Oklahoma State Department of Health

OASIS News You Can Use

Coding M1910

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Oklahoma State Department of Health

Quality Improvement & Evaluation Service

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It may surprise you to know that seniors who died from falls and fall-related injuries *almost doubled* from 2000-2013 according to a report from the National Vital Statistics System released in 2015. Falls are the leading cause of all types of injuries for elder Americans.

Not only do they cause injury, but falls threaten a senior's independence and bring about enormous financial and personal cost. An increasing number of older adults are afraid of falling and, as a result, limit their outings and social activities. This inactivity can result in further physical decline, social isolation, and feeling helpless.

Being a provider invited into a persons home, you have an invaluable and unique opportunity among the patient's health care providers to assess that individual's true fall risk.

Interestingly, CMS does not mandate that a particular fall risk assessment be used or even that the fall risk assessment be completed. Notice how M1910 is worded, "Has the patient had a multi-factor Fall Risk Assessment using a standardized validated assessment tool?"

While doing a fall risk assessment is not mandated, CMS looks closely at M1910 as evidence of whether an agency uses best practices. In fact, the coding of M1910 is one of the publicly reported process based measures. It is reported on the Home Health Compare website and it is used to help determine your agency's 5 Star Quality Rating.

There are specific requirements that the multi-factor falls risk assessment must include: 1) at least one standardized, validated tool that has been tested on similar patients, such as community-dwelling elders, and shown to be effective in identifying people at risk for falls; and 2) includes a standard response scale. An agency may use a single test or a combination of tests to meet the criteria. (Continued on Page 2)

(M1910) Has this patient had a multi-factor **Falls Risk Assessment** using a standardized, validated assessment tool?	
Enter Code ☐	0 No. 1 Yes, and it does not indicate a risk for falls. 2 Yes, and it does indicate a risk for falls.

M1910 (continued)

Let' s take a closer look: In order to be able to accurately code that a fall risk assessment has been completed, the fall risk assessment must have been completed by the home health agency during the specified time frames for completion of the comprehensive assessment and must have been completed by the single clinician responsible for completing the comprehensive assessment.

Correctly administering a fall risk assessment will assist home health agencies identify patients at increased risk of falls and implement measures that may reduce falls in the patient's home.

Despite best efforts, some patients may still experience a fall. If this occurs, it is important for clinicians to be trained on identifying the root cause of the fall.

For example, the Post-Fall Assessment below includes critical information that will help identify the location and time of the fall, as well as what the patient was doing immediately before the fall occurred. This information will assist the clinician in determining if the patient was attempting to go to the bathroom in the middle of the night, was rushing due to incontinence, and did not have adequate lighting, so they tripped over the bedframe; or, if the fall occurred in the kitchen where a loose rug or the pets food bowl contributed to the fall. By knowing this information, the clinician can implement further safety measures and teaching to help prevent future falls.

LiveOakMed.com. "Fall-Related Deaths Nearly Doubled for U.S. Seniors Since 2000." *LiveOakMed.com*. N.p., n.d. Web. 19 May 2017.

"Fall Risk Assessments in Home Care: OASIS-C Expectations." *Fall Risk Assessments in Home Care: OASIS-C Expectations Home Health Care Management & Practice - Wendy K. Anemaet, Linda H. Krulish, 2011*. N.p., n.d. Web. 19 May2017

"Falls Prevention Facts." *NCOA*. N.p., 15 Feb. 2017. Web. 19 May 2017.
OASIS-C2 Guidance Manual, 01/01/2017
HHQI-Home Health Quality Improvement ;http://www.homehealthquality.org/Education/Best-Practices.aspx

Posted on HHQI

Post Fall Assessment

Date and Time of fall: ______________________________

Location of fall: ____

Who was present when patient fell? ____________________________________

Prior to this fall, when was the last time the patient fell? ______________________

How often has the patient fallen in the past? ______________________________

Patient comments of symptoms surrounding this fall (examples: did patient report he / she was dizzy, faint, blackout, normal, pain, etc.): _______________
____

Contributing circumstances of fall (examples: wet floor, throw rug, pet, equipment not locked, etc.):
____

Was medical attention required? If so, what type and when?____

When was the most recent home visit prior to the fall?______________________

OASIS Q & A

M1910:

Question: If during the comprehensive assessment, I complete the MAHC-10 (reported by MAHC to be validated on 10/9/12) and a TUG test; one indicates the patient is at risk for falls and one does not, what is the appropriate response to M1910?

Answer: The response to M1910 should be based on whether a tool that meets the best practice criteria (validated, standardized, multifactor) was used to assess the patient. If more than one validated, standardized, multifactor tool was used and the findings differed, the clinician should err on the side of safety and report that the tool identified the patient as "at risk" for falls.

In your example, two validated tools were used to assess fall risk, a single factor assessment tool and a multi-factor assessment tool. In this case, the M1910 response is based on the multi-factor tool's risk finding.

If the agency combines a single factor, validated assessment tool with another factor or non-validated tool in order to meet the CMS requirement of a multi-factor assessment, M1910 should be Response 1 or Response 2, depending on whether or not risk was identified by the validated assessment tool.

If NO validated, standardized, multifactor assessment tool were positive, (e.g., the MAHC-10 indicates the patient is NOT at fall risk, but some other factor (patient history, a mobility assessment tool, clinical observation, etc.) indicates the patient is AT risk, M1910 should be Response 1 indicating no risk, but the clinician should document any concerns in the clinical record and use their judgment about the need for falls interventions. Care planning decisions to reduce fall risks should be based on clinical judgment.

(CMS Quarterly Q&As – January 2013)

Question: CMS OASIS Q&A 159.6 states that if the patient is not able to participate in tasks required to allow the completion and scoring of the assessment, then "0" is the correct response. Does this mean that, using the TUG for example, if the patient is not able to get up from the chair AND walk AND return to the chair AND sit, then all of the tasks were not completed and a response of "0" is appropriate? What if, after 14 seconds, the patient is just standing and beginning to walk; is it appropriate to consider them a fall risk since they were in process of trying to complete the TUG and not require them to finish the assessment since they've already surpassed the 14-second fall-risk threshold, and answer M1910 with "2"? Or, does the patient need to complete all tasks of the assessment in order for us to choose either "1" or "2" as a response?

Answer: The patient would have to be able to complete enough of the tasks in the standardized assessment in order to generate a risk factor finding. The risk factor finding is based on the scoring protocols of the assessment utilized, and depending on the assessment tool used, this may or may not require them to complete all the tasks. It is up to the individual provider/agency to determine which tool (s) will be used, and what the valid administration and scoring protocols are for each tool considered.

(CMS Quarterly Q&As – July 2012)

<u>**MARK YOUR CALENDAR**</u>

Compliance & Clinical Training:
7-20-2017

Quality Initiatives & Regulatory Compliance:
7-21-2017

Both trainings are at:
Eastern OK County Technology Center Choctaw, OK

Register by June 26, 2017

Sign up for OASIS trainings using our QR Code.

New CASPER Report

The HHA Review and Correct Report allows home health agencies to review their quality measure (QM) data to identify if there are any corrections or changes necessary prior to the quarter's data submission deadline, which is 4.5 months after the end of the quarter.

Correction periods for each quarter end as follows:

Q1 (1/1-3/31) – August 15

Q2 (4/1-6/30) – November 15

Q3 (7/1-9/30) – February 15

Q4 (10/1-12/31) – May 15

The HHA Review and Correct Report provides a breakdown, by measure and by quarter, of the agency's QM data for four rolling quarters. The report also identifies the open/closed status of each quarter's data correction period as of the report run date.

NOTE: Quality Measure calculations are performed weekly and on the first day of each quarter.

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New CoPs

The Centers for Medicare & Medicaid Services (CMS) released a final rule (CMS-3819-F) that modernizes the Home Health Agency Conditions of Participation (CoPs). The final rule, effective July 13, 2017, will improve the quality of health care services for all home health patients and strengthen patients' rights. The regulation reflects the most current home health agency practices by focusing on the care provided to patients and the impact of that care on patient outcomes.

Source: CMS.gov Home Health Final Rule 3819-F

<u>Automation Tips</u>

Reminder: Effective April 3, 2017, claims will be denied if the OASIS assessment has not been received and accepted by the CMS federal database.

Effective June 26, 2017 passwords to CASPER need to be refreshed every 60 days and will be deleted after 365 days of no activity.

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