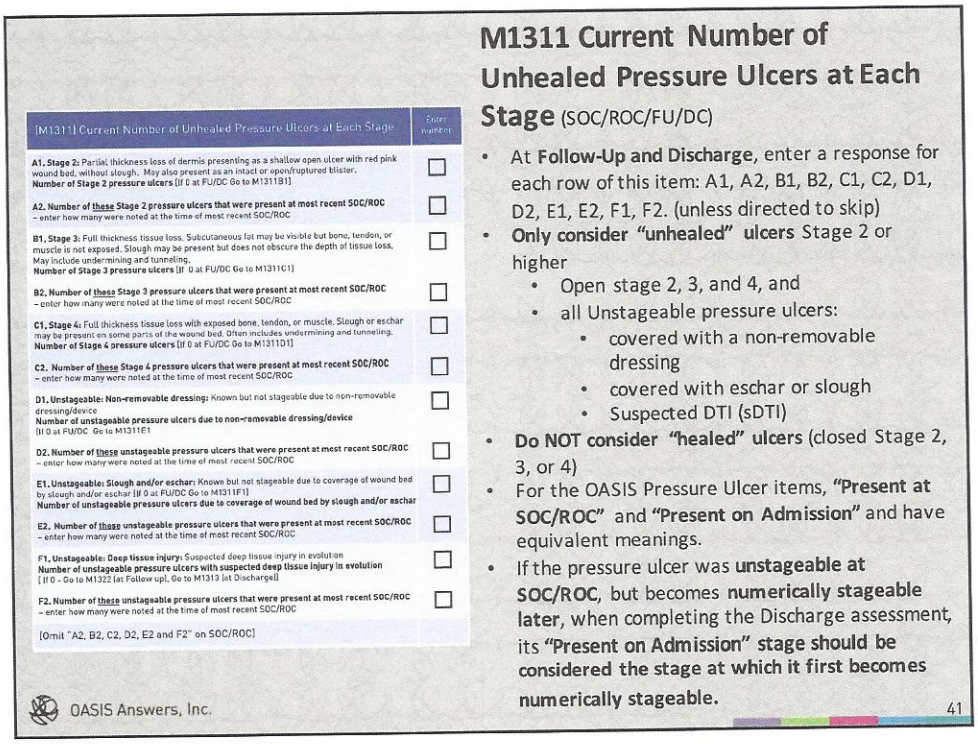

[M1311] Current Number of Unhealed Pressure Ulcers at Each Stage	Enter number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	☐
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	☐
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 at FU/DC Go to M1311D1]	☐
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 at FU/DC Go to M1311E1]	☐
D2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar [If 0 at FU/DC Go to M1311F1] **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)]	☐
F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
[Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC]	

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M1311 Current Number of Unhealed Pressure Ulcers at Each Stage (SOC/ROC/FU/DC)

- At **Follow-Up and Discharge**, enter a response for each row of this item: A1, A2, B1, B2, C1, C2, D1, D2, E1, E2, F1, F2. (unless directed to skip)
- **Only consider "unhealed" ulcers** Stage 2 or higher
  - Open stage 2, 3, and 4, and
  - all Unstageable pressure ulcers:
    - covered with a non-removable dressing
    - covered with eschar or slough
    - Suspected DTI (sDTI)
- **Do NOT consider "healed" ulcers** (closed Stage 2, 3, or 4)
- For the OASIS Pressure Ulcer items, **"Present at SOC/ROC"** and **"Present on Admission"** and have equivalent meanings.
- If the pressure ulcer was **unstageable at SOC/ROC**, but becomes **numerically stageable later**, when completing the Discharge assessment, its **"Present on Admission" stage should be considered the stage at which it first becomes numerically stageable.**

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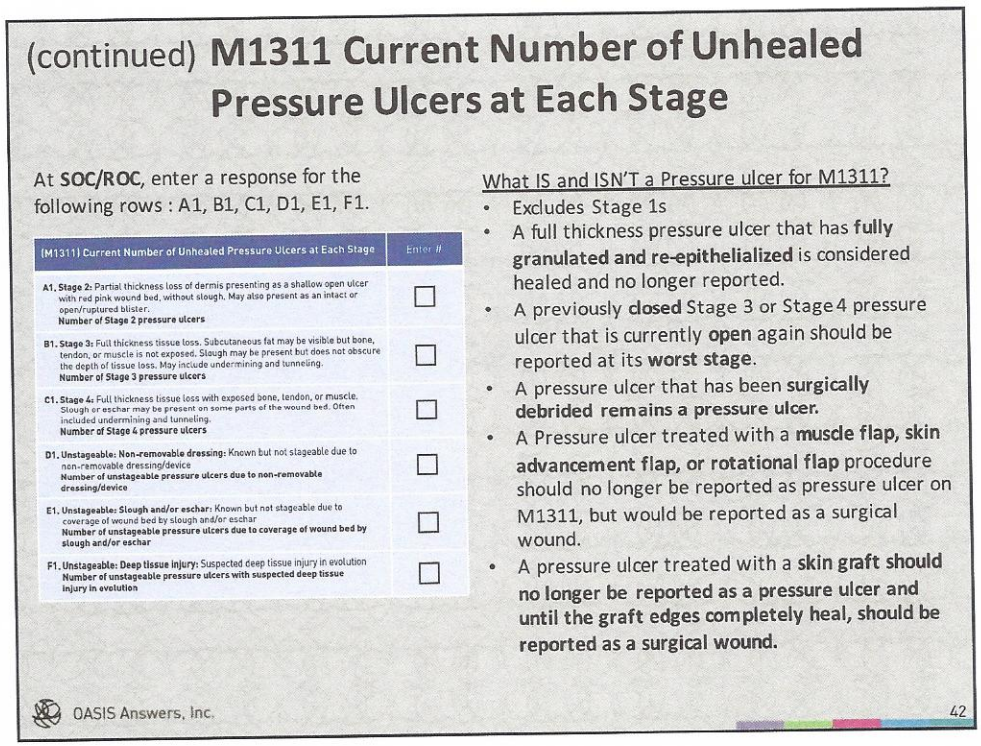

(continued) M1311 Current Number of Unhealed Pressure Ulcers at Each Stage

At **SOC/ROC**, enter a response for the following rows : A1, B1, C1, D1, E1, F1.

[M1311] Current Number of Unhealed Pressure Ulcers at Each Stage	Enter #
A1. Stage 2: 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 blister. **Number of Stage 2 pressure ulcers**	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers**	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often included undermining and tunneling. **Number of Stage 4 pressure ulcers**	☐
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device**	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**	☐

What IS and ISN'T a Pressure ulcer for M1311?

- Excludes Stage 1s
- A full thickness pressure ulcer that has **fully granulated and re-epithelialized** is considered healed and no longer reported.
- A previously **closed** Stage 3 or Stage 4 pressure ulcer that is currently **open** again should be reported at its **worst stage**.
- A pressure ulcer that has been **surgically debrided remains a pressure ulcer.**
- A Pressure ulcer treated with a **muscle flap, skin advancement flap, or rotational flap** procedure should no longer be reported as pressure ulcer on M1311, but would be reported as a surgical wound.
- A pressure ulcer treated with a **skin graft should no longer be reported as a pressure ulcer and until the graft edges completely heal, should be reported as a surgical wound.**

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CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE - M1311 (SOC, ROC, FU, DC)

All Time Points

- Identifies the pressure ulcers present at the time of the comprehensive assessment and

Just at FU & DC

- Whether the pressure ulcer present today was present **at the same stage** at the time of the most recent SOC/ROC

[M1311] Current Number of Unhealed Pressure Ulcers at Each Stage	Enter number
A1. Stage 2: 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 blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	☐
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	☐
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 at FU/DC Go to M1311D1]	☐
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 at FU/DC Go to M1311E1]	☐
D2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar [If 0 at FU/DC Go to M1311F1] **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 – Go to M1322 (at Follow up), Go to M1313 (at Discharge)]	☐
F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
[Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC]	

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CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE - M1311 (SOC, ROC, FU, DC)

(M1311)Current Number of Unhealed Pressure Ulcers at EachStage	Enter Number

Includes: All Unhealed Stage 2, 3, 4 and Unstageable pressure ulcers

Unstageable pressure ulcer defined:

- Known but covered with non-removable dressing/device
- Full thickness tissue loss in which slough/eschar obscures true wound depth
- Suspected deep tissue injury in evolution

Excludes: Stage 1 and Healed Stage 2, 3, 4 pressure ulcers.

Pressure ulcers should be assessed as close to the admission (SOC/ROC) as possible.

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CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE - M1311 (SOC, ROC, FU, DC)

At SOC

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. **Stage 2:** 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 blister. **Number of Stage 2 pressure ulcers**	☐
B1. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers**	☐
C1. **Stage 4:** Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers**	☐
D1. **Unstageable: Non-removable dressing:** Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device**	☐
E1. **Unstageable: Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
F1. **Unstageable: Deep tissue injury:** Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**	☐

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE - M1311 ("PRESENT ON ADMISSION")

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. **Stage 2:** 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 blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	☐
A2. **Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐

"Present at SOC/ROC" = "Present on Admission"

All Time Points

<u>Row A1.</u> Determine whether an unhealed pressure ulcer is present at the time of the assessment

Just at FU & DC

<u>Row A2</u>. Report the number of current **unhealed** pressure ulcer(s) reported in Row A1 that were "present at the most recent SOC/ROC" <u>at the same stage</u>.

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE - M1311 ("PRESENT ON ADMISSION")

At SOC/ROC, enter a response for the first rows of each section (Row A1, B1, C1, D1, E1, F1)

Row A2, B2, C2, D2, E2, F2 – Are not collected at the SOC/ROC time point

Example: At SOC, your patient has one stage 3 pressure ulcer on his elbow and no other pressure ulcers.

At SOC

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: 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 blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	0
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	1

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE - M1311 ("PRESENT ON ADMISSION")

At Follow-Up and Discharge, enter a response in each row for each section. (Rows: A1, A2, B1, B2, C1, C2, D1, D2, E1, E2, F1, F2.)

If a "0" in Row A (no pressure ulcers at that stage currently), then leave Row B blank (skip)

Example: At Discharge, Your patient has one Stage 3 pressure ulcer on his hip. It is smaller since the SOC when it was also identified as a Stage 3 pressure ulcer. He has no other pressure ulcers.

At DC

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: 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 blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	0
A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	blank
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	1
B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	1

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE - M1311 ("PRESENT ON ADMISSION")

If the pressure ulcer was unstageable at SOC/ROC, but becomes numerically stageable later, its "**Present on Admission**" stage should be considered the stage at which it first becomes numerically stageable.

Example: At **SOC**, Your patient had a pressure ulcer completely covered with eschar. Two weeks later, it was debrided and assessed to be a Stage 3 pressure ulcer. It remained observable as a Stage 3 pressure ulcer until discharge.

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: 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 blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	0
A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	blank
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	1
B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	1

At DC

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE - M1311 ("PRESENT ON ADMISSION")

If a pressure ulcer that is identified on the SOC date increases in numerical stage (worsens) within the **assessment time frame**,

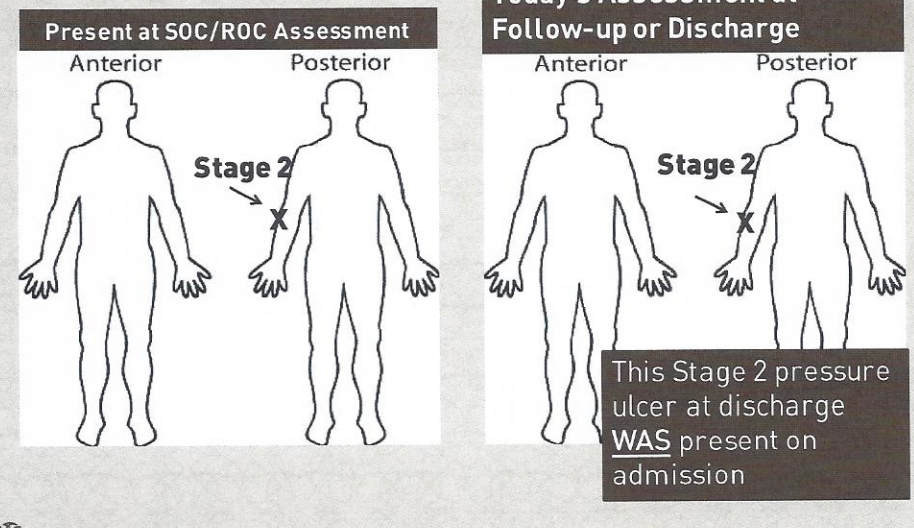
Report the initial stage of the pressure ulcer at the SOC.

Example: On the Monday **SOC** visit, Your patient is observed to have a stage 2 pressure ulcer on his R buttock. You visit again on Wednesday and observe the pressure ulcer has worsened and is a now a full thickness Stage 3. You have not completed your SOC assessment. The patient has no other pressure ulcers.

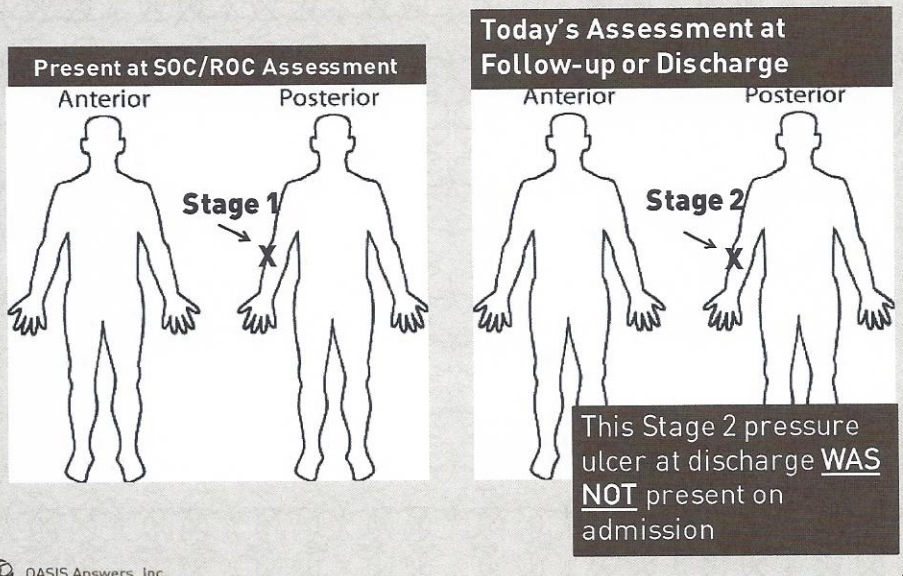
(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	1
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	0

At SOC

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE - M1311 ("PRESENT ON ADMISSION")



CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE - M1311 ("PRESENT ON ADMISSION")



M1309 replaced by M1313

(M1309) Worsening in Pressure Ulcer Status since SOC/ROC:	
Instructions for a – c: For Stage II, III and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC	
	Enter Number (Enter "0" if there are no current Stage II, III or IV pressure ulcers OR if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)
a. Stage II	____
b. Stage III	____
c. Stage IV	____
Instructions for d: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were a Stage I or II at the most recent SOC/ROC.	
	Enter Number (Enter "0" if there are no Unstageable pressure ulcers at discharge OR if all current Unstageable pressure ulcers were Stage III or IV or were Unstageable at most recent SOC/ROC)
d. Unstageable due to coverage of wound bed by slough or eschar	____

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:	
Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.	
	Enter Number
a. Stage 2	☐
b. Stage 3	☐
c. Stage 4	☐
Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.	
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	☐
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	☐
f. Unstageable – Suspected deep tissue injury in evolution.	☐

M1313 WORSENING IN PRESSURE ULCER STATUS SINCE SOC/ROC (DC)

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:	
Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.	
	Enter Number
a. Stage 2	☐
b. Stage 3	☐
c. Stage 4	☐
Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.	
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	☐
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	☐
f. Unstageable – Suspected deep tissue injury in evolution.	☐

M1313 WORSENING IN PRESSURE ULCER STATUS SINCE SOC/ROC (DC)

- Report the number of pressure ulcers present at Discharge that **were not present** (are new) or have **"worsened"** (increased in numerical stage) since the most recent SOC/ROC.
- Worsening means the pressure ulcer increased in numerical stage.
- If the pressure ulcer was **unstageable at SOC/ROC**, but becomes numerically stageable later, its "**Present on Admission**" stage should be considered the stage at which it first becomes numerically stageable.

M1313 WORSENING IN PRESSURE ULCER STATUS SINCE SOC/ROC (DC)

- If the pressure ulcer was **unstageable for any reason at the most recent SOC/ROC**, do not consider it new or worsened **if at some point between SOC/ROC and Discharge it became stageable and remained at that same stage at Discharge.**
- If the pressure ulcer was unstageable at SOC/ROC, then was stageable on a routine visit and/or Follow-Up assessment, and by Discharge the pressure ulcer had increased in numerical stage since the routine visit and/or Follow-Up assessment, is should be considered worsened at Discharge.

M1313 WORSENING IN PRESSURE ULCER STATUS SINCE SOC/ROC (DC)

- If a previously stageable pressure ulcer becomes unstageable, then was debrided sufficiently to be restaged by Discharge, **compare its stage before and after it was deemed unstageable.** If the pressure ulcer's stage has increased in numerical staging, it has worsened.
- Pressure ulcers that are Unstageable at Discharge due to a dressing/device, such as a cast that cannot be removed to assess the skin underneath cannot be reported as new or worsened unless no pressure ulcer existed at that site at the most recent SOC/ROC.

REPORTING ALGORITHM – M1313

OASIS ITEM
Reporting algorithm for M1313

CURRENT STAGE at Discharge	Look back to most recent SOC/ROC	PRIOR STAGE at most recent SOC/ROC		REPORT AS NEW OR WORSENED?
a. Stage 2 at Discharge	If same pressure ulcer at most recent SOC/ROC was:	• Not present • Stage 1 • Covered with a non-removable dressing/device, then documented as a Stage 1 at any home visit or Follow-Up assessment(s)	⇨	YES
		• Stage 2		NO
		• Stage 3 • Stage 4		NA (Stage 3 or 4 could not become a Stage 2)
		• Covered with a non-removable dressing/device and remains Unstageable until assessed as a Stage 2 at Discharge		NO
b. Stage 3 at Discharge	If same pressure ulcer at most recent SOC/ROC was:	• Not present • Stage 1 • Stage 2 • Unstageable with documented Stage 1 and/or 2 at any home visit or Follow-Up assessment(s)	⇨	YES
		• Stage 3		NO
		• Stage 4		NA (Stage 4 could not become a Stage 3)
		• Unstageable until assessed as a Stage 3 at Discharge		NO
c. Stage 4 at Discharge	If same pressure ulcer at most recent SOC/ROC was:	• Not present • Stage 1 • Stage 2 • Stage 3 • Unstageable with documented Stage 1, 2, and/or 3 at any home visit or Follow-Up assessment(s)	⇨	YES
		• Stage 4 • Unstageable until assessed as a Stage 4 at Discharge		NO
d. Unstageable due to non-removable dressing at Discharge	If same pressure ulcer at most recent SOC/ROC was:	• Not present	⇨	YES
		• Stage 1 • Stage 2 • Stage 3 • Stage 4 • Unstageable		NO

Helpful resource from Ch. 3

UPDATED FOR C2!

CURRENT STAGE at Discharge	Look back to most recent SOC/ROC	PRIOR STAGE at most recent SOC/ROC		REPORT AS NEW OR WORSENED?
e. Unstageable due to slough and/or eschar at Discharge	If same pressure ulcer at most recent SOC/ROC was:	• Not present • Stage 1 • Stage 2	⇨	YES
		• Stage 3 • Stage 4 • Unstageable		NO
f. Unstageable – suspected deep tissue injury at Discharge	If same pressure ulcer at most recent SOC/ROC was:	• Not present • Stage 1 • Stage 2	⇨	YES
		• Stage 3 • Stage 4 • Unstageable due to slough and/or eschar		NA (Full thickness pressure ulcer could not become a sDTI)
		• Unstageable – suspected DTI or due to a non-removable dressing/device		NO

DASH (–) RESPONSE

Standardization!

The following C2 items allow the use of a dash:

- GG0170C – Lying to sitting on side of bed
- M1028 Active Diagnoses
- M1060 Height and Weight
- M1313 Worsening in Pressure Ulcer Status
- M2001 Drug Regimen Review
- M2003 Medication Follow-up
- M2005 Medication Intervention

A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. CMS expects dash use to be a rare occurrence.

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?		
Enter Code [–]	0 No - No issues found during review 1 Yes - Issues found during review 9 NA - Patient is not taking any medications	*[Go to M2010]* *[Go to M2040]*

OASISanswers™

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