Outcome and Assessment Information Set

OASIS-D

Guidance Manual

Effective January 1, 2019

Centers for Medicare & Medicaid Services

PRA Disclosure Statement

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CHAPTER 1   OASIS GUIDANCE MANUAL INTRODUCTION

PREFACE

This manual provides guidance for home health agencies (HHAs) on how to ensure the collection of high-quality (accurate) OASIS data. It includes both general data collection conventions and item-specific guidance, as well as links to resources for agencies.

Since OASIS collection was implemented in 1999, national interest in the area of home health care quality measurement and improvement has been ongoing. CMS received hundreds of comments about OASIS from a variety of sources: providers, professional organizations (e.g., American Nurses Association and the American Physical Therapy Association), home care provider organizations, accrediting organizations, researchers, etc. In addition, individuals and groups with expertise in health care quality measurement, such as the Medicare Payment Advisory Commission (MedPAC), the National Quality Forum (NQF), and many technical expert panels commissioned by CMS to guide OASIS evolution have offered suggestions for improving OASIS and expanding the domains of home health quality measurement to address the six aims (safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness) articulated by the Institute of Medicine in their 2001 report "Crossing the Quality Chasm."

Input from the NQF, a nonprofit organization that endorses national consensus standards for measuring and publicly reporting on performance has been especially valuable in guiding the evolution of OASIS and associated performance reports. NQF-endorsed voluntary consensus standards are widely viewed as the gold standard for measurement of health care quality. NQF has endorsed a number of OASIS-based quality measures for public reporting. Endorsed measures are periodically reviewed for continuing endorsement, and, as measure development continues, new or revised measures are submitted to NQF for review.

INTRODUCTION

The Outcome and Assessment Information Set (OASIS) is a group of standard data elements developed, tested, and refined over the course of two decades through a research and demonstration program funded primarily by the Centers for Medicare & Medicaid Services (CMS), with additional funding from the Robert Wood Johnson Foundation and the New York State Department of Health. OASIS data elements were designed to enable systematic comparative measurement of home health care patient outcomes at two points in time.

OASIS-based quality measures can be used for quality improvement efforts that home health agencies (HHAs) can employ to assess and improve the quality of care they provide to patients. CMS provides HHAs with numerous quality measure reports including outcome, process, potentially avoidable event, patient-related characteristic, and patient tally reports. Reports are provided for up to two time intervals selected by the HHA requesting the reports. Process quality measures include indicators of how often the HHA follows best practices to improve patient outcomes. Outcome measures include end-result functional and physical health improvement/stabilization, health care utilization measures, and potentially avoidable events. Potentially avoidable events are negative outcomes that clinical evidence indicates can be influenced (although not necessarily totally avoided) by following best practices in providing care. In addition to quality measurement, certain OASIS data elements are used to adjust per-episode payment rates for patient conditions that affect care needs.

REVISION HISTORY

1. OASIS C Guidance Manual Original Publication: September 2009

2. Revision 1: December 2009

3. Revision 2: January 2011

4. Revision 3: January 2012

5.   Revision 4: December 2012

6.   OASIS-C1/ICD-9 Guidance Manual: June 2014

Note: Past revisions of the guidance manual have included an "errata" document that indicated where changes had occurred so that HHAs could replace only those manual pages that had changed. Because this revision is substantially more extensive than previous updates, this manual was intended to replace in its entirety the OASIS-C Guidance Manual and as such, changes to specific sections or pages were not tracked. However, there was a table included at the beginning of Chapter 3 that indicated which OASIS items and which item-by-item guidance sections had been revised.

7.   OASIS-C1/ICD-9 Guidance Manual: January 2015

Changes in this version included a new Chapter 2, in which the "draft" notation was removed from the OASIS forms and the OMB number was added to each time point version. The footer date throughout the entire manual was changed to January 2015.

8.   OASIS-C1/ICD-10 Guidance Manual: October 2015

This version of the manual included changes required to incorporate the newly-implemented ICD-10-CM codes into both the guidance manual and the corresponding OASIS-C1 data set items. The footer was changed in all chapters, including those that did not have changes related to the implementation of ICD-10-CM.

9.   OASIS-C2 Guidance Manual: Effective January 1, 2017

This version of the manual replaces the previous version in its entirety. This version includes changes required for standardization with other post-acute care data sets. Three new standardized items and guidance, and five revised items and guidance are included in this version. Other changes include guidance for a revised look-back period for five items, and clarifications in response to questions submitted to the OASIS Help Desk.

10. OASIS-C2 Guidance Manual: Effective January 1, 2018

This version of the manual replaces the previous version in its entirety. This version includes corrections and updates, including but not limited to errors listed in the September OASIS-C2 Guidance Manual Errata, and new guidance made available in October 2016 and February 2017 CMS National Provider Training Q&A documents.

11. OASIS D Guidance Manual: Effective January 1, 2019

This version of the manual introduces new and modified items. Some are standardized patient assessment data elements (SPADEs), added to meet the requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). Standardized guidance for the new items is included. The manual also includes revisions to correct, update or clarify guidance. (See Appendix G for a summary of changes from OASIS-C2 to OASIS-D).

MANUAL OVERVIEW

Chapter 1   –   The Introduction, which provides contextual information and other general information relevant to OASIS data collection.

Chapter 2   –   Includes versions of the OASIS data set for each data collection time point.

Chapter 3   –   Contains item-specific guidance, subdivided into sections.

Chapter 4   –   Illustrative Examples are retired. Page intentionally left blank.

Chapter 5   –   Includes relevant resources for HHAs, with hyperlinks when available.

Appendices   –   Include additional contextual information, including sections on OASIS and the comprehensive assessment, home health care regulations related to OASIS data collection, and recommendations for ensuring accuracy of OASIS data.

WHY IS OASIS BEING REVISED NOW?

- HHAs began collecting and transmitting OASIS data for adult skilled Medicare and Medicaid patients (with the exception of maternity patients) in 1999. Since 1999, numerous changes have occurred within the health care system, including specific recommendations for changes in the area of home health care quality measurement.

- Currently the main reason for revising OASIS is to increase standardization across post-acute care (PAC) settings to enable calculation of standardized, cross-setting QMs, pursuant to the provisions of the IMPACT Act. Standardized patient assessment data elements (SPADEs) are questions and response options that are identical in all four PAC assessment instruments, and to which identical standards and definitions apply.

WHAT'S NEW WITH THE OASIS-D ASSESSMENT INSTRUMENT?

- New items are added
- Different time point versions of some items
- Removal of items
- Revision of some items
- Updated Skip Patterns

WHAT'S NEW WITH THE OASIS-D GUIDANCE?

- Chapter 3, two new sections of standard guidance added:
  - Section J – Health Conditions
  - Section GG – Functional Abilities and Goals
- Chapter 4, Illustrative Examples are retired
- Removal of many items and their corresponding guidance
- Revisions to existing Guidance for some OASIS items to update or clarify information

- Appendix F - sample reports are not included in this version. Users may refer to the Casper Reporting User Manual, Section 6, OASIS Quality Improvement Reports, located at: https://qtso.cms.gov/hhatrain.html

COLLECTING OASIS DATA

This section will provide a basic overview for collecting OASIS data. For more detail on clinical strategies for collecting OASIS data as part of a comprehensive assessment, refer to Chapter 3 of this manual.

ELIGIBLE PATIENTS

OASIS data are collected for Medicare and Medicaid patients, 18 years and older, receiving skilled services, with the exception of patients receiving services for pre- or postnatal conditions. Those receiving only personal care, homemaker, or chore services are excluded since these are not considered skilled services.

TIME POINTS

OASIS data are collected at the following time points:

- Start of care
- Resumption of care following inpatient facility stay
- Recertification within the last five days of each 60-day recertification period
- Other follow-up during the home health episode of care
- Transfer to an inpatient facility
- Death at home
- Discharge from agency

All of these assessments, with the exception of transfer to inpatient facility and death at home, require the clinician to have an in-person encounter with the patient during a home visit. The transfer to an inpatient facility requires collection of limited OASIS data (most of which may be obtained through a telephone call). Not all OASIS items are completed at every assessment time point. Some items are completed only at start of care, some only at discharge. The table of "Items to be Used at Specific Time Points" included at the beginning of the OASIS data set allows the home health agency (or its selected medical record vendor) to integrate the necessary OASIS items at each time point into clinical documentation forms or an electronic health record.

At the start of care time point, the comprehensive assessment should be completed within five days after the start of care date.

At the resumption of care, the comprehensive assessment must be completed within 48 hours of return home after inpatient facility discharge, or within 48 hours of knowledge of a qualifying stay in an inpatient facility. A physician-ordered resumption of care (ROC) must be conducted on or within 2 calendar days of the physician-ordered ROC date.

For the transfer to inpatient facility, discharge from home care, death at home, and other follow-up, the assessments must be completed on, or within 48 hours of becoming aware of the significant change in condition, transfer, discharge, or death date.

WHO COMPLETES OASIS?

As identified in (M0080) Discipline of Person Completing Assessment, the comprehensive assessment and OASIS data collection are the responsibility of a registered nurse (RN) or any of the therapies, including physical therapist (PT), speech language pathologist/speech therapist (SLP/ST), or occupational therapist (OT). A licensed practical nurse or licensed vocational nurse (LPN/LVN), physical therapy assistant (PTA), occupational therapy assistant (OTA), medical social worker (MSW), or Aide may not be responsible for completing OASIS assessments.

In cases involving nursing, the RN is responsible for completing the comprehensive assessment document at the SOC, and may elicit input from the patient, caregivers, and other health care personnel, including the physician, the pharmacist and/or other agency staff to assist in completion of any or all OASIS items. Any discipline qualified to perform assessments – RN, PT, SLP, OT – may complete subsequent assessments. For a therapy-only case, the therapist usually conducts the comprehensive assessment. It is acceptable for a PT or SLP to conduct and complete the comprehensive assessment at SOC for a Medicare patient.

An OT may conduct and complete the assessment when the need for occupational therapy establishes program eligibility. Note: Occupational therapy alone does not establish eligibility for the Medicare home health benefit at the start of care; however, occupational therapy may establish eligibility under other programs, such as Medicaid. The Medicare home health patient who is receiving services from multiple disciplines (for example, skilled nursing, physical therapy, and occupational therapy) during the episode of care, can retain eligibility if, over time, occupational therapy is the only remaining skilled discipline providing care. At that time, an OT can conduct OASIS assessments.

Multidisciplinary cases may have multiple points of discipline-specific discharge, though there is only one HHA discharge, which must include completion of the OASIS discharge comprehensive assessment. Other non-OASIS required documentation for recertification and discharge are specified in the Condition of Participation:

Comprehensive Assessment of Patients.[1] OASIS items were designed to be discipline-neutral and have been tested and validated with clinicians from various disciplines.

COMPREHENSIVE ASSESSMENT AND PLAN OF CARE

OASIS data are collected as part of the comprehensive assessment required by the Medicare Conditions of Participation (see Appendix A of this manual). OASIS is not intended to represent a comprehensive assessment in and of itself. HHAs are expected to incorporate OASIS items into their comprehensive assessment documentation and follow their own assessment policies and procedures. Agencies are free to rearrange OASIS item sequence in a way that permits logical ordering within their own forms, as long as the actual item content, skip patterns, and OASIS number remain the same. Like other comprehensive assessment documentation, OASIS data are collected using a variety of strategies, including observation, interview, review of pertinent documentation when allowed (for example, hospital discharge summaries), discussions with other healthcare providers where relevant (for example, phone calls to the physician to verify diagnoses), and measurement (for example, intensity of pain). Although one clinician must take responsibility for the comprehensive assessment, collaboration with the patient, caregivers, and other health care personnel, including the physician, pharmacist, and/or other agency staff is appropriate. For items requiring patient assessment, the collaborating healthcare providers must have had direct contact with the patient. OASIS data should be collected at each time point based on a unique patient assessment, not simply carried over from a previous assessment. Comprehensive assessment data form the basis of the physician-ordered Plan of Care. Thus, there should be congruence between documentation of findings from the comprehensive assessment and the Plan of Care.

Agencies may have the comprehensive assessment completed by one clinician. If collaboration with other health care personnel and/or agency staff is utilized, the agency is responsible for establishing policies and practices related to collaborative efforts, including how assessment information from multiple clinicians will be documented within the clinical record, ensuring compliance with applicable requirements, and accepted standards of practice.

PROCESS OF CARE DATA ITEMS

Process of care data items (process items) document whether certain evidence-based practices were implemented. Process items collected at SOC/ROC document assessment such as whether the patient was assessed to be at risk for certain conditions like falls. These items refer to assessments that were completed within the five-day SOC period or the two-day ROC period.

Process items collected at transfer and discharge time points include documentation of interventions implemented as part of patient care at the time of or since the most recent start of care or resumption of care. Specific instructions about review periods are included in item guidance for the relevant OASIS items.

Process items collected at transfer and discharge may require a clinician to review documentation of care provided during the home health episode in order to accurately complete the items. Note that this review must consider care provided by all disciplines, and is not limited to care provided by the discipline of the clinician completing the OASIS assessment. The review can be accomplished in several different ways. The care provider may find it necessary to review clinical records, including the Plan of Care, updated orders, and visit notes. Alternatively, the agency may elect to create a flowsheet with the appropriate parameters that are checked off on each visit. Review of the flowsheet may provide the needed information, such that a review of the clinical record would be unnecessary. Another strategy for agencies using electronic health records is to create a report template that could pull the needed information from data fields incorporated into visit notes. Regardless of the technique that an agency chooses, the process data items completed at transfer and discharge will require knowledge of patient symptoms, initial and subsequent physician's orders, and clinical interventions performed to address patient symptoms that were present at the time of or since the most recent SOC/ROC assessment.

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[1]   http://www.ecfr.gov/cgi-
bin/retrieveECFR?gp=&SID=1c743ade23ae8533ee0732689c166e31&r=PART&n=42y5.0.1.1.3#se42.5.484 155

CONVENTIONS FOR COMPLETING OASIS

Listed below are conventions, or general rules, that should be observed when completing OASIS. Item-specific guidance is provided in Chapter 3. The OASIS Guidance is updated periodically to provide additional clarification based on "Frequently Asked Questions" sent to CMS. (A link to Frequently Asked Questions is provided in Chapter 5). It is not possible to address all of the situations that arise, due to the rare and unique nature of some of the questions, and exceptions that may be encountered in clinical practice.

Each patient scenario, clinical status, social and environmental situation is unique, requiring professional/clinical judgment and care coordination. In the event you cannot resolve your understanding of the OASIS questions, CMS will continue to provide avenues to accept and respond to questions.

GENERAL OASIS ITEM CONVENTIONS

1. Understand the time period under consideration for each item. Report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance. Day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home.

2. For OASIS purposes, a quality episode must have a beginning (that is, an SOC or ROC assessment) and a conclusion (that is, a Transfer, Discharge, Death at Home assessment) to be considered a complete quality episode.

3. If the patient's ability or status varies on the day of the assessment, report the patient's "usual status" or what is true greater than 50% of the assessment time frame, unless the item specifies differently.

4. Minimize the use of NA and Unknown responses.

5. Some items allow a dash response. A dash (–) value indicates that no information is available. CMS expects dash use to be a rare occurrence.

6. Responses to items documenting a patient's current status should be based on observation of the patient's condition and ability at the time of the assessment without referring back to prior assessments or documentation of status from a prior care setting. Several process items require review of documentation of care that occurred at the time of or at any time since the most recent SOC or ROC OASIS assessment. These instructions are included in item guidance for the relevant OASIS items.

7. Combine observation, interview, collaboration with other agency staff and other relevant strategies to complete any and all OASIS items as needed, unless otherwise noted in guidance. For example, it is acceptable to review the hospital discharge summary for information on a patient's episodes of confusion, or to interview the caregiver regarding the patient's incontinence. However, when assessing physiologic or functional health status, direct observation is the preferred strategy.

8. When an OASIS item refers to assistance, this means assistance from another person. Assistance is not limited to physical contact and can include necessary verbal cues and/or supervision.

9. Complete OASIS items accurately and comprehensively, and adhere to skip patterns.

10. Understand the definitions of words as used in the OASIS.

11. Follow rules included in the Item Specific Guidance (Chapter 3 of this manual).

12. Stay current with evolving CMS OASIS guidance via updates to the guidance manual and posted Q&A documents.

13. The comprehensive assessment includes the OASIS items and is part of the patient's legal home health agency clinical record. While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, s/he may collaborate to collect data for all OASIS items, if agency policy allows. Collaboration may consider information from others such as the patient, caregivers, and other health care personnel, including the physician, pharmacist, and/or other agency staff who have had direct contact with the patient or had some other means of gathering information to contribute to the OASIS data collection. When collaboration is utilized, the M0090 Date assessment completed should reflect the last date the assessing clinician gathered or received any input used to complete the comprehensive assessment, including the OASIS items. When used, collaboration must occur within the appropriate timeframe and consistent with data collection guidance. Any exception to this general convention concerning collaboration is identified in item-specific guidance.

14. The use of the term "specifically," means scoring of the item should be limited to only the circumstances listed. The use of "for example," means the clinician may consider other relevant circumstances or attributes when scoring the item.

CONVENTIONS SPECIFIC TO OASIS ADL/IADL ITEMS

1. Report the patient's physical and cognitive ability to perform a task. Do not report on the patient's preference or willingness to perform a specified task.

2. The level of ability refers to the level of assistance (if any) that the patient requires to safely complete a specified task.

3. While the presence or absence of a caregiver may impact the way a patient carries out an activity, it does not impact the assessing clinician's ability to assess the patient in order to determine and report the level of assistance that the patient requires to safely complete a task.

4. Understand what tasks are included and excluded in each item and select the OASIS response based only on included tasks.

5. If the patient's ability varies between the different tasks included in a multi-task item, report what is true in a majority of the included tasks, giving more weight to tasks that are more frequently performed.

6. Consider medical restrictions when determining ability. For example, if the physician has ordered activity restrictions, consider this when selecting the best response to functional items related to ambulation, transferring, bathing, etc.

OASIS DATA ACCURACY

In any data-driven system, the quality of the output is only as good as the quality of the data input. OASIS data are used for multiple purposes, including production of quality reports for agencies, public reports on the Medicare Home Health Compare website, and to determine payment. Thus, it is imperative that the OASIS data that HHAs collect and submit be accurate and complete. Regulatory language specifying accuracy of OASIS data can be found in the Medicare Conditions of Participation Accuracy of Encoded OASIS Data[2] (For additional discussion of OASIS Data Accuracy, see Appendix B of this manual.)

CMS recommends that agencies develop internal systems for monitoring data accuracy in addition to data checking features incorporated into CMS-supplied data entry software and other data entry systems. These may include clinical record audits, data entry audits, reports produced from electronic health record systems or other activities.

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[2] http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=1c743ade23ae8533ee0732689c166e31&r=PART&n=42y5.0.1.1.3#se42.5.484_120

HHAs can correct nearly all erroneous assessments themselves following professional standards for correcting documents. Information related to correction of erroneous OASIS data can be found in Appendix B of this manual.

OASIS DATA ENCODING AND TRANSMISSION

HHAs are required to encode and electronically submit OASIS data to CMS within 30 days of the date the assessment was completed. The requirements are specified in the Medicare Conditions of Participation[3] related to Encoding OASIS Data, Transmittal of OASIS Data, and Data Format, as summarized in Appendix E of this manual. Detailed instructions on encoding and transmitting OASIS data are found in the HHA System User's Guide and the OASIS Validation Report Messages and Description Guide (both available at QIES Technical Support Office – OASIS User Guides and Training).[4]

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[3]   http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=5aad0315b2e678ef56bbbd491bc8b31b&n=42y5.0.1.1.3&r=PART&ty=HTML#42:5.0.1.1.3.2.7.7

[4]   https://qtso.cms.gov/hhatrain.html

CHAPTER 2   ALL TIME POINTS VERSIONS

Chapter 2 contains the following sets of OASIS items:

- **All Items:** This is the entire set of OASIS Items that are collected at any point in time during a home health episode of care. At any one point in time, only a subset of OASIS items is collected.

- **Patient Tracking Sheet:** This information is collected at Start of Care and updated as needed at subsequent time points. Note: Patient Tracking Sheet items are required to be included in the data submission record for each time point, although they are collected at Start of Care and only updated as needed at subsequent time points. Refer to the OASIS Data Specifications on the CMS Web site at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/DataSpecifications.html.

- **Start of Care (SOC):** This information is collected at Start of Care in addition to all OASIS items on the Patient Tracking Sheet.

- **Resumption of Care (ROC):** This information is collected at Resumption of Care in addition to M0032 Resumption of Care Date on the Patient Tracking Sheet.

- **Follow-Up (FU):** This information is collected at Recertification and Other Follow-up.

- **Transfer (TRN):** This information is collected at Transfer to Inpatient Facility, with or without Discharge from Home Health Agency.

- **Discharge (DC):** This information is collected at discharge from home health agency other than Death at Home or Transfer to Inpatient Facility.

- **Death at Home (Death):** This information is collected when the patient dies while on service with the home health agency, and died somewhere other than an inpatient/outpatient facility or ED.

Home Health Patient Tracking Sheet

(M0010) CMS Certification Number: ☐☐☐☐☐☐

(M0014) Branch State: ☐☐

(M0016) Branch ID Number: ☐☐☐☐☐☐☐☐☐☐

(M0018) National Provider Identifier (NPI) for the attending physician who has signed the plan of care:

☐☐☐☐☐☐☐☐☐☐ ☐ **UK – Unknown or Not Available**

(M0020) Patient ID Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(M0030) Start of Care Date: ☐☐ / ☐☐ / ☐☐☐☐
month   day   year

(M0032) Resumption of Care Date: ☐☐ / ☐☐ / ☐☐☐☐ ☐ **NA – Not Applicable**
month   day   year

(M0040) Patient Name:

☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐
(First)   (M I)   (Last)   (Suffix)

(M0050) Patient State of Residence: ☐☐

(M0060) Patient ZIP Code: ☐☐☐☐☐ – ☐☐☐☐

(M0063) Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐☐ ☐ **NA – No Medicare**
(including suffix)

(M0064) Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐ ☐ **UK – Unknown or Not Available**

(M0065) Medicaid Number: ☐☐☐☐☐☐☐☐☐☐☐☐ ☐ **NA – No Medicaid**

(M0066) Birth Date: ☐☐ / ☐☐ / ☐☐☐☐
month   day   year

(M0069) Gender	
Enter Code ☐	1 Male 2 Female

(M0140) Race/Ethnicity: (Mark all that apply.)

   ☐   1 -   American Indian or Alaska Native

   ☐   2 -   Asian

   ☐   3 -   Black or African-American

   ☐   4 -   Hispanic or Latino

   ☐   5 -   Native Hawaiian or Pacific Islander

   ☐   6 -   White

(M0150) Current Payment Sources for Home Care: (Mark all that apply.)

   ☐   0 -   None; no charge for current services

   ☐   1 -   Medicare (traditional fee-for-service)

   ☐   2 -   Medicare (HMO/managed care/Advantage plan)

   ☐   3 -   Medicaid (traditional fee-for-service)

   ☐   4 -   Medicaid (HMO/managed care)

   ☐   5 -   Workers' compensation

   ☐   6 -   Title programs (for example, Title III, V, or XX)

   ☐   7 -   Other government (for example, TriCare, VA)

   ☐   8 -   Private insurance

   ☐   9 -   Private HMO/managed care

   ☐ 10 -   Self-pay

   ☐ 11 -   Other (specify) _____

☐ UK -   Unknown

Outcome and Assessment Information Set
Items to be Used at Specific Time Points

Time Point	Items Used
Start of Care -- Start of care – further visits planned	M0010-M0030, M0040-M0150, M1000-M1033, M1060-M1306, M1311-M2003, M2010, M2020-M2200, GG0100-GG0170
Resumption of Care --------------------------------------- Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1033, M1060-M1306, M1311-M2003, M2010, M2020-M2200, GG0100-GG0170
Follow-Up --- Recertification (follow-up) assessment Other follow-up assessment	M0080-M0100, M0110, M1021- M1023, M1030, M1200-M1306, M1311-M1400, M1610-M1630, M1810-M1840, M1850-M1860, M2030, M2200, GG0130-GG0170
Transfer to an Inpatient Facility ---------------------------- Transferred to an inpatient facility – patient not discharged from an agency Transferred to an inpatient facility – patient discharged from agency	M0080-M0100, M1041-M1056, M2005, M2016, M2301-M2410, M0906, J1800-J1900
Discharge from Agency – Not to an Inpatient Facility Death at home---	M0080-M0100, M2005, M0906, J1800-J1900
Discharge from agency------------------------------------	M0080-M0100, M1041-M1056, M1242-M1311, M1324-M1330, M1334-M1600, M1620, M1700-M1720, M1740-M1870, M2005, M2016-M2020, M2102, M2301-M2420, M0906, GG0130-J1900

CLINICAL RECORD ITEMS

(M0080)	**Discipline of Person Completing Assessment**
Enter Code ☐	1 RN 2 PT 3 SLP/ST 4 OT

(M0090) Date Assessment Completed:

☐☐ / ☐☐ / ☐☐☐☐
month   day   year

(M0100)	**This Assessment is Currently Being Completed for the Following Reason:**
Enter Code ☐	**Start/Resumption of Care** 1 Start of care – further visits planned 3 Resumption of care (after inpatient stay) **Follow-Up** 4 Recertification (follow-up) reassessment **[Go to M0110]** 5 Other follow-up **[Go to M0110]** **Transfer to an Inpatient Facility** 6 Transferred to an inpatient facility – patient not discharged from agency **[Go to M1041]** 7 Transferred to an inpatient facility – patient discharged from agency **[Go to M1041]** **Discharge from Agency – Not to an Inpatient Facility** 8 Death at home **[Go to M2005]** 9 Discharge from agency **[Go to M1041]**

CLINICAL RECORD ITEMS, continued

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

| | | / | | | / | | | | | **[*Go to M0110, if date entered*]**
month   day   year

☐ NA -   No specific SOC date ordered by physician

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

| | | / | | | / | | | | |
month   day   year

(M0110)	**Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?
Enter Code ☐	1 Early 2 Later UK Unknown NA Not Applicable: No Medicare case mix group to be defined by this assessment.

PATIENT HISTORY AND DIAGNOSES

(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*]**

(M1005) Inpatient Discharge Date (most recent):

| | | / | | | / | | | | |
month   day   year

☐ UK -   Unknown

PATIENT HISTORY AND DIAGNOSES, continued

(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.

(Form on next page)

(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

(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

(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

PATIENT HISTORY AND DIAGNOSES, continued

(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

(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
(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.
(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]*
(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

(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.)

LIVING ARRANGEMENTS

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)**

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

SENSORY STATUS

(M1200)	**Vision** (with corrective lenses if the patient usually wears them):
Enter Code ☐	0 Normal vision: sees adequately in most situations; can see medication labels, newsprint.
	1 Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length.
	2 Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.
(M1242)	**Frequency of Pain Interfering** with patient's activity or movement:
Enter Code ☐	0 Patient has no pain
	1 Patient has pain that does not interfere with activity or movement
	2 Less often than daily
	3 Daily, but not constantly
	4 All of the time

INTEGUMENTARY STATUS

(M1306)	Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)
Enter Code ☐	0 No **[Go to M1322 at SOC/ROC/FU; Go to M1324 at DC]** 1 Yes
(M1307)	The **Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 pressure ulcers)
Enter Code ☐	1 Was present at the most recent SOC/ROC assessment 2 Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: ☐☐ / ☐☐ / ☐☐☐☐ month day year NA No Stage 2 pressure ulcers are present at discharge

SOC/ROC

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or 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/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries 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 **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

Follow-Up

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or 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/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries 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 **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

INTEGUMENTARY STATUS, continued

Discharge

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 – Go to M1311B1, Stage 3]	☐
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	☐
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 – Go to M1311C1, Stage 4]	☐
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	☐
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 – Go to M1311D1, Unstageable: Non-removable dressing/device]	☐
C2. Number of <u>these</u> 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/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** [If 0 – Go to M1311E1, Unstageable: Slough and/or eschar]	☐
D2. Number of <u>these</u> unstageable pressure ulcers/injuries 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 – Go to M1311F1, Unstageable: Deep tissue injury]	☐
E2. Number of <u>these</u> 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 **Number of unstageable pressure injuries presenting as deep tissue injury** [If 0 – Go to M1324]	☐
F2. Number of <u>these</u> unstageable pressure injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

(M1322)	**Current Number of Stage 1 Pressure Injuries:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.	
Enter Code	0 1 2 3 4 or more	
(M1324)	**Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable:** (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)	
Enter Code	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries	
(M1330)	Does this patient have a **Stasis Ulcer**?	
Enter Code	0 No **[Go to M1340]** 1 Yes, patient has BOTH observable and unobservable stasis ulcers 2 Yes, patient has observable stasis ulcers ONLY 3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) **[Go to M1340]**	
(M1332)	**Current Number of Stasis Ulcer(s) that are Observable:**	
Enter Code	1 One 2 Two 3 Three 4 Four or more	
(M1334)	**Status of Most Problematic Stasis Ulcer that is Observable:**	
Enter Code	1 Fully granulating 2 Early/partial granulation 3 Not healing	
(M1340)	Does this patient have a **Surgical Wound?**	
Enter Code	0 No **[Go to M1400]** 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device **[Go to M1400]**	
(M1342)	**Status of Most Problematic Surgical Wound that is Observable**	
Enter Code	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing	

RESPIRATORY STATUS

(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)

ELIMINATION STATUS

(M1600)	Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?
Enter Code	0 No 1 Yes NA Patient on prophylactic treatment UK Unknown [*Omit "UK" option on DC*]
(M1610)	**Urinary Incontinence or Urinary Catheter Presence:**
Enter Code	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic)
(M1620)	**Bowel Incontinence Frequency:**
Enter Code	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination UK Unknown [*Omit "UK" option on FU, DC*]
(M1630)	**Ostomy for Bowel Elimination:** Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; <u>or</u> b) necessitated a change in medical or treatment regimen?
Enter Code	0 Patient does <u>not</u> have an ostomy for bowel elimination. 1 Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen. 2 The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M1700)	**Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
Enter Code ☐	0 Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
	1 Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
	2 Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
	3 Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
	4 Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

(M1710)	**When Confused (Reported or Observed Within the Last 14 Days):**
Enter Code ☐	0 Never
	1 In new or complex situations only
	2 On awakening or at night only
	3 During the day and evening, but not constantly
	4 Constantly
	NA Patient nonresponsive

(M1720)	**When Anxious (Reported or Observed Within the Last 14 Days):**
Enter Code ☐	0 None of the time
	1 Less often than daily
	2 Daily, but not constantly
	3 All of the time
	NA Patient nonresponsive

(M1730)	**Depression Screening:** Has the patient been screened for depression, using a standardized, validated depression screening tool?
Enter Code ☐	0 No
	1 Yes, patient was screened using the PHQ-2©* scale.

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2©*	Not at all 0-1 day	Several days 2-6 days	More than half of the days 7-11 days	Nearly every day 12-14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA
b) Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA

2   Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.

3   Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

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(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated <u>at least once a week</u> (Reported or Observed): (Mark all that apply.)

☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required

☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions

☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.

☐ 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)

☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)

☐ 6 - Delusional, hallucinatory, or paranoid behavior

☐ 7 - None of the above behaviors demonstrated

(M1745)	**Frequency of Disruptive Behavior Symptoms (Reported or Observed):** Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.
Enter Code ☐	0 Never 1 Less than once a month 2 Once a month 3 Several times each month 4 Several times a week 5 At least daily

ADL/IADLs

(M1800)	**Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code ☐	0 Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1 Grooming utensils must be placed within reach before able to complete grooming activities. 2 Someone must assist the patient to groom self. 3 Patient depends entirely upon someone else for grooming needs.
(M1810)	Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
Enter Code ☐	0 Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1 Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2 Someone must help the patient put on upper body clothing. 3 Patient depends entirely upon another person to dress the upper body.
(M1820)	Current **Ability to Dress <u>Lower</u> Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
Enter Code ☐	0 Able to obtain, put on, and remove clothing and shoes without assistance. 1 Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2 Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3 Patient depends entirely upon another person to dress lower body.

ADL/IADLs, continued

(M1830)	**Bathing:** Current ability to wash entire body safely. **Excludes** **grooming (washing face, washing hands, and shampooing hair).**
Enter Code ☐	0 Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
	1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
	2 Able to bathe in shower or tub with the intermittent assistance of another person:
	(a) for intermittent supervision or encouragement or reminders, OR
	(b) to get in and out of the shower or tub, OR
	(c) for washing difficult to reach areas.
	3 Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
	4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
	5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	6 Unable to participate effectively in bathing and is bathed totally by another person.
(M1840)	**Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.
Enter Code ☐	0 Able to get to and from the toilet and transfer independently with or without a device.
	1 When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
	2 Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3 Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4 Is totally dependent in toileting.
(M1845)	**Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.
Enter Code ☐	0 Able to manage toileting hygiene and clothing management without assistance.
	1 Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
	2 Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
	3 Patient depends entirely upon another person to maintain toileting hygiene.
(M1850)	**Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.
Enter Code ☐	0 Able to independently transfer.
	1 Able to transfer with minimal human assistance or with use of an assistive device.
	2 Able to bear weight and pivot during the transfer process but unable to transfer self.
	3 Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
	4 Bedfast, unable to transfer but is able to turn and position self in bed.
	5 Bedfast, unable to transfer and is unable to turn and position self.

ADL/IADLs, continued

(M1860)	**Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
Enter Code ☐	0 Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
	1 With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
	2 Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
	3 Able to walk only with the supervision or assistance of another person at all times.
	4 Chairfast, <u>unable</u> to ambulate but is able to wheel self independently.
	5 Chairfast, unable to ambulate and is <u>unable</u> to wheel self.
	6 Bedfast, unable to ambulate or be up in a chair.
(M1870)	**Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of <u>eating</u>, <u>chewing</u>, and <u>swallowing</u>, <u>not preparing</u> the food to be eaten.
Enter Code ☐	0 Able to independently feed self.
	1 Able to feed self independently but requires:
	(a) meal set-up; <u>OR</u>
	(b) intermittent assistance or supervision from another person; <u>OR</u>
	(c) a liquid, pureed or ground meat diet.
	2 <u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack.
	3 Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.
	4 <u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
	5 Unable to take in nutrients orally or by tube feeding.
(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.

MEDICATIONS

(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 M2102]**
(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
(M2010)	**Patient/Caregiver High-Risk Drug Education:** Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?
Enter Code ☐	0 No 1 Yes NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications
(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
(M2020)	**Management of Oral Medications:** <u>Patient's current ability</u> to prepare and take <u>all</u> oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **<u>Excludes</u> injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

Enter Code ☐	0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
	1 Able to take medication(s) at the correct times if:
	    (a) individual dosages are prepared in advance by another person; <u>OR</u>
	    (b) another person develops a drug diary or chart.
	2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
	3 <u>Unable</u> to take medication unless administered by another person.
	NA No oral medications prescribed.

(M2030)	**Management of Injectable Medications:** <u>Patient's current ability</u> to prepare and take <u>all</u> prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **<u>Excludes</u> IV medications.**

Enter Code
 	
[ ]
	0 Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
	1 Able to take injectable medication(s) at the correct times if:
	    (a) individual syringes are prepared in advance by another person; <u>OR</u>
	    (b) another person develops a drug diary or chart.
	2 Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
	3 <u>Unable</u> to take injectable medication unless administered by another person.
	NA No injectable medications prescribed.

CARE MANAGEMENT

SOC/ROC

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.

Enter Code
 	
[ ]
	f. **Supervision and safety** (for example, due to cognitive impairment)
	    0 No assistance needed –patient is independent or does not have needs in this area
	    1 Non-agency caregiver(s) currently provide assistance
	    2 Non-agency caregiver(s) need training/ supportive services to provide assistance
	    3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance
	    4 Assistance needed, but no non-agency caregiver(s) available

Discharge

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.

Enter Code
 	
[ ]
	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding)
	    0 No assistance needed –patient is independent or does not have needs in this area
	    1 Non-agency caregiver(s) currently provide assistance
	    2 Non-agency caregiver(s) need training/ supportive services to provide assistance
	    3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance
	    4 Assistance needed, but no non-agency caregiver(s) available

Enter Code
 	
[ ]
	c. **Medication administration** (for example, oral, inhaled or injectable)
	    0 No assistance needed –patient is independent or does not have needs in this area
	    1 Non-agency caregiver(s) currently provide assistance
	    2 Non-agency caregiver(s) need training/ supportive services to provide assistance
	    3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance
	    4 Assistance needed, but no non-agency caregiver(s) available

Enter Code
 	
[ ]
	d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program)
	    0 No assistance needed –patient is independent or does not have needs in this area
	    1 Non-agency caregiver(s) currently provide assistance
	    2 Non-agency caregiver(s) need training/ supportive services to provide assistance
	    3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance
	    4 Assistance needed, but no non-agency caregiver(s) available

Enter Code
 	
[ ]
	f. **Supervision and safety** (for example, due to cognitive impairment)
	    0 No assistance needed –patient is independent or does not have needs in this area
	    1 Non-agency caregiver(s) currently provide assistance
	    2 Non-agency caregiver(s) need training/ supportive services to provide assistance
	    3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance
	    4 Assistance needed, but no non-agency caregiver(s) available

THERAPY NEED AND PLAN OF CARE

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

($\Box\Box\Box$) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐ NA - Not Applicable: No case mix group defined by this assessment.

EMERGENT CARE

(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]**

(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis

☐ 10 - Hypo/Hyperglycemia, diabetes out of control

☐ 19 - Other than above reasons

☐ UK - Reason unknown

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(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.

(M2410)	To which **Inpatient Facility** has the patient been admitted?
Enter Code ☐	1 Hospital 2 Rehabilitation facility 3 Nursing home 4 Hospice NA No inpatient facility admission **[*Omit "NA" option on TRN*]**
(M2420)	**Discharge Disposition:** Where is the patient after discharge from your agency? **(Choose only one answer.)**
Enter Code ☐	1 Patient remained in the community (without formal assistive services) 2 Patient remained in the community (with formal assistive services) 3 Patient transferred to a non-institutional hospice 4 Unknown because patient moved to a geographic location not served by this agency UK Other unknown

(M0906)   Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

☐☐ / ☐☐ / ☐☐☐☐
month   day   year

Section GG	Functional Abilities and Goals

GG0100. Prior Functioning: Everyday Activities: Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

Coding:	↓ Enter Codes in Boxes		
3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. **2. Needed Some Help** – Patient needed partial assistance from another person to complete activities. **1. Dependent** – A helper completed the activities for the patient. **8. Unknown** **9. Not Applicable**	☐	**A.**	**Self Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
	☐	**B.**	**Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.
	☐	**C.**	**Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury.
	☐	**D.**	**Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ Check all that apply		
☐	**A.**	**Manual wheelchair**
☐	**B.**	**Motorized wheelchair and/or scooter**
☐	**C.**	**Mechanical lift**
☐	**D.**	**Walker**
☐	**E.**	**Orthotics/Prosthetics**
☐	**Z.**	**None of the above**

Section GG: Self-Care

SOC/ROC

GG0130. Self-Care

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A.** **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	☐☐	**B.** **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.
☐☐	☐☐	**C.** **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**E.** **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower
☐☐	☐☐	**F.** **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	**G.** **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐☐	**H.** **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

GG0130. Self-Care

Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up, code the reason.

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.

10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)

88. **Not attempted due to medical conditions or safety concerns**

4. Follow-Up Performance ↓ Enter Codes in Boxes	
☐☐	**A.** **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	**B.** **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C.** **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

GG0130. Self-Care

Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, code the reason.

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.

10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)

88. **Not attempted due to medical conditions or safety concerns**

3. Discharge Performance ↓ Enter Codes in Boxes ▼	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.
☐☐	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Section GG: Mobility

SOC/ROC

GG0170. Mobility
Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.

10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)

88. **Not attempted due to medical conditions or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
[ ][ ]	[ ][ ]	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
[ ][ ]	[ ][ ]	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
[ ][ ]	[ ][ ]	**C. Lying to sitting on side of bed:** The ability to 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.
[ ][ ]	[ ][ ]	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
[ ][ ]	[ ][ ]	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
[ ][ ]	[ ][ ]	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
[ ][ ]	[ ][ ]	**G. Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
[ ][ ]	[ ][ ]	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb)*
[ ][ ]	[ ][ ]	**J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.

☐☐	☐☐	**K.**	**Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐☐	☐☐	**L.**	**Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	**M.**	**1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
☐☐	☐☐	**N.**	**4 steps:** The ability to go up and down four steps with or without a rail. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
☐☐	☐☐	**O.**	**12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐	**P.**	**Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		☐	**Q.** **Does patient use wheelchair and/or scooter?** **0. No** → Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1. **1. Yes** → Continue to GG0170R, Wheel 50 feet with two turns.
☐☐	☐☐		**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		☐	**RR1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐		**S.** **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		☐	**SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

GG0170. Mobility

Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up code the reason.

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

4. Follow-Up Performance	
↓ Enter Codes in Boxes	
[ ][ ]	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
[ ][ ]	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
[ ][ ]	C. **Lying to sitting on side of bed:** The ability to 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.
[ ][ ]	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
[ ][ ]	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
[ ][ ]	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
[ ][ ]	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Follow-Up performance is coded 07, 09, 10 or 88 → skip to GG0170M, 1 step (curb).*
[ ][ ]	J. **Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
[ ][ ]	L. **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
[ ][ ]	M. **1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If Follow-up performance is coded 07, 09, 10 or 88, skip to GG0170Q, Does patient use wheelchair and/or scooter?*
[ ][ ]	N. **4 steps:** The ability to go up and down four steps with or without a rail.
[ ]	**Q. Does patient use wheelchair and/or scooter?** **0. No** →Skip GG0170R **1. Yes** → Continue to GG0170R, Wheel 50 feet with two turns.
[ ][ ]	R. **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

GG0170. Mobility

Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, code the reason.

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

3. Discharge Performance		
↓ Enter Codes in Boxes		
	A.	**Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
	B.	**Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
	C.	**Lying to sitting on side of bed:** The ability to 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.
	D.	**Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
	E.	**Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
	F.	**Toilet transfer:** The ability to get on and off a toilet or commode.
	G.	**Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
	I.	**Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb).*
	J.	**Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
	K.	**Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
	L.	**Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
	M.	**1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*

	N.	**4 steps:** The ability to go up and down four steps with or without a rail. *If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
	O.	**12 steps:** The ability to go up and down 12 steps with or without a rail.
	P.	**Picking up object**: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

	☐	**Q.** **Does patient use wheelchair and/or scooter?** **0. No →** Skip to J1800 Any falls since SOC/ROC, whichever is more recent. **1. Yes →** Continue to GG0170R, Wheel 50 feet with two turns.
☐☐		**R.** **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐	**RR3.** **Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**
☐☐		**S.** **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐	**SS3. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**

Section J: Health Conditions

J1800.	Any Falls Since SOC/ROC, whichever is more recent

Enter Code
 	
 ☐
	Has the patient **had any falls since SOC/ROC,** whichever is more recent**?**
	      0. **No** → Skip J1900
	      1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent

J1900.	Number of Falls Since SOC/ROC, whichever is more recent	
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	☐	**A.** **No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B.** **Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C.** **Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Home Health Patient Tracking Sheet

(M0010) CMS Certification Number:

(M0014) Branch State:

(M0016) Branch ID Number:

(M0018) National Provider Identifier (NPI) for the attending physician who has signed the plan of care**:**

☐ **UK – Unknown or Not Available**

(M0020) Patient ID Number:

(M0030) Start of Care Date:

month   day   year

(M0032) Resumption of Care Date: ☐ **NA – Not Applicable**

month   day   year

(M0040) Patient Name:

(First)   (M I)   (Last)   (Suffix)

(M0050) Patient State of Residence:

(M0060) Patient ZIP Code: –

(M0063) Medicare Number: ☐ **NA – No Medicare**

(including suffix)

(M0064) Social Security Number: -   -   ☐ **UK – Unknown or Not Available**

(M0065) Medicaid Number: ☐ **NA – No Medicaid**

(M0066) Birth Date: /   /

month   day   year

(M0069) Gender	
Enter Code	1 Male
☐	2 Female

(M0140) Race/Ethnicity: (Mark all that apply.)

    ☐ 1 -   American Indian or Alaska Native

    ☐ 2 -   Asian

    ☐ 3 -   Black or African-American

    ☐ 4 -   Hispanic or Latino

    ☐ 5 -   Native Hawaiian or Pacific Islander

    ☐ 6 -   White

(M0150) Current Payment Sources for Home Care: (Mark all that apply.)

    ☐ 0 -   None; no charge for current services

    ☐ 1 -   Medicare (traditional fee-for-service)

    ☐ 2 -   Medicare (HMO/managed care/Advantage plan)

    ☐ 3 -   Medicaid (traditional fee-for-service)

    ☐ 4 -   Medicaid (HMO/managed care)

    ☐ 5 -   Workers' compensation

    ☐ 6 -   Title programs (for example, Title III, V, or XX)

    ☐ 7 -   Other government (for example, TriCare, VA)

    ☐ 8 -   Private insurance

    ☐ 9 -   Private HMO/managed care

    ☐ 10 -   Self-pay

    ☐ 11 -   Other (specify) _____

  ☐ UK -   Unknown

Home Health Patient Tracking Sheet

(M0010) CMS Certification Number: ☐☐☐☐☐☐

(M0014) Branch State: ☐☐

(M0016) Branch ID Number: ☐☐☐☐☐☐☐☐☐☐

(M0018) National Provider Identifier (NPI) for the attending physician who has signed the plan of care:

☐☐☐☐☐☐☐☐☐☐   ☐ **UK – Unknown or Not Available**

(M0020) Patient ID Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(M0030) Start of Care Date: ☐☐ / ☐☐ / ☐☐☐☐
                              month   day   year

(M0040) Patient Name:

☐☐☐☐☐☐☐☐☐☐☐☐ ☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐
(First)   (M I)   (Last)   (Suffix)

(M0050) Patient State of Residence: ☐☐

(M0060) Patient ZIP Code: ☐☐☐☐☐ – ☐☐☐☐

(M0063) Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐   ☐ **NA – No Medicare**
                            (including suffix)

(M0064) Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐   ☐ **UK – Unknown or Not Available**

(M0065) Medicaid Number: ☐☐☐☐☐☐☐☐☐☐☐   ☐ **NA – No Medicaid**

(M0066) Birth Date: ☐☐ / ☐☐ / ☐☐☐☐
                        month   day   year

(M0069) Gender	
Enter Code ☐	1 Male 2 Female

(M0140) Race/Ethnicity: (Mark all that apply.)

☐ 1 - American Indian or Alaska Native

☐ 2 - Asian

☐ 3 - Black or African-American

☐ 4 - Hispanic or Latino

☐ 5 - Native Hawaiian or Pacific Islander

☐ 6 - White

(M0150) Current Payment Sources for Home Care: (Mark all that apply.)

☐ 0 - None; no charge for current services

☐ 1 - Medicare (traditional fee-for-service)

☐ 2 - Medicare (HMO/managed care/Advantage plan)

☐ 3 - Medicaid (traditional fee-for-service)

☐ 4 - Medicaid (HMO/managed care)

☐ 5 - Workers' compensation

☐ 6 - Title programs (for example, Title III, V, or XX)

☐ 7 - Other government (for example, TriCare, VA)

☐ 8 - Private insurance

☐ 9 - Private HMO/managed care

☐ 10 - Self-pay

☐ 11 - Other (specify) _____

☐ UK - Unknown

Items to be Used at Specific Time Points

Time Point	Items Used
Start of Care --	M0010-M0030, M0040-M0150, M1000-M1033, M1060-M1306, M1311-M2003, M2010, M2020-M2200, GG0100-GG0170
Start of care – further visits planned	

CLINICAL RECORD ITEMS

(M0080)	**Discipline of Person Completing Assessment**
Enter Code	1 RN
	2 PT
	3 SLP/ST
	4 OT

(M0090) Date Assessment Completed:

☐☐ / ☐☐ / ☐☐☐☐
month   day   year

(M0100)	**This Assessment is Currently Being Completed for the Following Reason:**
Enter Code	**Start/Resumption of Care**
	1 Start of care – further visits planned
	3 Resumption of care (after inpatient stay)
	Follow-Up
	4 Recertification (follow-up) reassessment **[Go to M0110]**
	5 Other follow-up **[Go to M0110]**
	Transfer to an Inpatient Facility
	6 Transferred to an inpatient facility – patient not discharged from agency **[Go to M1041]**
	7 Transferred to an inpatient facility – patient discharged from agency **[Go to M1041]**
	Discharge from Agency – Not to an Inpatient Facility
	8 Death at home **[Go to M2005]**
	9 Discharge from agency **[Go to M1041]**

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

☐☐ / ☐☐ / ☐☐☐☐ **[Go to M0110, if date entered]**
month   day   year

☐ NA - No specific SOC date ordered by physician

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

☐☐ / ☐☐ / ☐☐☐☐
month   day   year

(M0110)	**Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?
Enter Code	1 Early
	2 Later
	UK Unknown
	NA Not Applicable: No Medicare case mix group to be defined by this assessment.

PATIENT HISTORY AND DIAGNOSES

(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*]**

(M1005) Inpatient Discharge Date (most recent):

☐☐ / ☐☐ / ☐☐☐☐
month   day   year

☐ UK - Unknown

(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.

(Form on next page)

(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

(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

(M1030) Therapies the patient receives <u>at home</u>: **(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

(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

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

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

inches

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.)

pounds

LIVING ARRANGEMENTS

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)**

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

SENSORY STATUS

(M1200)	**Vision** (with corrective lenses if the patient usually wears them):
Enter Code ☐	0 Normal vision: sees adequately in most situations; can see medication labels, newsprint. 1 Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length. 2 Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.
(M1242)	**Frequency of Pain Interfering** with patient's activity or movement:
Enter Code ☐	0 Patient has no pain 1 Patient has pain that does not interfere with activity or movement 2 Less often than daily 3 Daily, but not constantly 4 All of the time

INTEGUMENTARY STATUS

(M1306)	Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)
Enter Code ☐	0 No *[Go to M1322 at SOC/ROC/FU; Go to M1324 at DC]* 1 Yes

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or 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/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries 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 **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

(M1322)	**Current Number of Stage 1 Pressure Injuries:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
Enter Code ☐	0 1 2 3 4 or more
(M1324)	**Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable:** (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)
Enter Code ☐	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries
(M1330)	Does this patient have a **Stasis Ulcer**?
Enter Code ☐	0 No **[Go to M1340]** 1 Yes, patient has BOTH observable and unobservable stasis ulcers 2 Yes, patient has observable stasis ulcers ONLY 3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) **[Go to M1340]**
(M1332)	**Current Number of Stasis Ulcer(s) that are Observable:**
Enter Code ☐	1 One 2 Two 3 Three 4 Four or more
(M1334)	**Status of Most Problematic Stasis Ulcer that is Observable:**
Enter Code ☐	1 Fully granulating 2 Early/partial granulation 3 Not healing
(M1340)	Does this patient have a **Surgical Wound?**
Enter Code ☐	0 No **[Go to M1400]** 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device **[Go to M1400]**
(M1342)	**Status of Most Problematic Surgical Wound that is Observable**
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

RESPIRATORY STATUS

(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)

ELIMINATION STATUS

(M1600)	Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?
Enter Code	0 No 1 Yes NA Patient on prophylactic treatment UK Unknown **[Omit "UK" option on DC]**
(M1610)	**Urinary Incontinence or Urinary Catheter Presence:**
Enter Code	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic)
(M1620)	**Bowel Incontinence Frequency:**
Enter Code	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination UK Unknown **[Omit "UK" option on FU, DC]**
(M1630)	**Ostomy for Bowel Elimination:** Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; <u>or</u> b) necessitated a change in medical or treatment regimen?
Enter Code	0 Patient does <u>not</u> have an ostomy for bowel elimination. 1 Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen. 2 The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M1700)	**Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
Enter Code ☐	0 Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
	1 Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
	2 Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
	3 Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
	4 Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

(M1710)	**When Confused (Reported or Observed Within the Last 14 Days):**
Enter Code ☐	0 Never
	1 In new or complex situations only
	2 On awakening or at night only
	3 During the day and evening, but not constantly
	4 Constantly
	NA Patient nonresponsive

(M1720)	**When Anxious (Reported or Observed Within the Last 14 Days):**
Enter Code ☐	0 None of the time
	1 Less often than daily
	2 Daily, but not constantly
	3 All of the time
	NA Patient nonresponsive

(M1730)	**Depression Screening:** Has the patient been screened for depression, using a standardized, validated depression screening tool?
Enter Code ☐	0 No
	1 Yes, patient was screened using the PHQ-2©* scale.

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2©*	Not at all 0-1 day	Several days 2-6 days	More than half of the days 7-11 days	Nearly every day 12-14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA
b) Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA

2   Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.

3   Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

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(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated <u>at least once a week</u> (Reported or Observed): (Mark all that apply.)

☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required

☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions

☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.

☐ 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)

☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)

☐ 6 - Delusional, hallucinatory, or paranoid behavior

☐ 7 - None of the above behaviors demonstrated

(M1745)	**Frequency of Disruptive Behavior Symptoms (Reported or Observed):** Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.
Enter Code ☐	0 Never 1 Less than once a month 2 Once a month 3 Several times each month 4 Several times a week 5 At least daily

ADL/IADLs

(M1800)	**Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code ☐	0 Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1 Grooming utensils must be placed within reach before able to complete grooming activities. 2 Someone must assist the patient to groom self. 3 Patient depends entirely upon someone else for grooming needs.
(M1810)	Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
Enter Code ☐	0 Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1 Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2 Someone must help the patient put on upper body clothing. 3 Patient depends entirely upon another person to dress the upper body.
(M1820)	Current **Ability to Dress <u>Lower</u> Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
Enter Code ☐	0 Able to obtain, put on, and remove clothing and shoes without assistance. 1 Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2 Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3 Patient depends entirely upon another person to dress lower body.

ADL/IADLs, continued

(M1830)	**Bathing:** Current ability to wash entire body safely. **Excludes** **grooming (washing face, washing hands, and shampooing hair).**
Enter Code ☐	0 Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower.
	1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.

	2 Able to bathe in shower or tub with the intermittent assistance of another person:
	    (a) for intermittent supervision or encouragement or reminders, <u>OR</u>
	    (b) to get in and out of the shower or tub, <u>OR</u>
	    (c) for washing difficult to reach areas.

	3 Able to participate in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision.
	4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
	5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	6 Unable to participate effectively in bathing and is bathed totally by another person.
(M1840)	**Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely <u>and</u> transfer on and off toilet/commode.
Enter Code ☐	0 Able to get to and from the toilet and transfer independently with or without a device.
	1 When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
	2 <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3 <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4 Is totally dependent in toileting.
(M1845)	**Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.
Enter Code ☐	0 Able to manage toileting hygiene and clothing management without assistance.
	1 Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
	2 Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
	3 Patient depends entirely upon another person to maintain toileting hygiene.
(M1850)	**Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.
Enter Code ☐	0 Able to independently transfer.
	1 Able to transfer with minimal human assistance or with use of an assistive device.
	2 Able to bear weight and pivot during the transfer process but unable to transfer self.
	3 Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
	4 Bedfast, unable to transfer but is able to turn and position self in bed.
	5 Bedfast, unable to transfer and is unable to turn and position self.

ADL/IADLs, continued

(M1860)	**Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
Enter Code ☐	0 Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
	1 With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
	2 Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
	3 Able to walk only with the supervision or assistance of another person at all times.
	4 Chairfast, unable to ambulate but is able to wheel self independently.
	5 Chairfast, unable to ambulate and is unable to wheel self.
	6 Bedfast, unable to ambulate or be up in a chair.
(M1870)	**Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.
Enter Code ☐	0 Able to independently feed self.
	1 Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet.
	2 Unable to feed self and must be assisted or supervised throughout the meal/snack.
	3 Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
	4 Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
	5 Unable to take in nutrients orally or by tube feeding.
(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.

MEDICATIONS

(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 M2102]**
(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
(M2010)	**Patient/Caregiver High-Risk Drug Education:** Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?
Enter Code ☐	0 No 1 Yes NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications
(M2020)	**Management of Oral Medications:** <u>Patient's current ability</u> to prepare and take <u>all</u> oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **<u>Excludes</u> injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

Enter Code ☐	0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
	1 Able to take medication(s) at the correct times if:
	      (a) individual dosages are prepared in advance by another person; <u>OR</u>
	      (b) another person develops a drug diary or chart.
	2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
	3 <u>Unable</u> to take medication unless administered by another person.
	NA No oral medications prescribed.

(M2030)	**Management of Injectable Medications:** <u>Patient's current ability</u> to prepare and take <u>all</u> prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **<u>Excludes</u> IV medications.**

Enter Code ☐	0 Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
	1 Able to take injectable medication(s) at the correct times if:
	      (a) individual syringes are prepared in advance by another person; <u>OR</u>
	      (b) another person develops a drug diary or chart.
	2 Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
	3 <u>Unable</u> to take injectable medication unless administered by another person.
	NA No injectable medications prescribed.

CARE MANAGEMENT

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.

Enter Code
 ☐
	f. **Supervision and safety** (for example, due to cognitive impairment)
	    0 No assistance needed –patient is independent or does not have needs in this area
	    1 Non-agency caregiver(s) currently provide assistance
	    2 Non-agency caregiver(s) need training/ supportive services to provide assistance
	    3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance
	    4 Assistance needed, but no non-agency caregiver(s) available

THERAPY NEED AND PLAN OF CARE

(M2200)   **Therapy Need:** In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(☐☐☐) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐   NA   -   Not Applicable: No case mix group defined by this assessment.

Section GG	Functional Abilities and Goals

GG0100. Prior Functioning: Everyday Activities: Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

Coding:	↓ Enter Codes in Boxes		
3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. **2. Needed Some Help** – Patient needed partial assistance from another person to complete activities. **1. Dependent** – A helper completed the activities for the patient. **8. Unknown** **9. Not Applicable**	☐	**A.**	**Self Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
	☐	**B.**	**Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.
	☐	**C.**	**Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury.
	☐	**D.**	**Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ **Check all that apply**

☐	**A.**	**Manual wheelchair**
☐	**B.**	**Motorized wheelchair and/or scooter**
☐	**C.**	**Mechanical lift**
☐	**D.**	**Walker**
☐	**E.**	**Orthotics/Prosthetics**
☐	**Z.**	**None of the above**

Section GG: Self-Care

GG0130. Self-Care

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A.** **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	☐☐	**B.** **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.
☐☐	☐☐	**C.** **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**E.** **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower
☐☐	☐☐	**F.** **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	**G.** **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐☐	**H.** **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Section GG: Mobility

GG0170. Mobility

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A.** **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	**B.** **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C.** **Lying to sitting on side of bed:** The ability to 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.
☐☐	☐☐	**D.** **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	**E.** **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F.** **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	☐☐	**G.** **Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	☐☐	**I.** **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb)*
☐☐	☐☐	**J.** **Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.

☐☐	☐☐	**K.** **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐☐	☐☐	**L.** **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	**M.** **1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
☐☐	☐☐	**N.** **4 steps:** The ability to go up and down four steps with or without a rail. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
☐☐	☐☐	**O.** **12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐	**P.** **Picking up object**: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	☐	**Q.** **Does patient use wheelchair and/or scooter?** **0. No** → Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1. **1. Yes** → Continue to GG0170R, Wheel 50 feet with two turns.
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐	**RR1.Indicate the type of wheelchair or scooter used.** **1.** **Manual** **2.** **Motorized**
☐☐	☐☐	**S.** **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐	**SS1. Indicate the type of wheelchair or scooter used.** **1.** **Manual** **2.** **Motorized**

Home Health Patient Tracking Sheet

(M0032)   Resumption of Care Date: ☐☐ / ☐☐ / ☐☐☐☐   ☐ **NA – Not Applicable**

month   day   year

Outcome and Assessment Information Set
Items to be Used at Specific Time Points

Time Point	Items Used
Resumption of Care --- Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1033, M1060-M1306, M1311-M2003, M2010, M2020-M2200, GG0100-GG0170

CLINICAL RECORD ITEMS

(M0080)	Discipline of Person Completing Assessment
Enter Code ☐	1 RN 2 PT 3 SLP/ST 4 OT

(M0090) Date Assessment Completed:

☐☐ / ☐☐ / ☐☐☐☐
  month   day   year

(M0100)	This Assessment is Currently Being Completed for the Following Reason:
Enter Code ☐	**Start/Resumption of Care** 1 Start of care – further visits planned 3 Resumption of care (after inpatient stay) **Follow-Up** 4 Recertification (follow-up) reassessment *[Go to M0110]* 5 Other follow-up *[Go to M0110]* **Transfer to an Inpatient Facility** 6 Transferred to an inpatient facility – patient not discharged from agency *[Go to M1041]* 7 Transferred to an inpatient facility – patient discharged from agency *[Go to M1041]* **Discharge from Agency – Not to an Inpatient Facility** 8 Death at home *[Go to M2005]* 9 Discharge from agency *[Go to M1041]*

(M0102) Date of Physician-ordered Start of Care (Resumption of Care): If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

☐☐ / ☐☐ / ☐☐☐☐ *[Go to M0110, if date entered]*
  month   day   year

☐ NA -   No specific SOC date ordered by physician

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

☐☐ / ☐☐ / ☐☐☐☐
  month   day   year

(M0110)	**Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?
Enter Code ☐	1 Early 2 Later UK Unknown NA Not Applicable: No Medicare case mix group to be defined by this assessment.

PATIENT HISTORY AND DIAGNOSES

(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*]

(M1005) **Inpatient Discharge Date** (most recent):

    ☐☐ / ☐☐ / ☐☐☐☐
    month   day   year

    ☐ UK -   Unknown

(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.

(Form on next page)

(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

(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

(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

(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

(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.)

LIVING ARRANGEMENTS

(M1100) Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)**

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

SENSORY STATUS

(M1200)	**Vision** (with corrective lenses if the patient usually wears them):
Enter Code ☐	0 Normal vision: sees adequately in most situations; can see medication labels, newsprint. 1 Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length. 2 Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.
(M1242)	**Frequency of Pain Interfering** with patient's activity or movement:
Enter Code ☐	0 Patient has no pain 1 Patient has pain that does not interfere with activity or movement 2 Less often than daily 3 Daily, but not constantly 4 All of the time

INTEGUMENTARY STATUS

(M1306)	Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)
Enter Code ☐	0 No **[Go to M1322 at SOC/ROC/FU; Go to M1324 at DC]** 1 Yes

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or 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/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries 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 **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

INTEGUMENTARY STATUS, continued

(M1322)	**Current Number of Stage 1 Pressure Injuries:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
Enter Code ☐	0 1 2 3 4 or more
(M1324)	**Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable:** (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)
Enter Code ☐	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries
(M1330)	Does this patient have a **Stasis Ulcer**?
Enter Code ☐	0 No **[Go to M1340]** 1 Yes, patient has BOTH observable and unobservable stasis ulcers 2 Yes, patient has observable stasis ulcers ONLY 3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) **[Go to M1340]**
(M1332)	**Current Number of Stasis Ulcer(s) that are Observable:**
Enter Code ☐	1 One 2 Two 3 Three 4 Four or more
(M1334)	**Status of Most Problematic Stasis Ulcer that is Observable:**
Enter Code ☐	1 Fully granulating 2 Early/partial granulation 3 Not healing
(M1340)	Does this patient have a **Surgical Wound**?
Enter Code ☐	0 No **[Go to M1400]** 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device **[Go to M1400]**
(M1342)	**Status of Most Problematic Surgical Wound that is Observable**
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

RESPIRATORY STATUS

(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)

ELIMINATION STATUS

(M1600)	Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?
Enter Code	0 No 1 Yes NA Patient on prophylactic treatment UK Unknown **[Omit "UK" option on DC]**
(M1610)	**Urinary Incontinence or Urinary Catheter Presence:**
Enter Code	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic)
(M1620)	**Bowel Incontinence Frequency:**
Enter Code	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination UK Unknown **[Omit "UK" option on FU, DC]**
(M1630)	**Ostomy for Bowel Elimination:** Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; <u>or</u> b) necessitated a change in medical or treatment regimen?
Enter Code	0 Patient does <u>not</u> have an ostomy for bowel elimination. 1 Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen. 2 The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M1700)	**Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
Enter Code ☐	0 Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
	1 Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
	2 Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
	3 Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
	4 Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

(M1710)	**When Confused (Reported or Observed Within the Last 14 Days):**
Enter Code ☐	0 Never
	1 In new or complex situations only
	2 On awakening or at night only
	3 During the day and evening, but not constantly
	4 Constantly
	NA Patient nonresponsive

(M1720)	**When Anxious (Reported or Observed Within the Last 14 Days):**
Enter Code ☐	0 None of the time
	1 Less often than daily
	2 Daily, but not constantly
	3 All of the time
	NA Patient nonresponsive

(M1730)	**Depression Screening:** Has the patient been screened for depression, using a standardized, validated depression screening tool?

Enter Code ☐

0 No
1 Yes, patient was screened using the PHQ-2©* scale.

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2©*	Not at all 0-1 day	Several days 2-6 days	More than half of the days 7-11 days	Nearly every day 12-14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA
b) Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA

2 Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.
3 Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

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(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated <u>at least once a week</u> (Reported or Observed): (Mark all that apply.)

- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required

- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions

- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.

- ☐ 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)

- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)

- ☐ 6 - Delusional, hallucinatory, or paranoid behavior

- ☐ 7 - None of the above behaviors demonstrated

(M1745)	**Frequency of Disruptive Behavior Symptoms (Reported or Observed):** Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.
Enter Code	0　Never 1　Less than once a month 2　Once a month 3　Several times each month 4　Several times a week 5　At least daily

ADL/IADLs

(M1800)	**Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code	0　Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1　Grooming utensils must be placed within reach before able to complete grooming activities. 2　Someone must assist the patient to groom self. 3　Patient depends entirely upon someone else for grooming needs.
(M1810)	Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
Enter Code	0　Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1　Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2　Someone must help the patient put on upper body clothing. 3　Patient depends entirely upon another person to dress the upper body.
(M1820)	Current **Ability to Dress <u>Lower</u> Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
Enter Code	0　Able to obtain, put on, and remove clothing and shoes without assistance. 1　Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2　Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3　Patient depends entirely upon another person to dress lower body.

ADL/IADLs, continued

(M1830)	**Bathing:** Current ability to wash entire body safely. <u>**Excludes**</u> **grooming (washing face, washing hands, and shampooing hair).**
Enter Code	0 Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower.
	1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
	2 Able to bathe in shower or tub with the intermittent assistance of another person:
	(a) for intermittent supervision or encouragement or reminders, <u>OR</u>
	(b) to get in and out of the shower or tub, <u>OR</u>
	(c) for washing difficult to reach areas.
	3 Able to participate in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision.
	4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
	5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	6 Unable to participate effectively in bathing and is bathed totally by another person.
(M1840)	**Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely <u>and</u> transfer on and off toilet/commode.
Enter Code	0 Able to get to and from the toilet and transfer independently with or without a device.
	1 When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
	2 <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3 <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4 Is totally dependent in toileting.
(M1845)	**Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.
Enter Code	0 Able to manage toileting hygiene and clothing management without assistance.
	1 Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
	2 Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
	3 Patient depends entirely upon another person to maintain toileting hygiene.
(M1850)	**Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.
Enter Code	0 Able to independently transfer.
	1 Able to transfer with minimal human assistance or with use of an assistive device.
	2 Able to bear weight and pivot during the transfer process but unable to transfer self.
	3 Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
	4 Bedfast, unable to transfer but is able to turn and position self in bed.
	5 Bedfast, unable to transfer and is unable to turn and position self.

ADL/IADLs, continued

(M1860)	**Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Enter Code		
☐	0	Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
	1	With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
	2	Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
	3	Able to walk only with the supervision or assistance of another person at all times.
	4	Chairfast, <u>unable</u> to ambulate but is able to wheel self independently.
	5	Chairfast, unable to ambulate and is <u>unable</u> to wheel self.
	6	Bedfast, unable to ambulate or be up in a chair.

(M1870)	**Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of <u>eating</u>, <u>chewing</u>, and <u>swallowing</u>, <u>not preparing</u> the food to be eaten.

Enter Code		
☐	0	Able to independently feed self.
	1	Able to feed self independently but requires:
		(a) meal set-up; <u>OR</u>
		(b) intermittent assistance or supervision from another person; <u>OR</u>
		(c) a liquid, pureed or ground meat diet.
	2	<u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack.
	3	Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.
	4	<u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
	5	Unable to take in nutrients orally or by tube feeding.

(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.

MEDICATIONS

(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 M2102]**
(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
(M2010)	**Patient/Caregiver High-Risk Drug Education:** Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?
Enter Code ☐	0 No 1 Yes NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications
(M2020)	**Management of Oral Medications:** <u>Patient's current ability</u> to prepare and take <u>all</u> oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. <u>**Excludes**</u> **injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

Enter Code ☐	0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
	1 Able to take medication(s) at the correct times if:
	    (a) individual dosages are prepared in advance by another person; <u>OR</u>
	    (b) another person develops a drug diary or chart.
	2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
	3 <u>Unable</u> to take medication unless administered by another person.
	NA No oral medications prescribed.

(M2030)	**Management of Injectable Medications:** <u>Patient's current ability</u> to prepare and take <u>all</u> prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. <u>**Excludes**</u> **IV medications.**

Enter Code ☐	0 Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
	1 Able to take injectable medication(s) at the correct times if:
	    (a) individual syringes are prepared in advance by another person; <u>OR</u>
	    (b) another person develops a drug diary or chart.
	2 Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
	3 <u>Unable</u> to take injectable medication unless administered by another person.
	NA No injectable medications prescribed.

CARE MANAGEMENT

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.

Enter Code
 ☐
	f. **Supervision and safety** (for example, due to cognitive impairment)
	    0 No assistance needed –patient is independent or does not have needs in this area
	    1 Non-agency caregiver(s) currently provide assistance
	    2 Non-agency caregiver(s) need training/ supportive services to provide assistance
	    3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance
	    4 Assistance needed, but no non-agency caregiver(s) available

THERAPY NEED AND PLAN OF CARE

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(☐☐☐) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐ NA -   Not Applicable: No case mix group defined by this assessment.

Section GG	Functional Abilities and Goals

GG0100. Prior Functioning: Everyday Activities: Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.

Coding:

3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.

2. Needed Some Help – Patient needed partial assistance from another person to complete activities.

1. Dependent – A helper completed the activities for the patient.

8. Unknown

9. Not Applicable

↓ **Enter Codes in Boxes**

☐	**A.**	**Self Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
☐	**B.**	**Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.
☐	**C.**	**Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury.
☐	**D.**	**Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.

↓ **Check all that apply**

☐	**A.**	**Manual wheelchair**
☐	**B.**	**Motorized wheelchair and/or scooter**
☐	**C.**	**Mechanical lift**
☐	**D.**	**Walker**
☐	**E.**	**Orthotics/Prosthetics**
☐	**Z.**	**None of the above**

Section GG: Self-Care

GG0130. Self-Care

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A.** **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	☐☐	**B.** **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.
☐☐	☐☐	**C.** **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**E.** **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower
☐☐	☐☐	**F.** **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	**G.** **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐☐	**H.** **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Section GG: Mobility

GG0170. Mobility

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to 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.
☐☐	☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	☐☐	**G. Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb)*
☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.

☐☐ ☐☐	**K.**	**Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐☐ ☐☐	**L.**	**Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐ ☐☐	**M.**	**1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
☐☐ ☐☐	**N.**	**4 steps:** The ability to go up and down four steps with or without a rail. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
☐☐ ☐☐	**O.**	**12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐ ☐☐	**P.**	**Picking up object**: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	☐	**Q.** **Does patient use wheelchair and/or scooter?** **0. No** → Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1. **1. Yes** → Continue to GG0170R, Wheel 50 feet with two turns.
☐☐ ☐☐	**R.**	**Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐	**RR1.Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐ ☐☐	**S.**	**Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐	**SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

Outcome and Assessment Information Set
Items to be Used at Specific Time Points

Time Point	Items Used

Follow-Up ---
 	
     Recertification (follow-up) assessment
     Other follow-up assessment
	M0080-M0100, M0110, M1021-M1023, M1030, M1200-M1306, M1311-M1400, M1610-M1630, M1810-M1840, M1850-M1860, M2030, M2200, GG0130-GG0170

CLINICAL RECORD ITEMS

(M0080)	**Discipline of Person Completing Assessment**
Enter Code ☐	1 RN 2 PT 3 SLP/ST 4 OT

(M0090) Date Assessment Completed:

☐☐ / ☐☐ / ☐☐☐☐
month   day   year

(M0100)	**This Assessment is Currently Being Completed for the Following Reason:**
Enter Code ☐	**Start/Resumption of Care** 1 Start of care – further visits planned 3 Resumption of care (after inpatient stay) **Follow-Up** 4 Recertification (follow-up) reassessment **[Go to M0110]** 5 Other follow-up **[Go to M0110]** **Transfer to an Inpatient Facility** 6 Transferred to an inpatient facility – patient not discharged from agency **[Go to M1041]** 7 Transferred to an inpatient facility – patient discharged from agency **[Go to M1041]** **Discharge from Agency – Not to an Inpatient Facility** 8 Death at home **[Go to M2005]** 9 Discharge from agency **[Go to M1041]**

(M0110)	**Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?
Enter Code ☐	1 Early 2 Later UK Unknown NA Not Applicable: No Medicare case mix group to be defined by this assessment.

PATIENT HISTORY AND DIAGNOSES

(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.

(Form on next page)

(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

(M1030) Therapies the patient receives <u>at home</u>: **(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

SENSORY STATUS

(M1200)	**Vision** (with corrective lenses if the patient usually wears them):	
Enter Code ☐	0	Normal vision: sees adequately in most situations; can see medication labels, newsprint.
	1	Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length.
	2	Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.
(M1242)	**Frequency of Pain Interfering** with patient's activity or movement:	
Enter Code ☐	0	Patient has no pain
	1	Patient has pain that does not interfere with activity or movement
	2	Less often than daily
	3	Daily, but not constantly
	4	All of the time

INTEGUMENTARY STATUS

(M1306)	Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)
Enter Code ☐	0 No *[Go to M1322 at SOC/ROC/FU; Go to M1324 at DC]* 1 Yes

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or 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/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries 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 **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

(M1322)	**Current Number of Stage 1 Pressure Injuries:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
Enter Code ☐	0 1 2 3 4 or more
(M1324)	**Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable:** (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)
Enter Code ☐	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries
(M1330)	Does this patient have a **Stasis Ulcer**?
Enter Code ☐	0 No *[Go to M1340]* 1 Yes, patient has BOTH observable and unobservable stasis ulcers 2 Yes, patient has observable stasis ulcers ONLY 3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) *[Go to M1340]*

INTEGUMENTARY STATUS, continued

(M1332)	Current Number of Stasis Ulcer(s) that are Observable:
Enter Code ☐	1 One 2 Two 3 Three 4 Four or more
(M1334)	Status of Most Problematic Stasis Ulcer that is Observable:
Enter Code ☐	1 Fully granulating 2 Early/partial granulation 3 Not healing
(M1340)	Does this patient have a **Surgical Wound?**
Enter Code ☐	0 No **[Go to M1400]** 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device **[Go to M1400]**
(M1342)	Status of Most Problematic Surgical Wound that is Observable
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

RESPIRATORY STATUS

(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)

ELIMINATION STATUS

(M1610)	Urinary Incontinence or Urinary Catheter Presence:
Enter Code ☐	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic)
(M1620)	Bowel Incontinence Frequency:
Enter Code ☐	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination UK Unknown **[Omit "UK" option on FU, DC]**
(M1630)	**Ostomy for Bowel Elimination:** Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?
Enter Code ☐	0 Patient does <u>not</u> have an ostomy for bowel elimination. 1 Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen. 2 The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.

ADL/IADLs

(M1810)	Current **Ability to Dress <u>Upper</u> Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
Enter Code ☐	0 Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1 Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2 Someone must help the patient put on upper body clothing. 3 Patient depends entirely upon another person to dress the upper body.
(M1820)	Current **Ability to Dress <u>Lower</u> Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
Enter Code ☐	0 Able to obtain, put on, and remove clothing and shoes without assistance. 1 Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2 Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3 Patient depends entirely upon another person to dress lower body.
(M1830)	**Bathing:** Current ability to wash entire body safely. <u>**Excludes**</u> **grooming (washing face, washing hands, and shampooing hair).**

Enter Code ☐	0 Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower.
	 1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
	 2 Able to bathe in shower or tub with the intermittent assistance of another person:
	     (a) for intermittent supervision or encouragement or reminders, <u>OR</u>
	     (b) to get in and out of the shower or tub, <u>OR</u>
	     (c) for washing difficult to reach areas.
	 3 Able to participate in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision.
	 4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
	 5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	 6 Unable to participate effectively in bathing and is bathed totally by another person.

(M1840)	**Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely <u>and</u> transfer on and off toilet/commode.
Enter Code ☐	0 Able to get to and from the toilet and transfer independently with or without a device. 1 When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer. 2 <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance). 3 <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. 4 Is totally dependent in toileting.
(M1850)	**Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.
Enter Code ☐	0 Able to independently transfer. 1 Able to transfer with minimal human assistance or with use of an assistive device. 2 Able to bear weight and pivot during the transfer process but unable to transfer self. 3 Unable to transfer self and is unable to bear weight or pivot when transferred by another person. 4 Bedfast, unable to transfer but is able to turn and position self in bed. 5 Bedfast, unable to transfer and is unable to turn and position self.

ADL/IADLs, continued

(M1860)	**Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
Enter Code ☐	0 Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
	1 With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
	2 Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
	3 Able to walk only with the supervision or assistance of another person at all times.
	4 Chairfast, <u>unable</u> to ambulate but is able to wheel self independently.
	5 Chairfast, unable to ambulate and is <u>unable</u> to wheel self.
	6 Bedfast, unable to ambulate or be up in a chair.

MEDICATIONS

(M2030)	**Management of Injectable Medications:** <u>Patient's current ability</u> to prepare and take <u>all</u> prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**
Enter Code ☐	0 Able to independently take the correct medication(s) and proper dosage(s) at the correct times.

	1 Able to take injectable medication(s) at the correct times if:
	    (a) individual syringes are prepared in advance by another person; <u>OR</u>
	    (b) another person develops a drug diary or chart.

	2 Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
	3 <u>Unable</u> to take injectable medication unless administered by another person.
	NA No injectable medications prescribed.

THERAPY NEED AND PLAN OF CARE

(M2200) **Therapy Need:** In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(☐☐☐) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐ NA - Not Applicable: No case mix group defined by this assessment.

Section GG	Functional Abilities and Goals

Section GG: Self-Care

GG0130. Self-Care

Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up, code the reason.

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.

10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)

88. **Not attempted due to medical conditions or safety concerns**

4. Follow-Up Performance ↓ Enter Codes in Boxes	
▢▢	**A.** **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
▢▢	**B.** **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
▢▢	**C.** **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

Section GG: Mobility

GG0170. Mobility

Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up code the reason.

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.

10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)

88. **Not attempted due to medical conditions or safety concerns**

4. Follow-Up Performance		
↓ **Enter Codes in Boxes** ▼		
☐☐	A.	**Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	B.	**Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	C.	**Lying to sitting on side of bed:** The ability to 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.
☐☐	D.	**Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E.	**Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F.	**Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	I.	**Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Follow-Up performance is coded 07, 09, 10 or 88 → skip to GG0170M, 1 step (curb).*
☐☐	J.	**Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	L.	**Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	M.	**1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If Follow-up performance is coded 07, 09, 10 or 88, skip to GG0170Q, Does patient use wheelchair and/or scooter?*
☐☐	N.	**4 steps:** The ability to go up and down four steps with or without a rail.
☐		**Q. Does patient use wheelchair and/or scooter?** **0. No** →Skip GG0170R **1. Yes** → Continue to GG0170R, Wheel 50 feet with two turns.
☐☐	R.	**Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

Outcome and Assessment Information Set
Items to be Used at Specific Time Points

Time Point	Items Used

Transfer to an Inpatient Facility ------------------------------
     Transferred to an inpatient facility – patient not
     discharged from an agency
     Transferred to an inpatient facility – patient
     discharged from agency
	M0080-M0100, M1041-M1056, M2005, M2016,
	 M2301-M2410, M0906, J1800-J1900

CLINICAL RECORD ITEMS

(M0080)	**Discipline of Person Completing Assessment**
Enter Code ☐	1 RN 2 PT 3 SLP/ST 4 OT

(M0090) Date Assessment Completed:

☐☐ / ☐☐ / ☐☐☐☐
month   day   year

(M0100)	**This Assessment is Currently Being Completed for the Following Reason:**
Enter Code ☐	**Start/Resumption of Care** 1 Start of care – further visits planned 3 Resumption of care (after inpatient stay) **Follow-Up** 4 Recertification (follow-up) reassessment **[Go to M0110]** 5 Other follow-up **[Go to M0110]** **Transfer to an Inpatient Facility** 6 Transferred to an inpatient facility – patient not discharged from agency **[Go to M1041]** 7 Transferred to an inpatient facility – patient discharged from agency **[Go to M1041]** **Discharge from Agency – Not to an Inpatient Facility** 8 Death at home **[Go to M2005]** 9 Discharge from agency **[Go to M1041]**

PATIENT HISTORY AND DIAGNOSES

(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

(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.

(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]*

(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

MEDICATIONS

(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
(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

EMERGENT CARE

(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]**

(M2310) **Reason for Emergent Care**: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

☐　1　-　Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis

☐　10　-　Hypo/Hyperglycemia, diabetes out of control

☐　19　-　Other than above reasons

☐　UK　-　Reason unknown

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(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.

(M2410)	To which **Inpatient Facility** has the patient been admitted?
Enter Code ☐	1 Hospital 2 Rehabilitation facility 3 Nursing home 4 Hospice NA No inpatient facility admission **[Omit "NA" option on TRN]**

(M0906) **Discharge/Transfer/Death Date:** Enter the date of the discharge, transfer, or death (at home) of the patient.

☐☐ / ☐☐ / ☐☐☐☐
month   day   year

Section J: Health Conditions

J1800.	Any Falls Since SOC/ROC, whichever is more recent

Enter Code
 ☐
	Has the patient **had any falls since SOC/ROC,** whichever is more recent**?**
	     0. **No** → Skip J1900
	     1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent

J1900.	Number of Falls Since SOC/ROC, whichever is more recent	
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	☐	**A.** **No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B.** **Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C.** **Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Outcome and Assessment Information Set
Items to be Used at Specific Time Points

Time Point	Items Used
Discharge from Agency – Not to an Inpatient Facility	
Discharge from agency -------------------------------------	M0080-M0100, M1041-M1056, M1242-M1311, M1324-M1330, M1334-M1600, M1620, M1700-M1720, M1740-M1870, M2005, M2016-M2020, M2102, M2301-M2420, M0906, GG0130-J1900

CLINICAL RECORD ITEMS

(M0080)	**Discipline of Person Completing Assessment**
Enter Code	1 RN 2 PT 3 SLP/ST 4 OT

(M0090) Date Assessment Completed:

☐☐ / ☐☐ / ☐☐☐☐
month   day   year

(M0100)	**This Assessment is Currently Being Completed for the Following Reason:**
Enter Code	**Start/Resumption of Care** 1 Start of care – further visits planned 3 Resumption of care (after inpatient stay) **Follow-Up** 4 Recertification (follow-up) reassessment **[Go to M0110]** 5 Other follow-up **[Go to M0110]** **Transfer to an Inpatient Facility** 6 Transferred to an inpatient facility – patient not discharged from agency **[Go to M1041]** 7 Transferred to an inpatient facility – patient discharged from agency **[Go to M1041]** **Discharge from Agency – Not to an Inpatient Facility** 8 Death at home **[Go to M2005]** 9 Discharge from agency **[Go to M1041]**

PATIENT HISTORY AND DIAGNOSES

(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

(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.

(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]*

(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

SENSORY STATUS

(M1242)	**Frequency of Pain Interfering** with patient's activity or movement:
Enter Code ☐	0 Patient has no pain 1 Patient has pain that does not interfere with activity or movement 2 Less often than daily 3 Daily, but not constantly 4 All of the time

INTEGUMENTARY STATUS

(M1306)	Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)
Enter Code ☐	0 No *[Go to M1322 at SOC/ROC/FU; Go to M1324 at DC]* 1 Yes
(M1307)	The **Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 pressure ulcers)
Enter Code ☐	1 Was present at the most recent SOC/ROC assessment 2 Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: ☐☐ / ☐☐ / ☐☐☐☐ month day year NA No Stage 2 pressure ulcers are present at discharge

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 – Go to M1311B1, Stage 3]	☐
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	☐
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 – Go to M1311C1, Stage 4]	☐
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	☐
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 – Go to M1311D1, Unstageable: Non-removable dressing/device]	☐
C2. Number of <u>these</u> 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/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** [If 0 – Go to M1311E1, Unstageable: Slough and/or eschar]	☐
D2. Number of <u>these</u> unstageable pressure ulcers/injuries 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 – Go to M1311F1, Unstageable: Deep tissue injury]	☐
E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury** [If 0 – Go to M1324]	☐
F2. Number of these unstageable pressure injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

(M1324)	**Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable:** (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)
Enter Code ☐	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries
(M1330)	Does this patient have a **Stasis Ulcer**?
Enter Code ☐	0 No **[Go to M1340]** 1 Yes, patient has BOTH observable and unobservable stasis ulcers 2 Yes, patient has observable stasis ulcers ONLY 3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) **[Go to M1340]**
(M1334)	**Status of Most Problematic Stasis Ulcer that is Observable:**
Enter Code ☐	1 Fully granulating 2 Early/partial granulation 3 Not healing
(M1340)	Does this patient have a **Surgical Wound**?
Enter Code ☐	0 No **[Go to M1400]** 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device **[Go to M1400]**
(M1342)	**Status of Most Problematic Surgical Wound that is Observable**
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

RESPIRATORY STATUS

(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)

ELIMINATION STATUS

(M1600)	Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?
Enter Code ☐	0 No 1 Yes NA Patient on prophylactic treatment UK Unknown **[*Omit "UK" option on DC*]**
(M1620)	**Bowel Incontinence Frequency:**
Enter Code ☐	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination UK Unknown **[*Omit "UK" option on FU, DC*]**

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M1700)	**Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
Enter Code ☐	0 Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. 1 Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions. 2 Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility. 3 Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time. 4 Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.
(M1710)	**When Confused (Reported or Observed Within the Last 14 Days):**
Enter Code ☐	0 Never 1 In new or complex situations only 2 On awakening or at night only 3 During the day and evening, but not constantly 4 Constantly NA Patient nonresponsive
(M1720)	**When Anxious (Reported or Observed Within the Last 14 Days):**
Enter Code ☐	0 None of the time 1 Less often than daily 2 Daily, but not constantly 3 All of the time NA Patient nonresponsive

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated <u>at least once a week</u> (Reported or Observed): (Mark all that apply.)

- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required

- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions

- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.

- ☐ 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)

- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)

- ☐ 6 - Delusional, hallucinatory, or paranoid behavior

- ☐ 7 - None of the above behaviors demonstrated

(M1745)	**Frequency of Disruptive Behavior Symptoms (Reported or Observed):** Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.
Enter Code ☐	0 Never 1 Less than once a month 2 Once a month 3 Several times each month 4 Several times a week 5 At least daily

ADL/IADLs

(M1800)	**Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code ☐	0 Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1 Grooming utensils must be placed within reach before able to complete grooming activities. 2 Someone must assist the patient to groom self. 3 Patient depends entirely upon someone else for grooming needs.
(M1810)	Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
Enter Code ☐	0 Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1 Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2 Someone must help the patient put on upper body clothing. 3 Patient depends entirely upon another person to dress the upper body.
(M1820)	Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
Enter Code ☐	0 Able to obtain, put on, and remove clothing and shoes without assistance. 1 Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2 Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3 Patient depends entirely upon another person to dress lower body.

ADL/IADLs, continued

(M1830)	**Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**
Enter Code ☐	0 Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower.
	1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
	2 Able to bathe in shower or tub with the intermittent assistance of another person:
	(a) for intermittent supervision or encouragement or reminders, <u>OR</u>
	(b) to get in and out of the shower or tub, <u>OR</u>
	(c) for washing difficult to reach areas.
	3 Able to participate in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision.
	4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
	5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	6 Unable to participate effectively in bathing and is bathed totally by another person.
(M1840)	**Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely <u>and</u> transfer on and off toilet/commode.
Enter Code ☐	0 Able to get to and from the toilet and transfer independently with or without a device.
	1 When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
	2 <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3 <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4 Is totally dependent in toileting.
(M1845)	**Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.
Enter Code ☐	0 Able to manage toileting hygiene and clothing management without assistance.
	1 Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
	2 Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
	3 Patient depends entirely upon another person to maintain toileting hygiene.
(M1850)	**Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.
Enter Code ☐	0 Able to independently transfer.
	1 Able to transfer with minimal human assistance or with use of an assistive device.
	2 Able to bear weight and pivot during the transfer process but unable to transfer self.
	3 Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
	4 Bedfast, unable to transfer but is able to turn and position self in bed.
	5 Bedfast, unable to transfer and is unable to turn and position self.

ADL/IADLs, continued

(M1860)	**Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
Enter Code ☐	0 Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device). 1 With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. 2 Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 3 Able to walk only with the supervision or assistance of another person at all times. 4 Chairfast, <u>unable</u> to ambulate but is able to wheel self independently. 5 Chairfast, unable to ambulate and is <u>unable</u> to wheel self. 6 Bedfast, unable to ambulate or be up in a chair.
(M1870)	**Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of <u>eating</u>, <u>chewing</u>, and <u>swallowing</u>, <u>not preparing</u> the food to be eaten.

Enter Code ☐	0 Able to independently feed self.
	 1 Able to feed self independently but requires:
	      (a) meal set-up; <u>OR</u>
	      (b) intermittent assistance or supervision from another person; <u>OR</u>
	      (c) a liquid, pureed or ground meat diet.
	 2 <u>Unable</u> to feed self and must be assisted or supervised throughout the meal/snack.
	 3 Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy.
	 4 <u>Unable</u> to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
	 5 Unable to take in nutrients orally or by tube feeding.

MEDICATIONS

(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
(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
(M2020)	**Management of Oral Medications:** <u>Patient's current ability</u> to prepare and take <u>all</u> oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **<u>Excludes</u> injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

Enter Code ☐	0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
	 1 Able to take medication(s) at the correct times if:
	      (a) individual dosages are prepared in advance by another person; <u>OR</u>
	      (b) another person develops a drug diary or chart.
	 2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
	 3 <u>Unable</u> to take medication unless administered by another person.
	 NA No oral medications prescribed.

CARE MANAGEMENT

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.
Enter Code ☐	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	c. **Medication administration** (for example, oral, inhaled or injectable) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

EMERGENT CARE

(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]**

(M2310) Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis

☐ 10 - Hypo/Hyperglycemia, diabetes out of control

☐ 19 - Other than above reasons

☐ UK - Reason unknown

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(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.

(M2410)	To which **Inpatient Facility** has the patient been admitted?
Enter Code ☐	1 Hospital 2 Rehabilitation facility 3 Nursing home 4 Hospice NA No inpatient facility admission **[Omit "NA" option on TRN]**
(M2420)	**Discharge Disposition:** Where is the patient after discharge from your agency? **(Choose only one answer.)**
Enter Code ☐	1 Patient remained in the community (without formal assistive services) 2 Patient remained in the community (with formal assistive services) 3 Patient transferred to a non-institutional hospice 4 Unknown because patient moved to a geographic location not served by this agency UK Other unknown

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

☐☐ / ☐☐ / ☐☐☐☐
month   day   year

Section GG	Functional Abilities and Goals

Section GG: Self-Care

GG0130. Self-Care

Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, code the reason.

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.

10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)

88. **Not attempted due to medical conditions or safety concerns**

3. Discharge Performance ↓ Enter Codes ▼ in Boxes		
☐☐	A.	**Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.
☐☐	B.	**Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	C.	**Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	E.	**Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	F.	**Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	G.	**Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	H.	**Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Section GG: Mobility

GG0170. Mobility

Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, code the reason.

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.

Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

3. Discharge Performance		
Enter Codes in Boxes ↓ ▼		
	A.	**Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
	B.	**Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
	C.	**Lying to sitting on side of bed:** The ability to 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.
	D.	**Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
	E.	**Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
	F.	**Toilet transfer:** The ability to get on and off a toilet or commode.
	G.	**Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
	I.	**Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb).*
	J.	**Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
	K.	**Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
	L.	**Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
	M.	**1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*

☐☐	**N.**	**4 steps:** The ability to go up and down four steps with or without a rail. *If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
☐☐	**O.**	**12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	**P.**	**Picking up object**: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
☐	**Q.**	**Does patient use wheelchair and/or scooter?** **0. No →** Skip to J1800 Any falls since SOC/ROC, whichever is more recent. **1. Yes →** Continue to GG0170R, Wheel 50 feet with two turns.
☐☐	**R.**	**Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
☐		**RR3. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**
☐☐	**S.**	**Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
☐		**SS3. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**

Section J: Health Conditions

J1800.	**Any Falls Since SOC/ROC,** whichever is more recent
Enter Code ☐	Has the patient **had any falls since SOC/ROC,** whichever is more recent**?** 0. **No** → Skip J1900 1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent
J1900.	**Number of Falls Since SOC/ROC,** whichever is more recent

CODING:	↓ Enter Codes in Boxes	
0. None 1. One 2. Two or more	☐	**A.** **No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B.** **Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C.** **Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Outcome and Assessment Information Set
Items to be Used at Specific Time Points

Time Point	Items Used
Discharge from Agency – Not to an Inpatient Facility	
Death at home --	M0080-M0100, M2005, M0906, J1800-J1900

CLINICAL RECORD ITEMS

(M0080)	**Discipline of Person Completing Assessment**
Enter Code ☐	1 RN 2 PT 3 SLP/ST 4 OT

(M0090) Date Assessment Completed:

☐☐ / ☐☐ / ☐☐☐☐
month   day   year

(M0100)	**This Assessment is Currently Being Completed for the Following Reason:**
Enter Code ☐	**Start/Resumption of Care** 1 Start of care – further visits planned 3 Resumption of care (after inpatient stay) **Follow-Up** 4 Recertification (follow-up) reassessment **[Go to M0110]** 5 Other follow-up **[Go to M0110]** **Transfer to an Inpatient Facility** 6 Transferred to an inpatient facility – patient not discharged from agency **[Go to M1041]** 7 Transferred to an inpatient facility – patient discharged from agency **[Go to M1041]** **Discharge from Agency – Not to an Inpatient Facility** 8 Death at home **[Go to M2005]** 9 Discharge from agency **[Go to M1041]**

MEDICATIONS

(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

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

☐☐ / ☐☐ / ☐☐☐☐
month   day   year

z

Section J: Health Conditions

J1800.	Any Falls Since SOC/ROC, whichever is more recent

Enter Code
 ☐
	Has the patient **had any falls since SOC/ROC,** whichever is more recent**?**
	     0. **No** → Skip J1900
	     1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent

J1900.	Number of Falls Since SOC/ROC, whichever is more recent	
CODING: 0. None 1. One 2. Two or more	↓ **Enter Codes in Boxes**	
	☐	**A.** **No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B.** **Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C.** **Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

CHAPTER 3   OASIS ITEM GUIDANCE

Chapter 3 contains item-by-item guidance for all OASIS items. For each data item, guidance is provided on the following topics:

- **OASIS ITEM**

- **ITEM INTENT:** Describes the rationale for collecting the information.

- **TIME POINTS COMPLETED:** Describes when the information is to be collected during the patient's home health episode of care.

- **RESPONSE-SPECIFIC INSTRUCTIONS:** Describes how the clinician should decide which of the possible responses apply. These instructions may not always provide definitive guidance for selecting responses in every case, because clinical judgment may be required to determine the most accurate response to a specific item.

- **DATA SOURCES/RESOURCES:** Describes the potential sources of information that may be accessed during the assessment process to determine the most accurate response to this specific item. This may include other clinicians, administrative records, online guidance regarding diagnosis coding or other assessment guidelines, or standards promulgated by professional or accrediting organizations.

Some items have additional guidance in the following categories:

- **CODING INSTRUCTIONS:** The proper method of recording each response, with explanations of individual response categories.

- **CODING TIPS:** Coding tips are clarifications, issues of note, and conditions to be considered when coding each OASIS item.

- **EXAMPLES:** Examples illustrate appropriate coding for several of the OASIS items.

OASIS ITEM

(M0010)   CMS Certification Number: | | | | | | |

ITEM INTENT

- Specifies the agency's Centers for Medicare & Medicaid Services (CMS) certification number (CCN/Medicare provider number).

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet)

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter the agency's CMS certification (Medicare provider) number, if applicable. If agency is not Medicare-certified, leave blank.
- This is NOT the Provider's NPI number.
- Preprinting this number on clinical documentation is allowed and recommended.

DATA SOURCES/RESOURCES

- Agency administrator and billing staff

OASIS ITEM

(M0014)   Branch State: ⬚⬚

ITEM INTENT

- Specifies the State where the agency branch office is located.

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet) and updated if change occurs during the episode

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter the two-letter postal service abbreviation of the State in which the branch office is located. If a branch ID (not N or P) is entered in M0016, then M0014 cannot be blank.
- Preprinting this abbreviation on clinical documentation is allowed and recommended.

DATA SOURCES/RESOURCES

- Agency or branch administrator

OASIS ITEM

(M0016)   Branch ID Number: | | | | | | | | | | |

ITEM INTENT

- Specifies the branch identification code, as assigned by CMS. The identifier consists of 10 digits – the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS-assigned branch number.

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet) and updated if change occurs during the episode

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter the Federal branch identification number specified for this branch as assigned by CMS.
- If you are an HHA with no branches, enter "N" followed by 9 blank boxes.
- If you are a parent HHA that has branches, enter "P" followed by 9 blank boxes.
- Preprinting this number on clinical documentation is allowed and recommended.

DATA SOURCES/RESOURCES

- Agency or branch administrator

OASIS ITEM

(M0018)   National Provider Identifier (NPI) for the attending physician who has signed the plan of care**:**

☐ **UK – Unknown or Not Available**

ITEM INTENT

- Identifies the physician who will sign the Plan of Care.

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet)

RESPONSE-SPECIFIC INSTRUCTIONS

- The NPI is a ten-digit numeric identifier.

DATA SOURCES/RESOURCES

- Agency medical records department
- For more information see the link for NPI registry in Chapter 5 of this manual

OASIS ITEM

(M0020)   Patient ID Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

ITEM INTENT

- Identifies the agency-specific patient identifier. This is the identification code the **agency** assigns to the patient and uses for record keeping purposes for this episode of care. The patient ID number may stay the same from one admission to the next or may change with each subsequent admission, depending on agency policy. However, it should remain constant throughout a single episode of care (for example, from admission to discharge).

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet)

RESPONSE-SPECIFIC INSTRUCTIONS

- If there are fewer digits than boxes provided, leave boxes at the end blank.

DATA SOURCES/RESOURCES

- Agency medical records department

OASIS ITEM

(M0030) Start of Care Date: ☐☐ / ☐☐ / ☐☐☐☐
                                    month   day   year

ITEM INTENT

- Specifies the start of care date, which is the date that the first reimbursable service is delivered.

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet)

RESPONSE-SPECIFIC INSTRUCTIONS

- In multidiscipline cases, coverage criteria, regulatory requirements (such as the Conditions of Participation), and agency policy establish which discipline's visit is considered the start of care. A reimbursable service must be delivered to be considered the start of care. All other coverage criteria must be met for this initial service to be billable and to establish the start of care.
- 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.
- For skilled PT or SLP to perform the start of care visit for a Medicare patient:

    – the HHA is expected to have orders from the patient's physician indicating the need for physical therapy or SLP prior to the initial assessment visit;
    – no orders are present for nursing at the start of care;
    – a reimbursable service must be provided; and
    – the need for this service establishes program eligibility for the Medicare home health benefit.

- Accuracy of this date is essential; many other aspects of data collection are based on this date.
- When the agency's policy/practice is for an RN to perform the SOC assessment in a therapy-only case, the nursing assessment visit must be made the same day or within five days after the therapist's first visit.
- If questions exist as to the start of care date, clarify the exact date with agency administrative personnel.

DATA SOURCES/RESOURCES

- Agency administrative staff

OASIS ITEM

(M0032)   Resumption of Care Date: ☐☐ / ☐☐ / ☐☐☐☐   ☐ **NA – Not Applicable**

month   day   year

ITEM INTENT

- Specifies the date of the first visit following an inpatient stay by a patient receiving service from the home health agency.

TIME POINTS ITEM(S) COMPLETED

- Resumption of Care
- The resumption of care date must be updated on the Patient Tracking Sheet each time a patient returns to service following an inpatient facility stay

RESPONSE-SPECIFIC INSTRUCTIONS

- At start of care, mark "NA."
- The most recent resumption of care date should be entered.
- 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.
- Assessment strategies: If question exists as to the resumption of care date, clarify with the agency administrative staff.

DATA SOURCES/RESOURCES

- Agency administrative staff

OASIS ITEM

(M0040) Patient Name:

(First)   (M I)   (Last)   (Suffix)

ITEM INTENT

- Specifies the full name of the patient: first name, middle initial, last name, and suffix (for example, Jr., III, etc.).

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet) and updated if change occurs during the episode

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter all letters of the first and last names, the middle initial, and the abbreviated suffix. Correct spelling is important.
- If no suffix, leave blank. If middle initial is not known, leave blank.
- The name entered should be exactly as it appears on the patient's Medicare or other insurance card.
- The name entered should be the patient's legal name, even if the patient consistently uses a nickname.
- The sequence of the names may be reordered (that is, last name, first name, etc.) in agency forms, if desired.

DATA SOURCES/RESOURCES

- Patient's Medicare card, private insurance card, HMO identification card, etc.

OASIS ITEM

(M0050)   Patient State of Residence: ☐☐

ITEM INTENT

- Specifies the State in which the patient is currently residing while receiving home care.

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet) and updated if change occurs during the episode

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter the two-letter postal service abbreviation of the State in which the patient is CURRENTLY residing, even if this is not the patient's usual (or legal) residence.

DATA SOURCES/RESOURCES

- Clarify the exact (State) location of the residence with municipal, county, or State officials, if necessary

OASIS ITEM

(M0060) Patient ZIP Code: ⬚⬚⬚⬚⬚ – ⬚⬚⬚⬚

ITEM INTENT

- Specifies the ZIP code for the address at which the patient is currently residing while receiving home care.

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet) and updated if change occurs during the episode

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter the ZIP code for the address of the patient's CURRENT residence, even if this is not the patient's usual (or legal) residence.
- Enter at least five digits (nine digits if known).
- The patient's ZIP code is used for Home Health Compare to determine places where your agency provided service. Be sure to use the ZIP code where the service is provided.

DATA SOURCES/RESOURCES

- Verify the ZIP code with the local post office, if necessary

OASIS ITEM

(M0063) Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐☐   ☐ **NA – No Medicare**

(including suffix)

ITEM INTENT

- For Medicare patients only.
- Specifies the patient's Medicare number, including any prefixes or suffixes.
- Use RRB number for railroad retirement program.

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet) and updated if change occurs during the episode

RESPONSE-SPECIFIC INSTRUCTIONS

- In an effort to fight identity theft for Medicare beneficiaries, CMS is replacing the Social Security number (SSN)-based Health Insurance Claim Number (HICN) with a new Medicare Beneficiary Identifier (MBI).

  - Prior to April 1, 2018: Enter the HICN, identified as the Medicare Claim Number on the patient's Medicare card. (Note: This may or may not be the patient's Social Security number.)
  - April 1, 2018-December 31, 2019: Enter either the patient's HICN, or the patient's new MBI.
  - After December 31, 2019: Enter the MBI. Do not report the patient's SSN-based HICN.

- If the patient does not have Medicare, mark "NA – No Medicare."
- If the patient is a member of a Medicare HMO, another Medicare Advantage plan, or Medicare Part C, enter the Medicare number if available. If not available, mark "NA – No Medicare." Do not enter the HMO identification number.
- Enter Medicare number (if known) whether or not Medicare is the primary payment source for this episode of care.
- If there are fewer digits than boxes provided, leave boxes at the end blank.

DATA SOURCES/RESOURCES

- Patient's Medicare card
- Referral information may include the number, but it should be verified with the patient.

OASIS ITEM

(M0064) Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐ ☐ **UK – Unknown or Not Available**

ITEM INTENT

- Specifies the patient's Social Security number.

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet)

RESPONSE-SPECIFIC INSTRUCTIONS

- Include all nine numbers. Mark "UK" if unknown or not available (for example, information cannot be obtained or patient refuses to provide information).

DATA SOURCES/RESOURCES

- Patient's Social Security card, if available
- Referral information may include the number, but it should be verified with the patient.

OASIS ITEM

(M0065) Medicaid Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐   ☐ **NA – No Medicaid**

ITEM INTENT

- Specifies the patient's Medicaid number.

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet) and updated if change occurs during the episode

RESPONSE-SPECIFIC INSTRUCTIONS

- Include all digits and letters. If patient does not have Medicaid coverage or Medicaid coverage is pending, mark "NA – No Medicaid."
- If the patient has Medicaid, answer this item whether or not Medicaid is the payer source for the home care episode.
- This number is assigned by an individual state and is found on the patient's Medicaid card.

DATA SOURCES/RESOURCES

- Patient's Medicaid card or other verifying documentation. Make sure that the coverage is still in effect, such as checking the expiration date. Depending on specific State regulations or procedures, you may need to verify coverage and effective dates with the social services agency.
- Referral information may include the number, but it should be verified with the patient.

OASIS ITEM

(M0066) Birth Date: ☐☐ / ☐☐ / ☐☐☐☐
                             month   day   year

ITEM INTENT

- Specifies the birth date of the patient, including month, day, and four digits for the year.

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet)

RESPONSE-SPECIFIC INSTRUCTIONS

- 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 or caregiver report
- Other legal documents (for example, driver's license, state-issued ID card, etc.)

OASIS ITEM

(M0069)	Gender
Enter Code ☐	1 Male 2 Female

ITEM INTENT

- Specifies the gender of the patient.

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet)

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter response for patient's gender.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- If the patient does not self-identify, referral information (including hospital or physician office clinical record data); observation
- Physical assessment

OASIS ITEM

(M0140) Race/Ethnicity: (Mark all that apply.)

☐ 1 - American Indian or Alaska Native

☐ 2 - Asian

☐ 3 - Black or African-American

☐ 4 - Hispanic or Latino

☐ 5 - Native Hawaiian or Pacific Islander

☐ 6 - White

ITEM INTENT

- Specifies the racial/ethnic groups or populations with which the patient is affiliated, as identified by the patient or caregiver. Office of Management and Budget (OMB) regulations state that "unknown" is not a permissible response for this item. The major purpose of this item is to track health disparities.

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet) and updated if change occurs during the episode

RESPONSE-SPECIFIC INSTRUCTIONS

- Response 1 – American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Response 2 – Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Response 3 – Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
- Response 4 – Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."
- Response 5 – Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- Response 6 – White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

DATA SOURCES/RESOURCES

- Patient/family interview
- If the patient does not self-identify, referral information (including hospital or physician office clinical record data); observation

OASIS ITEM

(M0150) Current Payment Sources for Home Care: (Mark all that apply.)

- ☐   0   -   None; no charge for current services
- ☐   1   -   Medicare (traditional fee-for-service)
- ☐   2   -   Medicare (HMO/managed care/Advantage plan)
- ☐   3   -   Medicaid (traditional fee-for-service)
- ☐   4   -   Medicaid (HMO/managed care)
- ☐   5   -   Workers' compensation
- ☐   6   -   Title programs (for example, Title III, V, or XX)
- ☐   7   -   Other government (for example, TriCare, VA)
- ☐   8   -   Private insurance
- ☐   9   -   Private HMO/managed care
- ☐ 10   -   Self-pay
- ☐ 11   -   Other (specify) _____
- ☐ UK   -   Unknown

ITEM INTENT

- This item is limited to identifying payers to which any **services** provided during this home care episode and included on the Plan of Care will be billed by **your home health agency.**

TIME POINTS ITEM(S) COMPLETED

- SOC (Patient Tracking Sheet) and updated if change occurs during the episode

RESPONSE-SPECIFIC INSTRUCTIONS

- Exclude "pending" payment sources.
- Accurate recording of this item is important because assessments for Medicare and Medicaid patients are handled differently than assessments for other payers. If the patient's care is being reimbursed by multiple payers (for example, Medicare and Medicaid; private insurance and self-pay; etc.), include all sources. If one or more payment sources are known but additional sources are uncertain, mark those that are known.
- Mark all current pay sources, whether considered primary or secondary.
- Do not consider any equipment, medications, or supplies being paid for by the patient, in part or in full.
- Select Response 2 if the payment source is a Medicare HMO, another Medicare Advantage Plan, or Medicare Part C.
- Select Response 3 if the patient is receiving services provided as part of a Medicaid waiver or home and community-based waiver (HCBS) program.
- Select Response 6 if the patient is receiving services through one of the following programs:

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M0150)

- Title III – State Agency on Aging grants, which encourage State Agencies on Aging to develop and implement comprehensive and coordinated community-based systems of service for older individuals via Statewide planning and area planning. The objective of these services and centers is to maximize the informal support provided to older Americans to enable them to remain in their homes and communities. This program insures that elders receive the services they need to remain independent by providing transportation services, in-home services, and caregiver support services;

- Title V – State programs to maintain and strengthen their leadership in planning, promoting, coordinating and evaluating health care for pregnant women, mothers, infants, and children, and children with special health care needs in providing health services for mothers and children who do not have access to adequate health care;

- Title XX – Social service block grants available to states to provide homemaking, chore service, home management or home health aide services and enable each State to furnish social services best suited to the needs of the individuals residing in the State. Federal block grant funds may be used to provide services directed toward one of the following five goals specified in the law: (1) To prevent, reduce, or eliminate dependency, (2) to achieve or maintain self-sufficiency, (3) to prevent neglect, abuse, or exploitation of children and adults, (4) to prevent or reduce inappropriate institutional care, and (5) to secure admission or referral for institutional care when other forms of care are not appropriate.

- Select Response 7 if the patient is a member of a Tri-Care program, which replaced CHAMPUS.
- Select Response 10 if patient is self-pay for all or part of the care (for example, copayments).

DATA SOURCES/RESOURCES

- Referral information regarding coverage. This can be verified with patient/caregiver.
- Copies of health insurance identification cards. The card(s) will provide the patient ID number as well as current status of coverage.

OASIS ITEM

(M0080)	Discipline of Person Completing Assessment
Enter Code ☐	1 RN 2 PT 3 SLP/ST 4 OT

ITEM INTENT

- Specifies the discipline of the clinician completing the comprehensive assessment during an actual visit to the patient's home at the specified OASIS time point or the clinician reporting the transfer to an inpatient facility or death at home.

TIME POINTS ITEM(S) COMPLETED

- All

RESPONSE-SPECIFIC INSTRUCTIONS

- While only the assessing clinician is responsible for accurately completing and signing a comprehensive assessment, he/she may collaborate to collect data for all OASIS items, if agency policy allows.
- Enter the response associated with the discipline of the individual completing the assessment (referred to as the assessing clinician).
- According to the comprehensive assessment regulation, when both the RN and PT/SLP are ordered on the initial referral, the RN must perform the SOC comprehensive assessment. An RN, PT, SLP, or OT may perform subsequent assessments.
- LPNs, PTAs, COTAs, MSWs, and home health aides do not meet the requirements specified in the comprehensive assessment regulation for disciplines authorized to complete the comprehensive assessment or collect OASIS data.
- When both the RN and qualified therapist are scheduled to conduct discharge visits on the same day, the last qualified clinician to see the patient is responsible for conducting the discharge comprehensive assessment.

DATA SOURCES/RESOURCES

- Agency policy
- Additional information can be found in Chapter 1 of the OASIS Guidance Manual

OASIS ITEM

(M0090) Date Assessment Completed:

		/			/				
month			day			year			

ITEM INTENT

- Specifies the actual date the assessment is completed.

TIME POINTS ITEM(S) COMPLETED

- All

RESPONSE-SPECIFIC INSTRUCTIONS

- 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.
- Date Assessment Completed cannot be before the SOC date.
- If agency policy allows assessments to be performed over more than one visit date, the last date (when the final assessment data are collected) is the appropriate date to record.

  – The M0090 date assessment completed will indicate the last day the clinician gathered or received any input used to complete the comprehensive assessment document, which includes the OASIS items.

- The comprehensive assessment is a legal document and when signed by the assessing clinician, the signature serves as an attestation that to the best of his/her knowledge, the document, including OASIS responses, reflects the patient status as assessed, documented and/or supported in the patient's clinical record.
- Some OASIS elements, for instance the Clinical Records Items (Patient Name, Birth Date, Medicare Number, etc.), may be completed initially by clerical staff as part of the intake/referral process; but should be verified by the assessing clinician when completing the assessment. For OASIS items requiring a patient assessment, the collaborating healthcare providers (e.g., other agency clinical staff: LPN/LVN, PTA, COTA, MSW, HHA) should 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 (health care monitoring devices, video streaming, review of photograph, phone call, etc.).
- When collaboration is utilized, the assessing clinician is responsible for considering available input from these other sources, and selecting the appropriate OASIS item response(s), within the appropriate timeframe and consistent with data collection guidance. M0090 (Date Assessment Completed) will indicate the last day the assessing clinician gathered or receive an input used to complete the comprehensive assessment document, which includes the OASIS items. Any exception to this general convention concerning collaboration is identified in item-specific guidance.
- If the assessing clinician gathers additional information during the assessment time frame that would result in changing the coding of one or more OASIS items (for instance, identifies functional or cognitive information that he/she believes is more representative of the patient's usual status than the code originally selected), the M0090 date would be changed to reflect the date the latest information was gathered and the response change was made.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M0090)

- If an error is identified at any time, it should be corrected following the agency's correction policy and M0090 would not necessarily be changed.
- For the following OASIS time points, Transfer to Inpatient Facility – patient not discharged from agency; Transfer to Inpatient Facility – patient discharged from agency or Death at Home, record the date the agency completes the data collection after learning of the event, as a visit is not necessarily associated with these events.
- See information on M0100 Reason for Assessment for additional clarification.

DATA SOURCES/RESOURCES

- Calendar

OASIS ITEM

(M0100)	This Assessment is Currently Being Completed for the Following Reason:
Enter Code ☐	**Start/Resumption of Care** 1 Start of care – further visits planned 3 Resumption of care (after inpatient stay) **Follow-Up** 4 Recertification (follow-up) reassessment *[Go to M0110]* 5 Other follow-up *[Go to M0110]* **Transfer to an Inpatient Facility** 6 Transferred to an inpatient facility – patient not discharged from agency *[Go to M1041]* 7 Transferred to an inpatient facility – patient discharged from agency *[Go to M1041]* **Discharge from Agency – Not to an Inpatient Facility** 8 Death at home *[Go to M2005]* 9 Discharge from agency *[Go to M1041]*

ITEM INTENT

- Identifies the "time point" – reason why the assessment data are being collected and reported. Accurate recording of this response is important as the logic in the data reporting software will accept or reject certain data according to the specific response that has been entered for this item.

TIME POINTS ITEM(S) COMPLETED

- All

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter only one response.

  - Response 1: This is the start of care comprehensive assessment. A Plan of Care is being established, whether or not further visits will be provided after the start of care visit. This is the appropriate response anytime an initial HIPPS code (for a Home Health Resource Group) is required.
  - Response 3: This comprehensive assessment is conducted when the patient resumes care following an inpatient stay of 24 hours or longer for reasons other than diagnostic tests. Remember to update the Patient Tracking Sheet ROC date (M0032) when this response is entered. When a patient is discharged from an inpatient facility and care is resumed within the last 5 days of the episode (that is, a recertification assessment is due), a ROC assessment, rather than a recertification assessment, is completed.
  - Response 4: This comprehensive follow-up assessment is conducted during the last five days of the 60-day certification period and is completed to continue the patient's services for an additional 60 day episode of care.
  - Response 5: This comprehensive assessment is conducted due to a major decline or improvement in patient's health status occurring at a time other than during the last five days of the episode. This assessment is done to re-evaluate the patient's condition, allowing revision to the patient's care plan as appropriate.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M0100)

   – Response 6: This "Transfer to an Inpatient Facility" OASIS is completed when the home care patient is admitted to an inpatient facility for 24 hours or longer for reasons other than diagnostic tests with the expectation that home health care will be resumed following inpatient discharge; thus the patient is not discharged from the agency. (When the patient resumes care, a Resumption of Care comprehensive assessment is conducted.) This response <u>does not</u> require a home visit; a telephone call may provide the information necessary to complete the required data items. Short stay observation periods in a hospital, regardless of duration, do not meet the definition for transfer to an inpatient facility.

   – Response 7: This "Transfer to an Inpatient Facility" OASIS is only completed when the home care patient is admitted to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests) and the agency does NOT anticipate the patient will be returning to care. The patient is discharged from the agency. This response does NOT require a home visit; a telephone call may provide the information necessary to complete the required data items. No additional OASIS discharge data are required. Short stay observation periods in a hospital, regardless of duration, do not meet the definition for transfer to an inpatient facility.

   – Response 8: Data regarding patient death anywhere other than death in an emergency department or inpatient facility. A patient who dies **before** being treated in an emergency department or before being admitted to an inpatient facility would have this response entered. Note the "skip pattern" included in the response. A home visit is <u>not required</u> to enter this response; the information necessary to complete the data items may be obtained by telephone.

   – Response 9: This comprehensive assessment is conducted when a patient is discharged from the agency for any reason other than transfer to an inpatient facility or death at home. This response includes transfer and **discharge** to another home health agency or an in-home hospice. A patient visit is required to complete this assessment. Note the "skip pattern" present in the response. The Discharge OASIS is not required when only a single visit is made in a care episode (SOC/ROC to TRF/DC).

- Assessment strategies: Why is the assessment being conducted (or the information being recorded)? What has happened to the patient? Accuracy of this response is critical.

DATA SOURCES/RESOURCES

- Agency case manager or other care team provider
- Clinical record
- Hospital or other health care provider information regarding transfer to inpatient facility or death at home

OASIS ITEM

(M0102) **Date of Physician-ordered Start of Care (Resumption of Care):** If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

☐☐ / ☐☐ / ☐☐☐☐   [*Go to M0110, if date entered*]
month   day   year

☐ NA -   No specific SOC date ordered by physician

ITEM INTENT

- Specifies the date that home care services are ordered to begin or to resume following an inpatient stay of 24 hours or longer and for reasons other than diagnostic tests, if a SOC/ROC date was specified by the physician. The item refers to the order to start home care services (that is, provide the first covered service), or resume home care services (that is provide the first visit following a qualifying inpatient stay) regardless of the type of services ordered (for example, therapy only).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- If the originally ordered Start of Care (SOC)/Resumption of Care (ROC) is delayed due to the patient's condition or physician request (for example, extended hospitalization), then the date specified on the updated/revised order to start/resume home care services would be considered the date of physician-ordered SOC/Resumption of Care (ROC). For example, a patient discharged home on May 15 but for whom the physician orders home care to begin May 20 for a specified order (for example, PT or administration of a subcutaneous drug), would have a physician-ordered SOC date of May 20.
- 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.
- Mark "N/A" if the initial orders did not specify a SOC or ROC date.
- In order to be considered a physician-ordered SOC/ROC date, the physician must give a specific date to initiate or resume care, not a range of dates. If a single date to initiate or resume services is not provided, the initial contact (via the initial assessment visit or resumption of care visit) must be conducted within 48 hours of the referral or within 48 hours of the patient's return home from the inpatient facility.

DATA SOURCES/RESOURCES

- Physician orders to initiate home care or resume home care following inpatient facility stay

OASIS ITEM

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

	/		/		
month		day		year	

ITEM INTENT

- Specifies the referral date, which is the most recent date that verbal, written, or electronic authorization to begin or resume home care was received by the home health agency.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- A valid referral is considered to have been received when the agency has received adequate information about a patient (name, address/contact info, and diagnosis and/or general home care needs) and the agency has ensured that the referring physician, or another physician, will provide the plan of care and ongoing orders. In cases where home care is requested by a hospitalist who will not be providing an ongoing plan of care for the patient, the agency must contact an alternate, or attending physician, and upon agreement from this following physician for referral and/or further orders, the agency will note this as the referral date in M0104 (unless referral details are later updated or revised).
- If Start of Care or Resumption of Care is delayed due to the patient's condition or physician request (for example, extended hospitalization), then the date the agency received **updated/revised** referral information for home care services to begin would be considered the date of referral. This does not refer to calls or documentation from others such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission.
- The date authorization was received from the patient's payer is NOT the date of the referral (for example, the date the Medicare Advantage case manager authorized service is not considered a referral date).
- 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

- Agency referral form
- Agency records specifying the date the referral was received by the agency
- Hospital or nursing home discharge information

OASIS ITEM

(M0110)	**Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?
Enter Code ☐	1 Early 2 Later UK Unknown NA Not Applicable: No Medicare case mix group to be defined by this assessment.

ITEM INTENT

- Identifies the placement of the current Medicare PPS payment episode in the patient's current sequence of adjacent Medicare PPS payment episodes.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- A "sequence of adjacent Medicare home health payment episodes" is a continuous series of Medicare PPS payment episodes, regardless of whether the same home health agency provided care for the entire series.

  - Low utilization payment adjustment (LUPA) episodes (less than 5 total visits) are counted.
  - "Adjacent" means that there was no gap between Medicare-covered episodes of more than 60 days.
  - Periods of time when the patient is "outside" a Medicare payment episode but on service with a different payer – such as HMO, Medicaid, or private pay – are counted as *gap* days when counting the sequence of Medicare payment episodes.

- "Early" includes the only PPS episode in a single episode case OR the first or second PPS episode in a sequence of adjacent PPS episodes. **Enter Response 1 – Early – if the episode of care you are assessing the patient for is the patient's first or second episode of care** in a current sequence of adjacent Medicare home health PPS payment episodes.
- "Later" means the third or later PPS episode in a sequence of adjacent episodes. **Enter Response 2 – Later – if this episode is the third or later episode of care** in a current sequence of adjacent Medicare home health PPS payment episodes.
- Enter "UK – Unknown" if the placement of this PPS payment episode in the sequence of adjacent episodes is unknown. For the purposes of assigning a case mix code to the episode, this will have the same effect as entering the "Early" response.
- Enter "NA" if no Medicare case mix group is to be defined for this episode.
- If the patient needs a case mix code for billing purposes (a HIPPS code), a response other than "NA" is required to generate the code. Some payment sources that are not Medicare-fee-for-service payers will use this information in setting an episode payment rate.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M0110)

- Assessment strategies: Consult all available sources of information to answer this item. Medicare systems, such as Health Insurance Query for Home Health (HIQH), can provide this information. If calculating manually, note that the Medicare home health payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date, and that there can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next. Remember that a sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies. Episodes where Medicare fee-for-service is not the payer (such as HMO, Medicaid, or private pay) do NOT count as part of a sequence. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence. Remember that the 60-day gap is counted from the end of the Medicare payment episode, not from the date of the last visit or discharge, which can occur earlier. (If the episode is ended by an intervening event that causes it to be paid as a partial episode payment [PEP] adjustment, then the last visit date is the end of the episode).

DATA SOURCES/RESOURCES

- Medicare systems, such as Health Insurance Query for Home Health (HIQH)

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 <u>at home</u>: **(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 <u>at home</u>, 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.

OASIS ITEM

(M1100)   **Patient Living Situation:** Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)**

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

ITEM INTENT

- This item identifies, using the care provider's professional judgment, a) whether the patient is living alone or with other(s) and b) the availability of caregiver(s) (other than home health agency staff) to provide in-person assistance.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- **To answer this question:**

  - **First, determine living arrangement** – whether the patient normally lives alone, in a home with others, or in a congregate setting.
  - **Second, determine availability of assistance** – how frequently caregiver(s) are in the home and available to provide assistance if needed.
  - **Only one response should be marked.** Select the appropriate row (a, b, or c) to reflect the patient's living situation, then select the one response in the column that best describes the availability of in-person assistance at the time of the OASIS assessment.

- **Living Arrangement**

  - Select a response from **Row a** if the patient lives alone in an independent (non-assisted) setting. For example, the patient lives alone in a home, in their own apartment, or in their own room at a boarding house. A patient with only live-in paid help is considered to be living alone. A patient who normally lives alone but temporarily has a caregiver staying in the home to provide assistance is considered to be living alone. A patient who lives alone but can obtain emergency help by phone or life-line, is still living alone.
  - Select a response from **Row b** if the patient lives with others in an independent (non-assisted) setting. For example, the patient lives with a spouse, family member or another significant other in an independent (non-assisted) setting. A patient who normally lives with others but is occasionally alone because caregiver(s) are traveling out of town is still considered to be living with others.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1100)

- Select a response from **Row c** if the patient lives in an "assisted living" setting (assistance, supervision and/or oversight are provided as part of the living arrangement). For example, the patient lives alone or with a spouse or partner in an apartment or room that is part of an assisted living facility, residential care home, or personal care home.
- If the patient has recently changed their living arrangement due to their condition, report the usual living arrangement prior to the illness, injury or exacerbation for which the patient is receiving care, unless the new living arrangement is expected to be permanent.

- **Availability of Assistance**

  - Identify the frequency with which any in-person assistance is available:

    - **Around the clock** means there is someone available in the home to provide assistance to the patient 24 hours a day.
    - **Regular daytime** means someone is in the home and available to provide assistance during daytime hours every day with infrequent exceptions.
    - **Regular nighttime** means someone is in the home and available to provide assistance during nighttime hours every night with infrequent exceptions.
    - **Occasional/short-term assistance** means someone is available to provide in-person assistance only for a few hours a day or on an irregular basis, or may be only able to help occasionally.
    - **No assistance available** means there is no one available to provide any in-person assistance.

  - Clinical judgment must be used to determine which hours constitute "regular daytime" and "regular nighttime" based on the patient's specific activities and routines. No hours are specifically designated as daytime or nighttime.
  - Availability of assistance refers to in-person assistance provided in the home of the patient. It includes any type of in-person assistance, including but not limited to ADLs and IADLs. If a person is in an assisted living or congregate setting with a call-bell that summons onsite, in-person help, this is considered in-person assistance. If its use is restricted to emergencies only, report the availability as occasional/short-term assistance unless other caregiver's availability meets a higher level.
  - The caregiver(s) need not live in the home with the patient, but assistance via telephone is not included in this question.
  - This item documents the time caregiver(s) are in the home and available without regard to the amount or types of assistance the patient requires, or whether the caregiver(s) are able to meet all or only some of the patient's needs. Adequacy of caregiver assistance for different types of needs is captured in M2102.
  - Use your professional judgment to determine if someone will be available to provide any assistance to the patient. If a person is living in the patient's home but is **completely unable to or unwilling to provide any assistance** to the patient, do not count them as a caregiver.
  - Availability of assistance refers to the expected availability and willingness of caregiver(s) for this upcoming care episode.

- **Examples:**

  - Patient lives alone in her own apartment. Since her discharge from the hospital, her two daughters alternate staying with her during the day and night so that one of them is always there, except for the times when one goes out to run an errand or pick up a child at day care. Response = 01 *(Patient still considered to be living alone, since daughters are only staying there temporarily. Daughters are providing round-the-clock care, even if one occasionally needs to be out of the house for brief periods.)*
  - Patient lives alone in her home but her son and daughter-in-law live across the street. They bring the patient dinner every night and are available around the clock by telephone. Response = 04 (Son and daughter-in-law are not there to provide in-person assistance consistently, day or evening, even if they live across the street and are available by phone.)

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1100)

- Patient lives with her daughter who works during the day but is home every evening and sleeps there every night. A paid aide comes in 3 days a week to assist with ADLs. Daughter has back problems that prevent her from lifting patient, but she assists the patient with dressing every morning and takes the patient to doctor's appointments. Response = 08 *(Patient lives in a home with others who are available every night to offer in-person assistance. Even if the daughter can't meet all of patient's needs, she is available all night.)*
- Patient lives with her husband who has significant cognitive and functional impairments, is wheelchair bound, and is unable to provide the patient with any assistance. A member of the church comes by one evening a week and brings groceries. Response = 09 *(Patient lives in a home with another person who is there 24 hours but is unavailable to provide assistance. Caregiver from church provides occasional assistance.)*
- Patient lives alone in an apartment that is part of an ALF. The apartment does not have a call-bell but her contract with the ALF includes having a home health aide assist her with ADLs 2 hours every morning. Her son also comes over occasionally to assist with bills, groceries, and errands. Response = 14 *(Patient is living in a congregate setting; one caregiver is available to assist for some part of every day on a regular basis, but not all day, another caregiver offers occasional assistance.)*

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Physical assessment
- Observation
- Referral information
- Assisted Living Facility agreement or contract

OASIS ITEM

(M1200)	**Vision** (with corrective lenses if the patient usually wears them):
Enter Code	0 Normal vision: sees adequately in most situations; can see medication labels, newsprint.
	1 Partially impaired: cannot see medication labels or newsprint, but <u>can</u> see obstacles in path, and the surrounding layout; can count fingers at arm's length.
	2 Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.

ITEM INTENT

- Identifies the patient's ability to see and visually manage (function) safely within his/her environment, wearing corrective lenses if these are usually worn.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- Be sensitive to requests to read, as patient may not be able to read though vision is adequate.
- "Nonresponsive" means that the patient is not able to respond.
- As specified within the OASIS question, only assess functional vision with corrective lenses if the patient usually wears corrective lenses.
- A magnifying glass (as might be used to read newsprint) is not an example of corrective lenses.
- Reading glasses (including "grocery store" reading glasses) are considered to be corrective lenses.
- Physical deficits or impairments that limit the patient's ability to use their existing vision in a functional way should be considered. For example, if a physical deficit/impairment (like limited neck range of motion) prevents a patient from seeing objects in his path, affecting safe function in his environment, M1200 should be Response 2 – Severely impaired.
- Assessment strategies: In the health history interview, ask the patient about vision problems (for example, cataracts) and whether or not the patient uses glasses. Observe ability to locate signature line on consent form, to count fingers at arm's length and ability to differentiate between medications, especially if medications are self-administered.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information (for example, history and physical)

OASIS ITEM

(M1242)	**Frequency of Pain Interfering** with patient's activity or movement:
Enter Code	0 Patient has no pain
☐	1 Patient has pain that does not interfere with activity or movement
	2 Less often than daily
	3 Daily, but not constantly
	4 All of the time

ITEM INTENT

- Identifies frequency with which pain interferes with patient's activities, with treatments if prescribed.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Responses are arranged in order of least to most interference with activity or movement.
- Pain interferes with activity when the pain results in the activity being performed less often than otherwise desired, requires the patient to have additional assistance in performing the activity, or causes the activity to take longer to complete. Include all activities (for example, sleeping, recreational activities, watching television), not just ADLs.
- When reviewing patient's medications, the presence of medication for pain or joint disease provides an opportunity to explore the presence of pain, when the pain is the most severe, activities with which the pain interferes, and the frequency of this interference with activity or movement. Be careful not to overlook seemingly unimportant activities (for example, the patient says she/he sits in the chair all day and puts off going to the bathroom, because it hurts so much to get up from the chair or to walk). Evaluating the patient's ability to perform ADLs and IADLs can provide additional information about such pain. Assessing pain in a nonverbal patient involves observation of facial expression (for example, frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual pain scales (for example, FACES). The patient's treatment for pain (whether pharmacologic or nonpharmacologic) must be considered when evaluating whether pain interferes with activity or movement. Pain that is well controlled with treatment may not interfere with activity or movement at all.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Observation of nonverbal indications of pain
- Physical assessment
- Referral information (for example, history and physical)
- Standardized, validated pain assessment tools. Links to these tools can be found in Chapter 5 of this manual

OASIS ITEM

(M1306)	Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)
Enter Code ☐	0 No **[Go to M1322 at SOC/ROC/FU; Go to M1324 at DC]** 1 Yes

ITEM INTENT

- Identifies the presence or absence of Unhealed Stage 2 or higher or Unstageable pressure ulcers/injuries only.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Home health agencies may adopt the NPUAP guidelines in their clinical practice and documentation. However, since CMS has adapted the NPUAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPUAP. When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&A's, providers should rely on the CMS OASIS instructions.
- Pressure ulcers/injuries are defined as localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
- If pressure is not the primary cause of the lesion, do not report the wound as a pressure ulcer/injury.
- Terminology referring to "healed" vs. "unhealed" ulcers can refer to whether the ulcer is "closed" vs. "open". Recognize, however, that Stage 1 pressure injuries and Deep Tissue Injury (DTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers/injuries, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.
- Enter Response 0 (No), if the only pressure ulcer/injury is one or more Stage 1 OR healed pressure ulcers/injuries (of any previous stage) AND the patient has no other pressure ulcers/injuries.
- Enter Response 1 (Yes), if the patient has an unhealed Stage 2, Stage 3, OR Stage 4 pressure ulcer OR if the patient has an Unstageable ulcer/injury, defined as:

  - Pressure ulcers/injuries that are known to be present but that are unobservable due to a dressing/device, such as a cast, that cannot be removed to assess the skin underneath. "Known" refers to when documentation is available that states a pressure ulcer/injury exists under the non-removable dressing/device.
  - Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized in the wound bed, should be classified as unstageable. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized, numerically stage the ulcer, and do not code this as unstageable.
    - Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1306)

- Deep tissue injury which is defined as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones.

- Stage 2 (partial thickness) pressure ulcers heal through the process of regeneration of the epidermis across a wound surface, known as "re-epithelialization."
- Stage 3 and 4 (full thickness) pressure ulcers heal through a process of granulation (filling of the wound with connective/scar tissue), contraction (wound margins contract and pull together), and re-epithelialization (covers with epithelial tissue from within wound bed and/or from wound margins). Once the pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered closed, and will continue to remodel and increase in tensile strength. For the purposes of scoring the OASIS, the wound is considered healed at this point, and should no longer be reported as an unhealed pressure ulcer.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Physician
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1307)	The **Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 pressure ulcers)
Enter Code □	1 Was present at the most recent SOC/ROC assessment 2 Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: ☐☐ ☐☐ ☐☐☐☐ Month day year
	NA No Stage 2 pressure ulcers are present at discharge

ITEM INTENT

- The intent of this item is to a) identify the oldest Stage 2 pressure ulcer that is present at the time of discharge and is not fully epithelialized (healed), b) assess the length of time this ulcer remained unhealed while the patient received care from the home health agency and c) identify patients who develop Stage 2 pressure ulcers while under the care of the agency.

TIME POINTS ITEM(S) COMPLETED

- Discharge from agency – not to inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Clinical standards require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has healed.
- Stage 2 (partial thickness) pressure ulcers heal through the process of regeneration of the epidermis across a wound surface called, "re-epithelialization."
- Enter Response 1 only if the oldest Stage 2 pressure ulcer that is present at discharge was already present as a Stage 2 pressure ulcer at the first skin assessment completed at the SOC/ROC.
- Enter Response 2 if the oldest Stage 2 pressure ulcer that is present at discharge was NOT a Stage 2 pressure ulcer at the first skin assessment completed at the SOC/ROC.
- If Response 2 is entered, specify the date the Stage 2 pressure ulcer was first identified. Use two digits to indicate the month (for example, May is 05), single-digit dates should begin with 0, and use four digits to indicate the year (for example, May 4, 2019 would be 05/04/2019).
- If no pressure ulcer existed at the SOC, then a Stage 1 pressure injury developed, which progressed to a Stage 2 by discharge, enter Response 2, and specify the date that the pressure ulcer was first identified as a Stage 2 ulcer.
- Enter "NA" if the patient has no Stage 2 pressure ulcers at the time of discharge, or all previous Stage 2 pressure ulcers have healed.
- An ulcer that is suspected of being a Stage 2, but is Unstageable due to non-removable dressing/device at the time of discharge, should <u>not</u> be identified as the "oldest Stage 2 pressure ulcer" (See M1311 for definition of Unstageable due to non-removable dressing/device).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Clinical Record
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

SOC/ROC

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or 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/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries 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 **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

Follow-up

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or 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/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries 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 **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

Discharge

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 – Go to M1311B1, Stage 3]	☐
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	☐
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 – Go to M1311C1, Stage 4]	☐
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	☐
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 – Go to M1311D1, Unstageable: Non-removable dressing/device]	☐
C2. Number of <u>these</u> 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/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** [If 0 – Go to M1311E1, Unstageable: Slough and/or eschar]	☐
D2. Number of <u>these</u> unstageable pressure ulcers/injuries 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 – Go to M1311F1, Unstageable: Deep tissue injury]	☐
E2. Number of <u>these</u> 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 **Number of unstageable pressure injuries presenting as deep tissue injury** [If 0 – Go to M1324]	☐
F2. Number of <u>these</u> unstageable pressure injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

ITEM INTENT

- This item identifies the number of pressure ulcers/injuries at each stage (Stage 2, 3, and 4) and designated as Unstageable, that are observed on assessment.
- At discharge, this item also identifies if each pressure ulcer/injury present on the discharge assessment was observed at the same stage at the time of the most recent SOC/ROC.
- Stage 1 pressure injuries and all healed pressure ulcers/injuries are not reported in this item.

TIME POINTS ITEMS COMPLETED

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency – not to inpatient facility

RESPONSE SPECIFIC INSTRUCTIONS

- Terminology referring to "healed" vs. "unhealed" ulcers/injuries can refer to whether the ulcer/injury is "closed" vs. "open". Recognize, however, that Stage 1 pressure injuries and Deep Tissue Injury (DTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers/injuries, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.

Determining "Present at the most recent SOC/ROC" to answer M1311X2

- For each pressure ulcer/injury observed and coded in items M1311A1-F1 on Discharge, determine whether that pressure ulcer/injury was observed at the same stage at the time of the most recent SOC/ROC, and did not form during this home health quality episode.
- If the pressure ulcer/injury was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge assessment, its "Present at the most recent SOC/ROC" stage should be considered the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, do not report the higher stage ulcer as being "present at the most recent SOC/ROC" when completing the Discharge assessment.
- The general standard of practice for patients starting or resuming care is that patient assessments are completed as close to the actual time of the SOC/ROC as possible. For example, if a pressure ulcer/injury that is identified on the SOC date increases in numerical stage within the assessment time frame, the stage of the pressure ulcer/injury at the first skin assessment completed would be reported in M1311X1 at the SOC.
- At SOC/ROC and FU, enter a response for the following rows of this item: A1, B1, C1, D1, E1, F1.

  – Example: At SOC, in B1, enter the number of Stage 3 pressure ulcers that are observed at the first skin assessment completed during the SOC assessment timeframe. Enter 0 if no Stage 3 pressure ulcers are observed.

- At 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.

  – Example: At Discharge, in A1 enter the number of Stage 2 pressure ulcers that are observed at the discharge assessment.
    o If no Stage 2 pressure ulcers are observed, enter 0 in A1 and skip A2.
    o If at least one Stage 2 pressure ulcer is observed, and reported in A1, enter in A2 the number of these Stage 2 pressure ulcers that were observed at the same stage at the most recent SOC/ROC.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1311)

Stage 2 Ulcers

- Report in M1311A1 the number of Stage 2 pressure ulcers that are observed on the current day of assessment.
- Definition: Stage 2 pressure ulcers are characterized by partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister.

- Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to or surrounding the blister demonstrates signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), these characteristics suggest a deep tissue injury (DTI) rather than a Stage 2 pressure ulcer.

Stage 3 and 4 Ulcers

- Definition: Stage 3 pressure ulcers are characterized by 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 or tunneling.
- Definition: Stage 4 pressure ulcers are characterized by 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.
- If any bone, tendon or muscle or joint capsule (Stage 4 structures) is visible, the pressure ulcer should be reported as a Stage 4 pressure ulcer, regardless of the presence or absence of slough and/or eschar in the wound bed.
- A previously closed Stage 3 pressure ulcer that is currently open again should be reported as a Stage 3 pressure ulcer. A previously closed Stage 4 pressure ulcer that is currently open again should be reported as a Stage 4 pressure ulcer.
- If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it challenging to know the highest numerical stage of the wound. The clinician should make every effort to contact previous providers (including patient's physician) to determine the highest numerical stage of the pressure ulcer.
- Any type of flap procedure performed to surgically replace a pressure ulcer is reported as a surgical wound, until healed. It should not be reported as a pressure ulcer/injury on M1311.
- A pressure ulcer treated with any type of graft is no longer reported as a pressure ulcer/injury, and until healed, should be reported as a surgical wound on M1340.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer and should not be reported as a surgical wound on M1340.

Unstageable Ulcers

- Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized in the wound bed, should be classified as unstageable. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized, numerically stage the ulcer, and do not code this as unstageable.

  – Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.

- Any numerically stageable pressure ulcer/injury observed at SOC/ROC that is unstageable due to slough and/or eschar at discharge, should be considered new, and not coded as present at the most recent SOC/ROC for M1311X2.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1311)

- Pressure ulcers/injuries that are known to be present but that are Unstageable due to a non-removable dressing/device, such as a cast that cannot be removed to assess the skin underneath, should be reported in M1311D1, Unstageable. "Known" refers to when documentation is available that states a pressure ulcer/injury exists under the non-removable dressing/device. Examples of a non-removable dressing/device include a dressing that is not to be removed per physician's order (such as those used in negative-pressure wound therapy [NPWT], an orthopedic device, or a cast).
- If an unknown pressure ulcer/injury is discovered upon removal of a non-removable dressing/device, that pressure ulcer/injury should be considered new, and not be coded as present at the most recent SOC/ROC for M1311X2.

> **DEFINITIONS**
>
> **SLOUGH TISSUE**
> Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.
>
> **ESCHAR TISSUE**
> Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

- Response F1 refers to deep tissue injury, which is defined as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. The number of pressure injuries meeting this definition should be counted to determine the response to F1. Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- A deep tissue injury with intact skin at SOC/ROC, that becomes stageable, is considered present at the most recent SOC/ROC at the stage at which it first becomes numerically stageable.

EXAMPLES – Identify "Present at the most recent SOC/ROC" to answer M1311 at Discharge

1. **Deep Tissue Injury (DTI) with intact skin at a SOC assessment becomes numerically stageable**

The RN assesses Mr. J's skin at the SOC and identifies a DTI with intact skin on his left heel. This DTI remains unchanged until the RN skin assessment 10 days later, which reveals open skin presenting as a Stage 3 pressure ulcer. The pressure ulcer does not change for the remainder of the episode. At the discharge (DC) skin assessment, the ulcer remains a Stage 3. (In this example, there are no other pressure ulcers/injuries at the SOC assessment, during the episode or at DC).

> **Coding:** On the DC assessment, M1311B1, Number of Stage 3 pressure ulcers, would be coded "1". M1311B2, Number of these Stage 3 pressure ulcers that were present at the most recent SOC/ROC would be coded "1". M1311F1, Number of unstageable pressure injuries presenting as DTI, would be coded "0". (Skip M1311F2).
>
> **Rationale**: At the DC assessment, Mr. J had one Stage 3 pressure ulcer, and zero unstageable pressure injuries presenting as DTI. The Stage 3 pressure ulcer observed on the DC skin assessment is reported "present at the most recent SOC/ROC" because that is the stage at which the DTI observed at the SOC assessment first became numerically stageable.

2. **Deep tissue injury (DTI) with intact skin at SOC, becomes numerically stageable and increases in numerical stage by discharge (DC)**

The RN completes a skin assessment during the SOC visit for Mrs. K, and identifies a right hip DTI with intact skin. This DTI is first numerically stageable 10 days later as a Stage 3 pressure ulcer and increases in numerical stage five days after that, to a Stage 4 pressure ulcer. The pressure ulcer remains a Stage 4 at DC.

> **Coding:** On the DC assessment M1311C1, Number of Stage 4 pressure ulcers, would be coded "1". M1311C2, Number of these Stage 4 pressure ulcers that were present at the most recent SOC/ROC, would be coded "0". M1311F1, unstageable pressure injuries presenting as DTI, would be coded "0". (Skip M1311F2).

Rationale: The DTI with intact skin observed on the SOC skin assessment first became numerically stageable as a Stage 3. Because the Stage 3 pressure ulcer increased in numerical stage to a Stage 4 by the DC assessment, the Stage 4 pressure ulcer at DC is considered new, and not coded as present at the most recent SOC/ROC.

3. **Deep Tissue Injury (DTI) with intact skin at SOC, becomes numerically stageable, then is unstageable due to slough and/or eschar at DC**

The RN assesses Mr. L's skin during the assessment timeframe for the SOC, and identifies a DTI with intact skin on his right heel. This DTI first becomes numerically stageable at the third home visit, as a Stage 3 pressure ulcer. At the DC skin assessment, this pressure ulcer is unstageable due to slough and eschar.

Coding: On the DC assessment, M1311E1, number of unstageable pressure ulcers due to slough and/or eschar, would be coded "1". M1311E2, number of these unstageable pressure ulcers that were present at the most recent SOC/ROC, would be coded "0". M1311F1, unstageable pressure injuries presenting as DTI, would be coded "0". (Skip M1311F2).

Rationale: The DTI with intact skin observed on the SOC skin assessment first became stageable as a Stage 3 pressure ulcer. This ulcer did not remain a Stage 3, however. At the DC skin assessment the ulcer was observed to be unstageable due to slough and eschar. Any pressure ulcer/injury that is observed to be unstageable due to slough and/or eschar, but was previously numerically stageable, is considered new, and not coded as present at the most recent SOC/ROC.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Clinical record
- Referral documentation
- Physician
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1322)	**Current Number of Stage 1 Pressure Injuries:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
Enter Code ☐	0 1 2 3 4 or more

ITEM INTENT

- Identifies the presence and number of Stage 1 pressure injuries.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- NPUAP defines a Stage 1 pressure injury as follows: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Stage 1 injuries may be difficult to detect in individuals with dark skin tones and may indicate "at risk" persons (a heralding sign of risk)."
- Recognize that although Stage 1 pressure injuries are closed (intact skin), they would not be considered healed.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1324)	**Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable:** (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)
Enter Code ☐	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries

ITEM INTENT

- Identifies the stage of the most problematic stageable pressure ulcer/injury.
- Please note; pressure ulcers/injuries that have healed are not considered for this item.

TIME POINTS ITEM(S) COMPLETED

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Terminology referring to "healed" vs. "unhealed" ulcers can refer to whether the ulcer is "closed" vs. "open". Recognize, however, that Stage 1 pressure injuries and Deep Tissue Injury (DTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers/injuries, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.
- Determine which pressure ulcer(s)/injur(ies) are stageable or Unstageable. A pressure ulcer/injury is considered Unstageable if:

    – it is covered with a non-removable dressing/device, such as a cast, that cannot be removed.
    – it presents as a deep tissue injury, or
    – the wound bed is obscured by some degree of necrotic tissue AND no bone, muscle, tendon, or joint capsule (Stage 4 structures) are visible. Note that if a Stage 4 structure is visible, the pressure ulcer is reportable as a Stage 4 even if slough or eschar is present.

- Determine which stageable pressure ulcer is the most problematic.

    – "Most problematic" may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.
    – If the patient has only one stageable pressure ulcer, then that ulcer is the most problematic.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1324)

- Enter the response that most accurately describes the stage of the most problematic stageable pressure ulcer/injury using the definitions of Stage in M1311. Enter "NA" if the patient has NO pressure ulcers or only has pressure ulcers that are Unstageable as defined above.

  - Do not reverse stage pressure ulcers as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Unless it becomes unstageable, clinical standards require that a Stage 4 pressure ulcer continue to be documented as a Stage 4 pressure ulcer until it has healed.
  - If a pressure ulcer is Stage 4 at SOC and is granulating at the Follow-up Assessment, the ulcer remains a Stage 4 ulcer.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral documentation
- Review of health history
- Physician
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1330)	Does this patient have a **Stasis Ulcer**?
Enter Code ☐	0 No **[Go to M1340]**
	1 Yes, patient has BOTH observable and unobservable stasis ulcers
	2 Yes, patient has observable stasis ulcers ONLY
	3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) **[Go to M1340]**

ITEM INTENT

- Identifies patients with ulcers caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis.
- Stasis ulcers DO NOT include arterial lesions or arterial ulcers.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- A response of "Yes" identifies the presence of an ulcer caused by inadequate venous circulation in the area affected (usually lower legs).
- It is important to differentiate stasis ulcers from other types of skin lesions, and only report stasis ulcers in this item.
- Once a stasis ulcer has completely epithelialized, it is considered healed and should not be reported as a current stasis ulcer.
- Enter Response 1 if the patient has both an observable stasis ulcer AND a reported stasis ulcer that cannot be observed because of a dressing or device, such as a cast or Unna boot) that cannot be removed. Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.
- Enter Response 3 ONLY if the patient has a reported stasis ulcer that cannot be observed because of a dressing or device, such as a cast or Unna boot that cannot be removed, and has no observable stasis ulcers. Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Physician's orders
- Referral information
- Review of health history
- Observation
- Physical assessment
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1332)	Current Number of Stasis Ulcer(s) that are Observable:
Enter Code ☐	1 One 2 Two 3 Three 4 Four or more

ITEM INTENT

- Identifies the number of visible (observable) stasis ulcers.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- All stasis ulcers except those that are covered by a non-removable dressing/device, such as a cast or Unna boot, are considered observable.

DATA SOURCES / RESOURCES

- Observation
- Physical Assessment
- Review of health history
- Physician
- Referral information
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1334)	Status of Most Problematic Stasis Ulcer that is Observable:
Enter Code ☐	1 Fully granulating 2 Early/partial granulation 3 Not healing

ITEM INTENT

- Identifies the degree of healing present in the most problematic, observable stasis ulcer. The "most problematic" ulcer may be the largest, the most resistant to treatment, an ulcer that is infected, etc., depending on the specific situation.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Determine which stasis ulcers are observable. Includes all stasis ulcers that are not covered with a non-removable dressing/device, such as a cast or Unna boot.
- Determine which observable stasis ulcer is the most problematic.

  - "Most problematic" may be based on healing status, size, difficulty in accessing for treatment, etc., depending on clinical judgment and the specific situation.
  - If the patient has only one observable stasis ulcer, that ulcer is the most problematic.

- Determine status of the most problematic stasis ulcer that is observable using healing status definitions developed by the Wound Ostomy and Continence Nurses (WOCN) Society:

  - Response 1 – Fully Granulating: Enter Response 1 when a stasis ulcer has a wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open.
  - Response 2 – Early/Partial Granulation: Enter Response 2 when ≥ 25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (that is, <25% of the wound bed is covered with avascular tissue); may have dead space; no signs or symptoms of infection; wound edges open.
  - Response 3 – Not Healing: Enter Response 3 when wound has ≥25% avascular tissue OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

- Once a stasis ulcer has completely epithelialized and is without signs/symptoms of infection, it is considered healed and should not be reported as a current stasis ulcer.

DATA SOURCES / RESOURCES

- Observation
- Physical Assessment
- Review of health history
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(M1340)	Does this patient have a **Surgical Wound?**
Enter Code	0 No **[Go to M1400]**
☐	1 Yes, patient has at least one observable surgical wound
	2 Surgical wound known but not observable due to non-removable dressing/device **[Go to M1400]**

ITEM INTENT

- Identifies the presence of a wound resulting from a surgical procedure.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Old surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds and should not be included in this item.
- If the patient has both an observable and an unobservable wound, the best response is 1 – Yes, patient has at least one observable surgical wound.
- Enter Response 2 if the only surgical wound(s) is/are not observable. A wound is considered not observable if it is covered by a dressing/device, such as a cast, which is not to be removed per physician order.
- For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection. After 30 days, it is generally described as a scar and should not be included in this item. The incision line would be considered the surgical wound. The staple or suture sites are not considered as surgical wounds for M1340.
- If a pressure ulcer is surgically closed with a flap or graft it is no longer reported as a pressure ulcer. It should be reported as a surgical wound until healed. If the flap or graft fails, it should continue to be considered a surgical wound until healed.
- A bowel ostomy is excluded as a surgical wound, unless a "take-down" procedure of a previous bowel ostomy is performed, in which case the surgical take-down produces a surgical wound. A bowel ostomy being allowed to close on its own is excluded as a surgical wound.
- All other ostomies are excluded from consideration under this item and should not be counted as surgical wounds. There are many types of "ostomies," all of which involve a surgically formed opening from outside the body to an internal organ or cavity. Examples include cystostomy, urostomy, thoracostomy, tracheostomy, gastrostomy, etc.
- Orthopedic pin sites, central line sites (centrally-inserted venous catheters), stapled or sutured incisions, and wounds with drains are all considered surgical wounds. Medi-port sites and other implanted infusion devices or venous access devices are considered surgical wounds.
- A PICC line (peripherally-inserted venous catheter), either tunneled or non-tunneled, is NOT a surgical wound, when it is peripherally inserted.
- Cataract surgery of the eye, surgery to the mucosal membranes, or a gynecological surgical procedure via a vaginal approach does not create a surgical wound for the purpose of this item.
- For additional guidance on questions related to surgical wounds, please see Q & As for M1340.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Observation.
- Physical Assessment.
- Referral documentation.
- Review of health history.
- Physician.
- CMS OASIS Q & As can be accessed through the CMS OASIS web page.
- See references/resources in Chapter 5 of the OASIS Guidance Manual.

OASIS ITEM

(M1342)	Status of Most Problematic Surgical Wound that is Observable
Enter Code ⬜	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing

ITEM INTENT

- Identifies the degree of healing present in the most problematic, observable surgical wound.

TIME POINTS ITEM(S) COMPLETED

- Start of Care
- Resumption of Care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Determine which surgical wounds are observable.

  - Includes all surgical wounds (as defined in M1340 guidance) that are not covered with a non-removable dressing/device, such as a cast.
  - For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection. After 30 days, it is generally described as a scar and no longer a surgical wound.
  - Openings in the skin adjacent to the incision line caused by the removal of staples or sutures are not to be considered as part of the surgical wound for M1342.

- Identify the most problematic observable surgical wound.

  - The "most problematic" surgical wound may be the largest, the most resistant to treatment, an infected surgical wound, etc., depending on clinical judgment and the specific situation.
  - If the patient has only one observable surgical wound, that wound is the most problematic.

- Determine status of the most problematic surgical wound using healing status definitions developed by the Wound Ostomy and Continence Nurses (WOCN) Society. The clinician must first assess if the wound is healing entirely by primary intention (well-approximated with no dehiscence), or if there is a portion healing by secondary intention, (due to dehiscence, interruption of the incision, or intentional secondary healing).

  - Surgical wounds healing by primary intention (approximated incisions) do not granulate, therefore the only appropriate responses would be Response 0 – "Newly epithelialized" or Response 3 – "Not healing". If the wound is healing solely by primary intention, observe if the incision line has re-epithelialized. Epithelialization is regeneration of the epidermis across a wound surface. (If there is no interruption in the healing process, this generally takes within a matter of hours to three days post-operatively.) If there is not full epithelial resurfacing such as in the case of a scab adhering to underlying tissue, the correct response would be "Not healing" for the wound healing exclusively by primary intention. A surgical incision would not automatically be considered 3 – Not healing solely due to the presence of staples.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1342)

– Secondary Intention: If it is determined that there is incisional separation, healing will be by secondary intention. Surgical incisions healing by secondary intention do granulate, therefore may be reported as "Not healing," "Early/partial granulation," "Fully granulating," and eventually "Newly epithelialized."

– Response "0 – Newly epithelialized": Enter Response 0 when the wound bed has completely covered with new epithelium; no exudate; no avascular tissue (eschar and/or slough); no signs or symptoms or infection. Epithelialization is characterized by "Epidermal resurfacing" and means the opening created during the surgery is covered by epithelial cells. If epidermal resurfacing has occurred completely, the correct response in the OASIS would be "Newly epithelialized" until approximately 30 days of complete epidermal resurfacing have passed without complication, at which time it is no longer a reportable surgical wound.

– Enter Response 0 – Newly epithelialized for implanted venous access devices and infusion devices when the insertion site is healed and without signs and symptoms of infection.

– Response 1 – Fully granulating: Enter Response 1 when a surgical wound has a wound bed filled with granulation tissue to the level of the surrounding skin; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open.

– Response 2 – Early/partial granulation: Enter Response 2 when ≥25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (that is, <25% of the wound bed is covered with avascular tissue); no signs or symptoms of infection; wound edges open.

– Response 3 – Not healing: Enter Response 3 when wound has ≥25% avascular tissue OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- CMS OASIS Q & As can be accessed through the CMS OASIS web page
- See references/resources in Chapter 5 of the OASIS Guidance Manual

OASIS ITEM

(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)

ITEM INTENT

- Identifies the level of exertion/activity that results in a patient's dyspnea or shortness of breath.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- If the patient uses oxygen continuously, enter the response based on assessment of the patient's shortness of breath while using oxygen. If the patient uses oxygen intermittently, enter the response based on the patient's shortness of breath WITHOUT the use of oxygen.

  – Responses are based on the patient's actual use of oxygen in the home, not on the physician's oxygen order.

- The responses represent increasing severity of shortness of breath.
- For a chairfast or bedbound patient, evaluate the level of exertion required to produce shortness of breath. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest.

  – Response 0 would apply if the patient has not been short of breath during the day of assessment.
  – Response 1 would be appropriate if demanding bed-mobility activities produce dyspnea in the bedbound patient (or physically demanding transfer activities produce dyspnea in the chairfast patient).
  – See Responses 2, 3, and 4 for assessment examples for these patients as well as ambulatory patients.

DATA SOURCES/RESOURCES

- Observation
- Physical assessment
- Patient/caregiver interview
- Review of health history

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OASIS ITEM

(M1600)	Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?
Enter Code ☐	0 No 1 Yes NA Patient on prophylactic treatment UK Unknown **[*Omit "UK" option on DC*]**

ITEM INTENT

- Identifies treatment of urinary tract infection during the past 14 days.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- The term "past 14 days" is the two-week period immediately preceding the Start/Resumption of Care date (or for Discharge, the M0090 Date Assessment Completed). 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 treatment for a UTI occurring on or after August 6 would be considered.
- Unknown is not an option at Discharge from Agency.
- Enter Response 0 – No, if patient has not been treated for a UTI within the past two weeks, including if the patient had symptoms of a UTI or a positive culture for which the physician did not prescribe treatment, or the treatment ended more than 14 days ago.
- Enter Response 1 – Yes, when the patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed or suspected UTI.
- Enter Response 1 – Yes, if the patient is on prophylactic treatment and develops a UTI.
- Enter "NA" – if the patient is on prophylactic treatment to prevent UTIs.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Physician orders
- Review of health history
- Referral information
- Physician
- Medication list

OASIS ITEM

(M1610)	Urinary Incontinence or Urinary Catheter Presence:
Enter Code ☐	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic)

ITEM INTENT

- Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling. The etiology (cause) of incontinence is not addressed in this item.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter Response 0 if the patient has anuria or an ostomy for urinary drainage (for example: an ileal conduit), or if the patient has a urinary diversion that is pouched (ileal conduit, urostomy, ureterostomy, nephrostomy), with or without a stoma.
- Enter Response 1 if the patient is incontinent at any time (including "occasionally," "only when I sneeze," "sometimes I leak a little bit," etc.).
- Enter Response 1 if the patient is incontinent or is dependent on a timed-voiding program. Timed voiding is defined as scheduled toileting assistance or prompted voiding to manage incontinence based on identified patterns. Time voiding is a compensatory strategy; it does not cure incontinence.
- Enter Response 2 if a catheter or tube is utilized for drainage (even if catheterizations are intermittent).
- Enter Response 2 if the patient requires the use of a catheter for urinary drainage for any reason (for example: retention, post-surgery, incontinence). Enter Response 2 and follow the skip pattern if the patient is both incontinent and requires a urinary catheter.
- Enter Response 2 if a catheter was inserted during the comprehensive assessment.
- A leaking urinary drainage appliance is not incontinence.
- A catheter solely utilized for irrigation of the bladder or installation with an antibiotic is not reported in this item.
- If a catheter was discontinued during the comprehensive assessment or if a catheter is both inserted and discontinued during the comprehensive assessment, Response 0 or 1 would be appropriate, depending on whether or not the patient is continent.
- Assessment strategies: Review the urinary elimination pattern as you take the health history. Does the patient admit having difficulty controlling the urine, or is he/she embarrassed about needing to wear a pad so as not to wet on clothing? Do you have orders to change a catheter? Is your stroke patient using an external catheter? Be alert for an odor of urine, which might indicate there is a problem with bladder sphincter control. If the patient receives aide services for bathing and/or dressing, ask for input from the aide (at follow-up assessment). This information can then be discussed with the patient. Urinary incontinence may result from multiple causes, including physiologic reasons, cognitive impairments, or mobility problems.

DATA SOURCES/RESOURCES

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

OASIS ITEM

(M1620)	Bowel Incontinence Frequency:
Enter Code ☐	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination UK Unknown **[*Omit "UK" option on FU, DC*]**

ITEM INTENT

- Identifies how often the patient experiences bowel incontinence. Refers to the frequency of a symptom (bowel incontinence), not to the etiology (cause) of that symptom. This item does not address treatment of incontinence or constipation (for example: a bowel program).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Responses are arranged in order of least to most frequency of bowel incontinence.
- Response 4 – On a daily basis – indicates that the patient experiences bowel incontinence once per day.
- Enter "NA" if patient has an ostomy for bowel elimination.
- Unknown is not an option at follow-up or discharge.
- Assessment strategies: Review the bowel elimination pattern as you take the health history. Observe the cleanliness around the toilet when you are in the bathroom. Note any visible evidence of soiled clothing. Ask the patient if she/he has difficulty controlling stools, has problems with soiling clothing, uncontrollable diarrhea, etc. The patient's responses to these items may make you aware of an as yet unidentified problem that needs further investigation. If the patient is receiving aide services, question the aide about evidence of bowel incontinence at follow-up time points. This information can then be discussed with the patient. Incontinence may result from multiple causes, including physiologic reasons, mobility problems, or cognitive impairments.

DATA SOURCES/RESOURCES

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

OASIS ITEM

(M1630)	**Ostomy for Bowel Elimination:** Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; <u>or</u> b) necessitated a change in medical or treatment regimen?
Enter Code ☐	0 Patient does <u>not</u> have an ostomy for bowel elimination. 1 Patient's ostomy was <u>not</u> related to an inpatient stay and did <u>not</u> necessitate change in medical or treatment regimen. 2 The ostomy <u>was</u> related to an inpatient stay or <u>did</u> necessitate change in medical or treatment regimen.

ITEM INTENT

- Identifies whether the patient has an ostomy for bowel elimination and, if so, whether the ostomy was related to a recent inpatient stay or caused a change in medical treatment plan.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- Applies to any type of ostomy for bowel elimination (for example: colostomy, ileostomy). This item only addresses bowel ostomies, not other types of ostomies (for example: urinary ostomies, tracheostomies).
- If an ostomy has been reversed, then the patient does not have an ostomy at the time of assessment.
- If patient does not have an ostomy for bowel elimination, enter Response 0 – Patient does not have an ostomy for bowel elimination.
- If the patient does have an ostomy for bowel elimination, determine whether the ostomy was related to an inpatient stay or necessitated a change in the medical or treatment regimen within the last 14 days.
- The term "past fourteen days" is the two-week period immediately preceding the Start/Resumption of Care or Follow-Up assessment. 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 ostomy related to an inpatient stay or requiring medical or treatment regimen change that occurred on or after August 6 would be considered.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Physician orders
- Review of health history
- Referral information
- Physician
- Supplies list

OASIS ITEM

(M1700)	**Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
Enter Code ☐	0 Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
	1 Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
	2 Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
	3 Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
	4 Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

ITEM INTENT

- Identifies the patient's current (at the time of the assessment and in the preceding 24 hours) level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Responses progress from no impairment to severely impaired. Consider the degree of impairment.
- Consider the patient's signs/symptoms of cognitive dysfunction that have occurred over the past 24 hours.
- Consider the amount of supervision and care the patient has required due to cognitive deficits.
- Patients with diagnoses such as dementia, delirium, development delay disorders, mental retardation, etc., will have various degrees of cognitive dysfunction.
- Patients with neurological deficits related to stroke, mood/anxiety disorders, or who receive opioid therapy may have cognitive deficits.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Links to cognitive assessment tools can be found in Chapter 5 of this manual
- Review of past health history
- Physician

OASIS ITEM

(M1710)	When Confused (Reported or Observed Within the Last 14 Days):
Enter Code ☐	0 Never 1 In new or complex situations only 2 On awakening or at night only 3 During the day and evening, but not constantly 4 Constantly
	NA Patient nonresponsive

ITEM INTENT

- Identifies the time of day or situations when the patient experienced confusion, if at all.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- This item may not relate directly to Item M1700. Assess specifically for confusion in the past 14 days.
- The term "past 14 days" is the two-week period immediately preceding the Start/Resumption of Care date (or for Discharge, the M0090 Date Assessment Completed). 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 confusion occurring on or after August 6 would be considered.
- Enter Response 0 if the patient had no confusion in the last 14 days. Enter Response 1, 2, 3, or 4 if the patient has experienced confusion and each response represents a worsening of confusion frequency. Response 1 is entered when the patient's confusion is isolated to a new or a complex situation; for example, the patient became confused when a new caregiver was introduced or when a procedure was performed the first time. Response 2, 3, or 4 is entered when confusion occurs without the stimulus of a new or complex situation, or when confusion that initially presented with a new or complex situation persists days after the new or complex situation becomes more routine. Responses 2, 3 and 4 differ from each other based on the time when the confusion occurred. Enter Response 2 if the confusion only occurred when the patient was awakening from a sleep or during the night. Enter Response 3 if the confusion occurs during the day and evening, but is not constant. If confusion was not constant, but occurred more often than just upon awakening or at night, enter Response 3.
- "Nonresponsive" means that the patient is unable to respond or the patient responds in a way that you cannot make a clinical judgment about the patient's level of orientation. If the patient is nonresponsive at the time of assessment, report whether the patient experienced any confusion during the past 14 days if this information can be elicited from the caregiver or other source. If the patient is nonresponsive at the time of assessment and the information cannot be elicited from the caregiver or other source, enter "NA – Patient nonresponsive."

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Review of recent (past 14 days) health history
- Physician
- Links to a resource for patients with Alzheimer's disease or dementia can be found in Chapter 5 of this manual

OASIS ITEM

(M1720)	When Anxious (Reported or Observed Within the Last 14 Days):
Enter Code ☐	0 None of the time 1 Less often than daily 2 Daily, but not constantly 3 All of the time NA Patient nonresponsive

ITEM INTENT

- Identifies the frequency with which the patient has felt anxious within the past 14 days.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Anxiety includes:

  - Worry that interferes with learning and normal activities,
  - Feelings of being overwhelmed and having difficulty coping, or
  - Symptoms of anxiety disorders.

- Responses appear in order of increasing frequency of anxiety.
- "Nonresponsive" means that the patient is unable to respond or the patient responds in a way that you can't make a clinical judgment about the patient's level of anxiety. If the patient is nonresponsive at the time of assessment, report whether the patient experienced any anxiety during the past 14 days if this information can be elicited from the caregiver or other source. If the patient is nonresponsive at the time of assessment and the information cannot be elicited from the caregiver or other source, enter "NA – Patient nonresponsive."
- The term "past 14 days" is the two-week period immediately preceding the Start/Resumption of Care date (or for Discharge, the M0090 Date Assessment Completed). 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 anxiety occurring on or after August 6 would be considered. If nonresponsive on the day of assessment, report whether patient experienced anxiety during the past 14 days.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Review of recent (past 14 days) health history
- Physician
- Links to standardized anxiety screening tools can be found in Chapter 5 of this manual

OASIS ITEM

(M1730)	**Depression Screening:** Has the patient been screened for depression, using a standardized, validated depression screening tool?
Enter Code ☐	0 No 1 Yes, patient was screened using the PHQ-2©* scale. Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2©*	Not at all 0-1 day	Several days 2-6 days	More than half of the days 7-11 days	Nearly every day 12-14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA
b) Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3	☐ NA

2   Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.

3   Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

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ITEM INTENT

- Identifies if the home health agency screened the patient for depression using a standardized, validated depression-screening tool.
- CMS does not mandate that clinicians conduct depression screening for all patients, nor is there a mandate for the use of the PHQ-2© or any other particular standardized, validated tool. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- Depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or others as allowed by the standardized, validated tool's administration instructions.
- To meet the definition of "standardized, validated," the depression screening tool must 1) have been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, noninstitutionalized adults with disabilities, etc.) and 2) include a standard response scale.

  - The standardized, validated tool must be both appropriate for the patient based on their cognitive and communication deficits and appropriately administered per the tool's instructions.
  - If a standardized, validated depression-screening tool is used, use the scoring parameters specified for the tool to identify if a patient meets criteria for further evaluation of depression.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1730)

- – In order to enter Response 1, 2 or 3, the standardized, validated depression screening must be completed during the time frame specified by CMS for completion of the assessment (specifically, within five days of SOC or within two days of inpatient facility discharge at ROC, or on the physician-ordered ROC date.
- – A clinician other than the assessing clinician may complete the standardized, validated depression screening for consideration by the assessing clinician.

- Enter Response 0 if a standardized, validated depression screening was not conducted.

  - – If the clinician chooses not to assess the patient (because there is no appropriate depression screening tool available or for any other reason), Response 0 – No should be entered.

- Enter Response 1 if the PHQ-2© is completed, and select the appropriate responses in rows a and b. Please note that the PHQ-2© instructions indicate that the patient is interviewed, not family or others. If the patient scores three points or more on the PHQ-2©, then further depression screening is indicated.

  - – If the PHQ-2© is not used to assess the patient, you may choose to administer a different standardized, validated depression screening tool with instructions that may allow for information to be gathered by observation and caregiver interview as well as self-report. In this case, the clinician would enter Response 2 or 3 for M1730, depending on the outcome of the assessment.

- Enter Response 2 if the patient is screened with a different standardized, validated assessment AND the tool indicated the need for further evaluation.
- Enter Response 3 if the patient is screened with a different standardized, validated assessment BUT the tool indicates no need for further evaluation.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Physician
- A link with more information on the PHQ–2© can be found in Chapter 5 of this manual
- There are many depression screening tools available. Links to several tools can be found in Chapter 5 of this manual.

OASIS ITEM

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated <u>at least once a week</u> **(Reported or Observed): (Mark all that apply.)**

☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required

☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions

☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.

☐ 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)

☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)

☐ 6 - Delusional, hallucinatory, or paranoid behavior

☐ 7 - None of the above behaviors demonstrated

ITEM INTENT

- Identifies specific behaviors associated with significant neurological, developmental, behavioral, or psychiatric disorders.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Behaviors may be observed by the clinician or reported by the patient, family, or others.
- Behaviors reported could be identified by a formal diagnosis and/or determined by the assessing clinician to be associated with a significant neurological, developmental, behavioral and/or psychiatric disorder.
- Include behaviors which are severe enough to:

  - make the patient unsafe to self or others,
  - cause considerable stress to the caregivers, or
  - require supervision or intervention.

- If Response 7 is selected, none of the other responses should be selected.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Physician
- Links to standardized cognitive screening tools can be found in Chapter 5 of this manual

OASIS ITEM

(M1745)	**Frequency of Disruptive Behavior Symptoms (Reported or Observed):** Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.		
Enter Code	0	Never	
	1	Less than once a month	
	2	Once a month	
	3	Several times each month	
	4	Several times a week	
	5	At least daily	

ITEM INTENT

- Identifies frequency of any behaviors that are disruptive or dangerous to the patient or the caregivers.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Consider if the patient has any problematic behaviors – not just the behaviors listed in M1740 – which jeopardize or could jeopardize the safety and well-being of the patient or caregiver. Then consider how frequently these behaviors occur.
- Include behaviors considered symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders, identified either by diagnosis and/or based on the assessing clinician's clinical judgment.
- Use clinical judgment to determine if the degree of the behavior is disruptive or dangerous to the patient or caregiver.
- Behaviors can be observed by the clinician or reported by the patient, family, or others.
- Examples of disruptive/dangerous behaviors include sleeplessness, "sun-downing," agitation, wandering, aggression, combativeness, getting lost in familiar places, etc.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Review of past health history
- Physician
- Links to additional information sources can be found in Chapter 5 of this manual

OASIS ITEM

(M1800)	**Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code ☐	0 Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1 Grooming utensils must be placed within reach before able to complete grooming activities. 2 Someone must assist the patient to groom self. 3 Patient depends entirely upon someone else for grooming needs.

ITEM INTENT

- Identifies the patient's ability to tend to personal hygiene needs, excluding bathing, shampooing hair, and toileting hygiene.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely perform grooming, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments, (for example, impaired vision or pain)
  - environmental barriers (for example, accessing grooming aids, mirror and sink).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.

  - The grooming scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is currently able to do.
  - Grooming includes several activities. The frequency with which selected activities are performed (such as washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more frequently performed activities (for example, washing hands and face) but unable to do less frequently performed activities (trimming fingernails) should be considered to have more ability in grooming.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1800)

- In cases where a patient's ability is different for various grooming tasks, enter the response that best describes the patient's level of ability to perform the majority of grooming tasks.
- Response 2 includes standby assistance or verbal cueing.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1810)	Current **Ability to Dress <u>Upper</u> Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:
Enter Code	0 — Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
	1 — Able to dress upper body without assistance if clothing is laid out or handed to the patient.
	2 — Someone must help the patient put on upper body clothing.
	3 — Patient depends entirely upon another person to dress the upper body.

ITEM INTENT

- Identifies the patient's ability to dress upper body, including the ability to obtain, put on, and remove upper body clothing. Assess ability to put on whatever clothing is routinely worn. This specifically includes the ability to manage zippers, buttons, and snaps if these are routinely worn.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely dress the upper body, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

    - physical impairments (for example, limited range of motion, impaired balance)
    - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
    - sensory impairments (for example, impaired vision or pain)
    - environmental barriers (for example, stairs, narrow doorways, location where dressing items are stored).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- Prosthetic, orthotic, or other support devices applied to the upper body (for example, upper extremity prosthesis, cervical collar, or arm sling) should be considered as upper body dressing items/tasks.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- The ability to dress upper body scale presents the most independent level first then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1810)

- In cases where a patient's ability is different for various upper body dressing tasks, enter the response that best describes the patient's level of ability to perform the majority of upper body dressing tasks.
- If the patient requires standby assistance (a "spotter") to dress safely or requires verbal cueing/reminders, enter Response 2.
- If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing.
- The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient if he/she has difficulty dressing upper body. Observe the patient's general appearance and clothing and ask questions to determine if the patient has been able to dress independently and safely. Opening and removing upper body garments during the physical assessment of the heart and lung provides an excellent opportunity to evaluate the upper extremity range of motion, coordination, and manual dexterity needed for dressing. The patient also can be asked to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

DATA SOURCES/RESOURCES

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1820)	Current **Ability to Dress <u>Lower</u> Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
Enter Code	0 Able to obtain, put on, and remove clothing and shoes without assistance.
	1 Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
	2 Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
	3 Patient depends entirely upon another person to dress lower body.

ITEM INTENT

- Identifies the patient's ability to dress lower body, including the ability to obtain, put on, and remove lower body clothing. Assess ability to put on whatever clothing is routinely worn.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely dress the lower body, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments (for example, impaired vision or pain)
  - environmental barriers (for example, stairs, narrow doorways, location where dressing items are stored).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- Prosthetic, orthotic, or other support devices applied to the lower body (for example, lower extremity prosthesis, ankle-foot orthosis [AFO], or anti-embolism stockings) should be considered as lower body dressing items/tasks.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- The ability to dress lower body scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1820)

- In cases where a patient's ability is different for various dressing lower body tasks, enter the response that best describes the patient's level of ability to perform the majority of dressing lower body tasks.
- If the patient requires standby assistance (a "spotter") to dress safely or verbal cueing/reminders, enter Response 2.
- If a patient modifies the clothing they wear due to a physical impairment, the modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing. There is no specified timeframe at which the modified clothing style will become the routine clothing.
- The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. The patient can report the lower body dressing procedure. Observe spinal flexion, joint range of motion, shoulder and upper arm strength, and manual dexterity during the assessment. Ask the patient to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1830)	**Bathing:** Current ability to wash entire body safely. **Excludes** grooming (washing face, washing hands, and shampooing hair).
Enter Code [ ]	0 Able to bathe self in <u>shower or tub</u> independently, including getting in and out of tub/shower.
	1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.

	2 Able to bathe in shower or tub with the intermittent assistance of another person:
	    (a) for intermittent supervision or encouragement or reminders, <u>OR</u>
	    (b) to get in and out of the shower or tub, <u>OR</u>
	    (c) for washing difficult to reach areas.

	3 Able to participate in bathing self in shower or tub, <u>but</u> requires presence of another person throughout the bath for assistance or supervision.
	4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
	5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
	6 Unable to participate effectively in bathing and is bathed totally by another person.

ITEM INTENT

- Identifies the patient's ability to bathe entire body and the assistance that may be required to safely bathe, including transferring in/out of the tub/shower.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely bathe, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

    − physical impairments (for example, limited range of motion, impaired balance)
    − emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
    − sensory impairments (for example, impaired vision or pain)
    − environmental barriers (for example, stairs, narrow doorways, location of tub/shower, wash basin/sink).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- Specifically excludes washing face and hands, and shampooing hair.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- The bathing scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.
- If the patient requires standby assistance to bathe safely in the tub or shower or requires verbal cueing/reminders, then enter Response 2 or Response 3, depending on whether the assistance needed is intermittent ("2") or continuous ("3").
- If the patient's ability to transfer into/out of the tub or shower is the only bathing task requiring human assistance, enter Response 2. If a patient requires one, two, or all three of the types of assistance listed in Response 2 of M1830 but not the continuous presence of another person as noted in Response 3, then Response 2 is the best response.
- The patient's status should not be based on an assumption of a patient's ability to perform a task with equipment they do not currently have, preventing assessment.
- If a patient is medically restricted from stair climbing, and the only tub/shower requires climbing stairs, the patient is temporarily unable to bathe in the tub or shower due to combined medical restrictions and environmental barriers. Responses 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities.
- If the patient does not have a tub or shower in the home, or if the tub/shower is nonfunctioning or not safe for patient use, the patient should be considered unable to bathe in the tub or shower. Responses 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities.
- For Response 4, the patient must be able to safely and independently bathe outside the tub/shower, including independently accessing water at the sink, or setting up a basin at the bedside, etc.

    - Enter Response 5 if the patient is unable to bathe in the tub/shower and needs intermittent or continuous assistance to wash their entire body safely at a sink, in a chair, or on a commode.
    - Enter Response 6 if the patient is totally unable to participate in bathing and is totally bathed by another person, regardless of where bathing occurs or if patient has a functioning tub or shower.

- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient what type of assistance is needed to wash entire body in tub or shower. Observe the patient's general appearance in determining if the patient has been able to bathe self independently and safely. Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely. The patient who only performs a sponge bath may be able to bathe in the tub or shower with assistance and/or a device. Evaluate the amount of assistance needed for the patient to be able to safely bathe in tub or shower.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1840)	**Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely <u>and</u> transfer on and off toilet/commode.
Enter Code □	0 Able to get to and from the toilet and transfer independently with or without a device.
	1 When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
	2 <u>Unable</u> to get to and from the toilet but is able to use a bedside commode (with or without assistance).
	3 <u>Unable</u> to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
	4 Is totally dependent in toileting.

ITEM INTENT

- Identifies the patient's ability to safely get to and from and transfer on and off the toilet or bedside commode.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely perform toilet transferring, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

  – physical impairments (for example, limited range of motion, impaired balance)
  – emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  – sensory impairments (for example, impaired vision or pain)
  – environmental barriers (for example, stairs, narrow doorways, location of toilet or bedside commode).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- Excludes personal hygiene and management of clothing when toileting.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- The toilet transferring scale presents the most optimal level first, then proceeds to less optimal toileting methods. Read each response carefully to determine which one best describes what the patient is able to do.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1840)

- If the patient can get to and from the toilet during the day independently, but uses the commode at night for convenience, enter Response 0.
- If the patient requires standby assistance to get to and from the toilet safely or requires verbal cueing/reminders, enter Response 1.
- If the patient needs assistance getting to/from the toilet or with toileting transfer or both, then Response 1 is the best option.
- If the patient can independently get to the toilet, but requires assistance to get on and off the toilet, enter Response 1.
- A patient who is unable to get to/from the toilet or bedside commode, but is able to place and remove a bedpan/urinal independently, enter Response 3. This is the best response whether or not a patient requires assistance to empty the bedpan/urinal.
- In the absence of a toilet in the home, the assessing clinician would need to determine if the patient is able to use a bedside commode (Response 2), or if unable to use a bedside commode, if he is able to use a bedpan/urinal independently (Response 3). If the patient is not able to use the bedside commode or bedpan/urinal as defined in the responses, or if such equipment is not present in the home to allow assessment, then Response 4 – totally dependent in toileting would be appropriate.
- Assessment Strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient if he/she has any difficulty getting to and from the toilet or bedside commode. Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc. Determine the level of assistance needed by the patient to safely get on and off the toilet or commode. Tasks related to personal hygiene and management of clothing are not considered when responding to this item.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1845)	**Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.
Enter Code ☐	0 Able to manage toileting hygiene and clothing management without assistance.
	1 Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
	2 Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
	3 Patient depends entirely upon another person to maintain toileting hygiene.

ITEM INTENT

- Identifies the patient's ability to manage personal hygiene and clothing when toileting.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely perform toileting hygiene, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

  - physical impairments (for example, limited range of motion, impaired balance)
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  - sensory impairments (for example, impaired vision or pain)
  - environmental barriers (for example, stairs, narrow doorways, location of hygiene/clothing management supplies/implements).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- Toileting hygiene includes several activities, including pulling clothes up or down and adequately cleaning (wiping) the perineal area.
- Toileting hygiene includes the patient's ability to maintain hygiene related to catheter care and the ability to cleanse around all stomas that are used for urinary or bowel elimination (for example, urostomies, colostomies, ileostomies).
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- The toileting hygiene scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1845)

- This item refers to the patient's ability to manage personal hygiene and clothing with or without assistive devices. The word "assistance" in this question refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- Enter Response 0 if the patient is independent in managing toileting hygiene and managing clothing.
- Enter Response 1 if the patient is able to manage toileting hygiene and manage clothing IF supplies are laid out for the patient.
- If the patient can participate in hygiene and/or clothing management but needs some assistance with either or both activities, enter Response 2.
- Response 2 includes standby assistance or verbal cueing.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

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

ITEM INTENT

- Identifies the patient's ability to safely transfer from bed to chair (and chair to bed), or position self in bed if bedfast.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely transfer, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

    − physical impairments (for example, limited range of motion, impaired balance)
    − emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
    − sensory impairments (for example, impaired vision or pain)
    − environmental barriers environmental barriers (for example, stairs, narrow doorways, location of current sleeping surface and a sitting surface).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- For most patients, the transfer between bed and chair will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair, and back into bed from the chair or sitting surface.
- If there is no chair in the patient's bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, report the patient's ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and then sit on whatever surface is applicable to the patient's environment and need, (for example, a chair in another room, a bedside commode, the toilet, a bench, etc.). Include the ability to return back into bed from the sitting surface.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1850)

- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.
- The transferring scale presents the most optimal level first, then proceeds to less optimal levels of transferring. Read each response carefully to determine which one best describes what the patient is able to do.
- Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (for example, a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities). If the patient is able to transfer self from bed to chair, but requires standby assistance to transfer safely, or requires verbal cueing/reminders, enter Response 1.
- For Response 1, "minimal human assistance" could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance.
- In order for the assistance to be considered minimal, it would mean the individual assisting the patient is contributing less than 25% of the total effort required to perform the transfer.
- If the patient transfers either with minimal human assistance (but not device), or with the use of a device (but no human assistance), enter Response 1. If the patient requires both minimal human assistance and an assistive device to transfer safely, enter Response 2.
- If the patient can bear weight and pivot, but requires more than minimal human assist, enter Response 2.
- The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, enter Response 3.
- If the patient is bedfast, enter Response 4 or 5, depending on the patient's ability to turn and position self in bed. Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient about transferring ability. Observe the patient during transfers and determine the amount of assistance required for safe transfer from bed to chair.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1860)	**Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
Enter Code	0 Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
	1 With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
	2 Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
	3 Able to walk only with the supervision or assistance of another person at all times.
	4 Chairfast, <u>unable</u> to ambulate but is able to wheel self independently.
	5 Chairfast, unable to ambulate and is <u>unable</u> to wheel self.
	6 Bedfast, unable to ambulate or be up in a chair.

ITEM INTENT

- Identifies the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely ambulate or use a wheelchair, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

    - physical impairments (for example, limited range of motion, impaired balance)
    - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
    - sensory impairments (for example, impaired vision or pain)
    - environmental barriers (for example, stairs, narrow doorways, unsafe flooring).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Follow-up
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- Variety of surfaces refers to typical surfaces that the patient would routinely encounter in his/her environment, and may vary based on the individual residence.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is able to do on the day of the assessment.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1860)

- The ambulation/locomotion scale presents the most optimal level first, then proceeds to less optimal mobility abilities. Read each response carefully to determine which one best describes what the patient is able to do.
- Regardless of the need for an assistive device, if the patient requires human assistance (hands on, supervision and/or verbal cueing) to safely ambulate, enter Response 2 or Response 3, depending on whether the assistance required is intermittent ("2") or continuous ("3").

    – If the patient is safely able to ambulate without a device on a level surface, but requires minimal assistance on stairs, steps, and uneven surfaces, enter Response 2 (requires human supervision or assistance to negotiate stairs or steps or uneven surfaces).

    – If a patient does not require human assistance, but safely ambulates with a walker in some areas of the home, and a cane in other areas (due to space limitations, distances, etc.), enter the response that reflects the device that best supports safe ambulation on all surfaces the patient routinely encounters (for example, Response 2 is appropriate if a walker is required for safe ambulation in the hallway and living room, even if there are some situations in the home where a cane provides adequate support).

    – If a patient does not have a walking device but is clearly not safe walking alone, enter Response 3, able to walk only with the supervision or assistance should be reported, unless the patient is chairfast.

    – Responses 4 and 5 refer to a patient who is unable to ambulate, even with the use of assistive devices and/or continuous assistance. For a patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, enter Response 4 or 5, based on ability to wheel self.

    – Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Ask the patient about ambulation ability. Observe the patient ambulating across the room or to the bathroom and the type of assistance required. Note if the patient uses furniture or walls for support, or demonstrates loss of balance or other actions that suggest a need for additional support for safe ambulation. Observe patient's ability and safety on stairs. If chairfast, assess ability to safely propel wheelchair independently, whether the wheelchair is a powered or manual version.

DATA SOURCES/RESOURCES

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1870)	**Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of <u>eating</u>, <u>chewing</u>, and <u>swallowing</u>, <u>not preparing</u> the food to be eaten.
Enter Code ☐	0 Able to independently feed self. 1 Able to feed self independently but requires: (a) meal set-up; <u>OR</u> (b) intermittent assistance or supervision from another person; <u>OR</u> (c) a liquid, pureed or ground meat diet. 2 <u>Unable </u>to feed self and must be assisted or supervised throughout the meal/snack. 3 Able to take in nutrients orally <u>and</u> receives supplemental nutrients through a nasogastric tube or gastrostomy. 4 <u>Unable </u>to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. 5 Unable to take in nutrients orally or by tube feeding.

ITEM INTENT

- Identifies the patient's ability to feed him/herself, including the process of eating, chewing, and swallowing food.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely self-feed, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

  − physical impairments (for example, limited range of motion, impaired balance)
  − emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear)
  − sensory impairments (for example, impaired vision or hearing, pain).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- When coding this item, the assessing clinician may consider available input from other agency staff who have had direct patient contact. Refer to Chapter 1 for additional details on this and other OASIS conventions.
- This item excludes evaluation of the preparation of food items, and transport to the table. Respond to this item based on the assistance needed by the patient to feed himself once the food is placed in front of him. Assistance means human assistance by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- The patient's ability may change as the patient's condition improves or declines, or as medical restrictions are imposed or lifted. The clinician must consider what the patient is able to do on the day of the assessment. If ability varies over time, enter the response describing the patient's ability more than 50% of the time period under consideration.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1870)
- The feeding/eating scale presents the most optimal level first, then proceeds to less optimal feeding/eating abilities. Read each response carefully to determine which one best describes what the patient is able to do.
- Meal "set-up" (Response 1) includes activities such as mashing a potato, cutting up meat/vegetables when served, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, arranging the food on the plate for ease of access, etc. – all of which are special adaptations of the meal for the patient.
- Enter Response 2 if the patient is either unable to feed themselves and/or must be assisted or supervised while eating.
- If a tube is being used to provide all or some nutrition, enter Response 3 or 4, depending on the patient's ability to take in nutrients orally. If a patient is being weaned from tube feeding, Response 3 or 4 will continue to apply until the patient no longer uses the tube for nutrition, at which time, enter Response 0, 1, or 2. This is true, even if the tube remains in place, unused for a period of time.
- Responses 4 and 5 include non-oral intake.
- Response 5 is the best response for patients who are not able to take in nutrients orally or by tube feeding. This may be the case for patients who receive all nutrition intravenously (such as TPN) or for patients who are receiving only intravenous hydration.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Nutritional assessment
- Physician orders
- Plan of Care
- Referral information
- Review of past health history

OASIS ITEM

(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.

ITEM INTENT

- Identifies whether the home health agency has assessed the patient and home environment for characteristics that place the patient at risk for falls. The multi-factor falls risk assessment must include at least one standardized, validated tool that 1) has been scientifically tested in a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elders, noninstitutionalized adults with disabilities, etc.) and shown to be effective in identifying people at risk for falls; and 2) includes a standard response scale. The standardized, validated tool must be both appropriate for the patient based on their cognitive and physical status and appropriately administered per the tool's instructions.
- The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- CMS does not mandate that clinicians conduct falls risk screening for all patients, nor is there a mandate for the use of a specific tool.

  - A clinician other than the assessing clinician may complete the standardized, validated fall risk screening for consideration by the assessing clinician.

- For Responses 1 and 2, an agency may use a single comprehensive multi-factor falls risk assessment tool that meets the criteria as described in the item intent. Alternatively, an agency may incorporate several tools as long as one of them meets the criteria as described in the item intent. For example, a physical performance component (for example, Timed Up and Go), a medication review, review of patient history of falls, assessment of lower limb function and selected OASIS items (for example, OASIS items for cognitive status, vision, incontinence, ambulation, transferring).
- Use the scoring parameters specified in the tool to identify if a patient is at risk for falls. Enter Response 1 if the standardized, validated response scale rates the patient as no-risk, low-risk, or minimal risk. Enter Response 2 if the standardized, validated response scale rates the patient as anything above low/minimal-risk. If the tool does not provide various levels, but simply has a single threshold separating those "at risk" from those "not at risk," then enter Response 2 for the patient scoring "at risk."

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1910)

- Enter Response 0 if:

    − a standardized, validated multi-factor falls risk screening was NOT conducted by the home health agency,

    − a standardized, validated multi-factor falls risk screening was conducted by the home health agency but NOT during the required assessment time frame,

    − the patient is not able to participate in tasks required to allow the completion and scoring of the standardized, validated assessment(s) that the agency chooses to utilize.

DATA SOURCES/RESOURCES

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment
- Referral information
- Review of past health history
- Several links to guidelines listing Falls Risk Assessment factors can be found in Chapter 5 of this manual

OASIS ITEM

(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 M2102*]**

ITEM INTENT

- Identifies if review of the patient's medications indicated any potential or actual clinically significant medication issues.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- The drug regimen review includes all medications, prescribed and over the counter (OTC) including nutritional supplements, vitamins and herbals, administered by any route (for example, oral, topical, sublingual and by infusion). The drug regimen review also includes total parenteral nutrition (TPN) and oxygen.
- Potential or actual clinically significant medication issues may include, but are not limited to, the following:

  - adverse reactions to medications (such as a rash)
  - ineffective drug therapy (such as analgesic that does not reduce pain)
  - side effects (such as potential bleeding from an anticoagulant)
  - drug interactions (such as serious drug-drug, drug-food and drug-disease interactions)
  - duplicate therapy (such as generic name and brand name equivalent drugs are both prescribed)
  - omissions (such as missing drugs from a prescribed regimen)
  - dosage errors (either too high or too low)
  - nonadherence (purposeful or accidental)

- Any of the circumstances listed above 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 for the purpose of the drug regimen review items.
- The drug regimen review is part of the comprehensive patient assessment. The comprehensive patient assessment is the responsibility of and must ultimately be completed by one clinician, but collaboration is allowed. Agency policy and practice will determine this process and how it is documented.

> **DEFINITION**
>
> **DRUG REGIMEN REVIEW**
> The drug regimen review in post-acute care is generally considered to include medication reconciliation, a review of all medications a patient is currently using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.

> **DEFINITION**
>
> **POTENTIAL OR ACTUAL CLINICALLY SIGNIFICANT MEDICATION ISSUE**
> A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day (at the latest).

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2001)

- − For example, for this drug regimen review item, collaboration in which the assessing clinician evaluates patient status (for example, presence of potential ineffective drug therapy or patient nonadherence), and another clinician (in the office) assists with review of the medication list (for example, possible duplicate drug therapy or omissions) is allowed.
- − If portions of the drug regimen review (for example, identification of potential drug-drug interactions or potential dosage errors) are completed by agency staff other than the clinician responsible for completing the SOC/ROC OASIS, information on drug regimen review findings must be communicated to the assessing clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2001 may be entered.
- − The M0090 date assessment completed will indicate the last day the clinician gathered or received any input used to complete the comprehensive assessment document, which includes the OASIS items.

Coding Instructions:

Code 0, No, No issues found during review, if, based on assessing clinician's professional judgment, no potential or actual clinically significant issues are identified. Examples may include, but are not limited to:

- Patient's inpatient facility discharge medication list matches medications patient has on hand.
- Patient has a plan for taking medications safely at the right time.
- Patient is not showing signs/symptoms that could be adverse reactions caused by medications.
- The diagnoses/conditions for which the patient is taking the medications appear adequately controlled.

Code 1, Yes, **issues found during review** if a drug regimen review is conducted upon SOC/ROC and based on assessing clinician's professional judgment, potential or actual clinically significant medication issues are identified. Examples may include, but are not limited to:

- Patient's list of medications from the inpatient facility discharge instructions DO NOT match the medications the patient shows the clinician at the SOC/ROC assessment visit.
- Assessment shows that diagnoses/symptoms for which the patient is taking medications are NOT adequately controlled.
- Patient seems confused about when/how to take medications indicating a high risk for medication errors.
- Patient has not obtained medications or indicates that s/he will not take prescribed medications because of financial, access, cultural, or other issues with medications.
- Patient has signs/symptoms that could be adverse reactions from medications.
- Patient takes multiple non-prescribed medications (OTCs, herbals) that could interact with prescribed medications.
- Patient has a complex medication plan with medications prescribed by multiple physicians and/or obtained from multiple pharmacies so that the risk of drug interactions is high.

Code 9, NA – Patient is not taking any medications, if a drug regimen review indicates there are no medications prescribed for the patient and the patient is not taking any medications, by any route, at the time of the assessment.

A dash is a valid response for this item. CMS expects dash use to be a rare occurrence. If elements of the drug regimen review were skipped, (for example drug-to-drug interactions were not completed), a dash (–) should be reported, indicating the drug regimen review was not completed.

EXAMPLES

1.   No issues identified

During the comprehensive assessment visit to Mr. K., the PT reviews all the patient's medications and identifies no problems except that the patient's newly prescribed pain medication is not in the home. The daughter, Nancy, states they were only going to pick it up from the pharmacy if "the pain got bad enough." The PT reviews the physician's instructions for the new medication with the Mr. K and Nancy; they agree the medication should be on hand, and to follow physician's instructions for administration. Prior to the PT leaving the home, the daughter has gone to the drugstore and returned with the medication.

> **Coding:** M2001 would be coded 0, No – No issues found during review.

> **Rationale:** Because the issue, in the PT's professional judgment, did not require physician (or physician-designee) contact by midnight of the next calendar day, at the latest to resolve, it does not meet the criteria for a potential or actual clinically significant medication issue.

2.   Drug regimen review (DRR) not complete; use of the dash

During the SOC comprehensive assessment, Nurse Richard completes all elements of the DRR except for checking for drug-drug interactions.

> **Coding:** M2001, enter a dash, "–"

> **Rationale:** When any element is not assessed, the DRR is considered incomplete.

DATA SOURCES/RESOURCES

- Patient assessment
- HH Condition of Participation
- Clinical record including communication notes, medication list
- Collaboration with other agency staff as allowed, including review of documentation
- CMS OASIS Q&As related to the drug regimen review can be accessed through the CMS OASIS web page

OASIS ITEM

(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

ITEM INTENT

- Identifies if potential or actual clinically significant medication issues identified through the drug regimen review were communicated to the physician (or physician-designee) and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- For each potential or actual clinically significant medication issue identified during the SOC/ROC comprehensive assessment, identify if the physician/physician-designee was contacted, and prescribed/recommended actions were completed by midnight of the next calendar day (at the latest).
- Examples of *by midnight of the next calendar day*:
- A clinically significant medication issue is identified at 10:00 AM on February 12th and physician/physician-designee prescribed/recommended action is completed on or before 11:59 PM on February 13th.
- A clinically significant medication issue is identified at 10:00 PM on February 12th. physician/physician-designee prescribed/recommended action is completed on or before 11:59 PM on February 13th.

> **DEFINITION**
>
> **POTENTIAL OR ACTUAL CLINICALLY SIGNIFICANT MEDICATION ISSUE**
> A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day (at the latest).

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2003)

Coding Instructions

Code 0, No, if all identified potential or actual clinically significant medication issues were not communicated to the physician/physician designee, with prescribed/recommended actions completed to the extent possible by midnight of the next calendar day.

- Examples:

  – Clinician did not communicate all clinically significant medication issues to physician/physician-designee until after midnight of the next calendar day.
  – Clinician communicated all clinically significant medication issues to physician/physician-designee by midnight of the next calendar day, but the clinician did not receive a response from the physician/physician-designee to communicate prescribed/recommended actions until after midnight of the next calendar day.
  – Clinician did not complete all physician/physician-designee prescribed/recommended actions until after midnight of the next calendar day.

Code 1, Yes, if the two-way communication AND completion of the prescribed/recommended actions to the extent possible occurred by midnight of the next calendar day after the potential clinically significant medication issue was identified.

- Examples:

  – Clinician communicated all identified clinically significant medication issue to the physician/physician-designee, and all physician/physician-designee prescribed/recommended actions for all identified medication issues were completed by midnight of the next calendar day.
  – Clinician contacted the physician/physician-designee regarding all identified medication issues, and the physician/physician-designee communicated to the clinician that no actions were necessary regarding the reported issues. All communications took place before midnight of the next calendar day.
  – 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.

  ▪ An example of a recommended action that would take longer than the allowed time to complete might include physician order(s) for intervention followed by monitoring the issue over the weekend and call if problem persists, or the physician instructs the patient to address the concern with his PCP on a visit that is scheduled in two days.
  ▪ The actual type of actions recommended should be considered in determining if the agency has taken whatever actions are possible by midnight of the next calendar day.

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

DEFINITIONS

CONTACT WITH PHYSICIAN/ PHYSICIAN DESIGNEE

- Communication to the physician/physician-designee to convey an identified potential or actual clinically significant medication issue, AND a response from the physician/physician-designee to acknowledge receipt and/or convey prescribed/recommended actions in response to the medication issue.
- Communication can be in person, by telephone, voicemail, electronic means, facsimile, 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.

MEDICATION FOLLOW-UP

- The process of contacting a physician/physician-designee to communicate the identified medication issue and, to the extent possible, completing all physician/physician-designee prescribed/recommended actions by midnight of the next calendar day (at the latest).

EXAMPLE

1. **Clinically significant medication issue identified, with follow-up**

During the SOC comprehensive assessment visit, the RN completes a drug regimen review and identifies that the patient is taking two antihypertensives; one which was newly prescribed during her recent hospital stay, and another that she was taking prior to her hospitalization. During the home visit, the RN contacts the physician's office, and leaves a message with office staff providing notification of the potential duplicative drug therapy and a request for clarification. The next day, the RN returns to the home to complete the comprehensive assessment and again contacts the physician from the patient's home. The physician's office nurse reports to the agency and patient that the physician would like the patient to continue with only the newly prescribed antihypertensive and discontinue the previous medication.

> **Coding:** M2001, Drug Regimen Review, would be coded 1, Yes, Issues found during review.
> M2003, Medication Follow-up, would be coded 1, Yes.

> **Rationale:** Because the issue identified was determined by the clinician to be clinically significant, requiring physician contact by midnight of the next calendar day, it meets the criteria for a potential clinically significant medication issue (M2001). As the clinically significant issue was communicated to the physician and the prescribed/recommended action was completed by midnight of the next calendar day, M2003 would be coded 1 – Yes.

DATA SOURCES/RESOURCES

- Clinical record
- Communication notes
- Plan of Care
- Medication list

OASIS ITEM

(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

ITEM INTENT

- Identifies if potential or actual clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC were communicated to the physician (or physician-designee) and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.

TIME POINTS ITEM(S) COMPLETED

- Transfer to an inpatient facility
- Death at home
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

> **DEFINITION**
>
> **POTENTIAL OR ACTUAL CLINICALLY SIGNIFICANT MEDICATION ISSUE**
> A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day (at the latest).

- To complete M2005, the assessing clinician (alone or in collaboration with other agency staff) reviews the patient's clinical record back to and including the most recent SOC/ROC, to determine if for each clinically significant medication issue identified, communication occurred **and**, to the extent possible, physician (or physician-designee) prescribed or recommended actions were completed by midnight of the next calendar day.
- Potential or actual clinically significant medication issues may include, but are not limited to, the following:

  – adverse reactions to medications (such as a rash)
  – ineffective drug therapy (such as analgesic that does not reduce pain)
  – side effects (such as potential bleeding from an anticoagulant)
  – drug interactions (such as serious drug-drug, drug-food and drug-disease interactions)
  – duplicate therapy (such as generic name and brand name equivalent drugs are both prescribed)
  – omissions (such as missing drugs from a prescribed regimen)
  – dosage errors (either too high or too low)
  – nonadherence (purposeful or accidental)

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2005)

- Examples of *by midnight of the next calendar day*:

  – A clinically significant medication issue is identified at 10:00 AM on February 12th. Communication occurs and the physician/physician-designee prescribed/recommended action is completed on or before 11:59 PM on February 13th.

  – A clinically significant medication issue is identified at 10:00 PM on February 12th. Communication occurs and the physician/physician-designee prescribed/recommended action is completed on or before 11:59 PM on February 13th.

Coding Instructions

Code 0, No, if all clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC were not communicated to the physician/physician-designee and/or all prescribed/recommended actions were not completed, to the extent possible, by midnight of the next calendar day.

- Examples:

  – At the time of or at any time since the most recent SOC/ROC, the clinician(s) did not communicate all identified potential or actual clinically significant medication issues to the physician until after midnight of the next calendar day.

  – At the time of or at any time since the most recent SOC/ROC, the clinician's communicated to the physician/physician-designee all identified potential or actual clinically significant medication issues, but the physician/physician-designee did not respond until after midnight of the next calendar day.

  – At the time of or at any time since the most recent SOC/ROC, the clinician(s) did not complete all physician/physician-designee prescribed/recommended actions for all identified potential or actual clinically significant medication issues by midnight of the next calendar day.

Code 1, Yes, if all clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC were communicated to the physician/physician-designee and all prescribed/recommended actions were completed, to the extent possible, by midnight of the next calendar day each time a potential clinically significant issue was identified.

- Examples:

  – At the most recent SOC/ROC and throughout the quality episode, the clinician(s) communicated all identified clinically significant medication issues to the physician/physician-designee, and all physician/physician-designee prescribed/recommended actions for the identified issues were completed by midnight of the next calendar day.

  – At the most recent SOC/ROC and throughout the quality episode, the clinician(s) contacted the physician/physician-designee regarding all identified potential or actual clinically significant medication issues, and the physician/physician-designee communicated to the clinician(s) that no actions were necessary regarding the reported issues. All communications took place before midnight of the next calendar day.

DEFINITIONS

CONTACT WITH PHYSICIAN/ PHYSICIAN DESIGNEE

- Communication to the physician/physician-designee to convey an identified potential or actual clinically significant medication issue, AND a response from the physician/physician-designee to acknowledge receipt and/or convey prescribed/ recommended actions in response to the medication issue.

- Communication can be in person, by telephone, voicemail, electronic means, facsimile, 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.

MEDICATION FOLLOW-UP

- The process of contacting a physician/physician-designee to communicate the identified medication issue and, to the extent possible, completing all physician/ physician-designee prescribed/ recommended actions by midnight of the next calendar day (at the latest).

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2005)

- 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. An example of a recommended action that would take longer than the allowed time to complete might include physician instruction to agency staff to continue to monitor the issue over the weekend and call if problem persists. The actual type of actions recommended should be considered in determining if the agency has taken whatever actions are possible by midnight of the next calendar day.

Code 9, NA, if there were no potential or actual clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC, or if the patient is not taking any medications at the time of or at any time since the most recent SOC/ROC.

A dash (–) value is a valid response for this item. CMS expects dash use to be a rare occurrence.

EXAMPLES

1. **No clinically significant medication issues identified throughout the episode**

During the Discharge assessment visit, the RN reviews the patient's medication list and confirms that no potential clinically significant medication issues are present. In reviewing the clinical record, there is documentation that a drug regimen review was conducted at SOC, and no potential clinically significant medication issues were identified. There is no other documentation to indicate that potential or actual clinically significant medication issues occurred during the episode of care.

> **Coding**: M2005: ENTER Response 9 (NA) – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications.

> **Rationale:** This item is reported as NA because there is documentation that the agency looked for potential clinically significant medication issues via completion of a drug regimen review and that no potential or actual clinically significant medication issues were identified at any time during the episode, from SOC through Discharge.

2. **Clinically significant medication issue identified, late follow-up**

During the SOC comprehensive assessment, the RN completes the drug regimen review and identifies a potential clinically significant medication issue. On that day of admission, the RN calls and leaves a message with the physician's office related to the medication issue. The physician does not return her call until after midnight of the next calendar day. No other medication issues arise during the episode, and the patient is discharged from home health.

> **Coding**:

> At SOC:
> M2001: ENTER Response 1 – Yes – Issues found during review.
> M2003: ENTER Response 0 – No.

> At DC:
> M2005: enter Response 0 – No.

> **Rationale:** Because an issue identified was determined by the clinician to be clinically significant, warranting physician contact by midnight of the next calendar day, it meets the criteria for a clinically significant medication issue (1 – Yes for M2001). While the clinician initiated communication with the physician, the required two-way communication did not occur until after midnight of the next calendar day, resulting in 0 – No responses for M2003 and M2005.

DATA SOURCES/RESOURCES

- Clinical record
- Communication notes
- Medication list
- Plan of Care

OASIS ITEM

(M2010)	**Patient/Caregiver High-Risk Drug Education:** Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?
Enter Code ☐	0 No 1 Yes NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

ITEM INTENT

- Identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes. High-risk medications are those identified by an authoritative source, such as the Institute for Safe Medication Practices as having considerable potential for causing significant patient harm when they are used erroneously.
- This item is targeted to high-risk medications as it may be unrealistic to expect that patient education on all medications occur on admission and failure to provide patient education on high-risk medications such as hypoglycemics and anticoagulants (and others) at SOC/ROC could have severe negative impacts on patient safety and health.
- The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care

RESPONSE-SPECIFIC INSTRUCTIONS

- Enter Response 0 – No, if the interventions are not completed as outlined in this item. However, in this case, the care provider should document rationale in the clinical record unless the patient is not taking any drugs.
- Enter Response 1 – Yes, if high-risk medications are prescribed and education was provided.
- Enter Response NA – If patient/caregiver is fully knowledgeable about special precautions associated with all high-risk medications in his/her medication profile.
- High-risk medications should be identified based on one or more authoritative sources.
- If agency staff other than the clinician responsible for completing the SOC/ROC OASIS provided education to the patient/caregiver on high-risk medications, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2010 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of and ultimately must be completed by one clinician.

DATA SOURCES/RESOURCES

- Clinical record
- Communication notes
- Medication list
- Plan of Care
- Documentation of other agency staff responsible for educating patient/caregivers on medications.
- Authoritative sources to identify high-risk medications for the purposes of responding to this item can include but are not limited to the Institute for Safe Medication Practices, the American Geriatrics Society, and The Joint Commission.
- Links to resources for identifying high-risk medications can be found in Chapter 5 of this manual.

OASIS ITEM

(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

ITEM INTENT

- Identifies if agency staff and/or other health care providers, such as pharmacists, instructed the patient/caregiver about how to manage all medications effectively and safely within the time period under consideration, including instruction related to monitoring the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur.
- The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- Drug education interventions for M2016 should address all medications the patient is taking, prescribed and over-the-counter, by any route.
- Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider.
- Enter Response 1 if *all* interventions were provided (monitor effectiveness of drug therapy, adverse drug reactions and significant side effects, and how and when to report problems that may occur).

  – AND, Within the time period under consideration (at or since the most recent SOC/ROC)
  – AND, By agency staff and/or other health care providers

- If the interventions are not completed as outlined in this item, enter Response 0 (No). However, in this case, the care provider should document rationale in the clinical record.

DATA SOURCES/RESOURCES

- Review of clinical record including teaching guidelines, flow sheets, clinical notes, etc.
- Medication list
- Plan of Care
- Documentation of other agency staff responsible for educating patient/caregivers on medications
- Links to a resource for drug information can be found in Chapter 5 of this manual

OASIS ITEM

(M2020)	**Management of Oral Medications:** <u>Patient's current ability</u> to prepare and take <u>all</u> oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **<u>Excludes</u> injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

Enter Code
 	
 ☐
	0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
	 1 Able to take medication(s) at the correct times if:
	    (a) individual dosages are prepared in advance by another person; <u>OR</u>
	    (b) another person develops a drug diary or chart.
	 2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
	 3 <u>Unable</u> to take medication unless administered by another person.
	 NA No oral medications prescribed.

ITEM INTENT

- This item is intended to identify the patient's ability to take **all** oral (p.o.) medications reliably and safely on the day of assessment.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely take oral medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:

    - physical impairments (for example, limited manual dexterity);
    - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear);
    - sensory impairments (for example, impaired vision, pain);
    - environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorways).

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Includes all prescribed and OTC (over-the-counter) p.o. medications that the patient is currently taking and are included on the Plan of Care.
- Excludes topical, injectable, and IV medications.
- Only medications whose route of administration is p.o. should be considered for this item. Medications are considered to be p.o. if they are placed in the mouth and swallowed, with absorption occurring through the gastrointestinal system. Medications administered by other routes, including sublingual, buccal, swish and expectorate, or administered per gastrostomy (or other) tube are not to be considered for this item.
- If the patient sets up her/his own "planner device" and is able to take the correct medication in the correct dosage at the correct time as a result of using this device, enter Response 0.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2020)

- Includes assessment of the patient's ability to obtain the medication from where it is routinely stored, the ability to read the label (or otherwise identify the medication correctly, for example patients unable to read and/or write may place a special mark or character on the label to distinguish between medications), open the container, select the pill/tablet or milliliters of liquid and orally ingest it at the correct times.
- Enter Response 1 if the patient is independent in oral medication administration if another person must prepare individual doses (for example, place medications in a medi-planner or other device) and/or if another person in the home must modify the original medication container to enable patient access (for example, removing childproof lids, marking labels for the visually impaired or those who cannot read), or if someone in the home must develop a drug diary or chart which the patient relies on to take medications appropriately.
- Enter Response 2 if daily reminders to take medications are necessary, regardless of whether the patient is independent or needs assistance in preparing individual doses (for example, setting up a "planner device") and/or developing a drug diary or chart. (Reminders provided by a device that the patient can independently set up and manage are not considered "assistance" or "reminders.")
- If a medication is ordered PRN and the medication is needed by the patient on the day of assessment – and the patient needed a reminder to take this PRN medication on the day of assessment, Enter Response 2. If the patient did not need any PRN medications on the day of the assessment and therefore no reminders were necessary, assess the patient's ability on all of the medications taken on the day of assessment.
- Enter Response 3 if the patient does not have the physical or cognitive ability on the day of assessment to take all medications correctly (right medication, right dose, right time) as ordered and every time ordered, and it has not been established (and therefore the clinician cannot assume) that set up, diary, or reminders have already been successful. The clinician would need to return to assess if the new interventions, such as reminders or a med planner, provided adequate support for the patient to take all medications safely.
- If the patient's ability to manage oral medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.
- For a patient residing in an assisted living facility where the facility holds and administers medications, M2020 should continue to report the patient's ability to take the correct oral medication(s) and proper dosage(s) at the correct times. Report ability based on assessment of the patient's vision, strength and manual dexterity in the hands and fingers, as well as cognitive ability, despite the facility's requirement.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Documentation of other agency staff
- Patient/caregiver interview
- Physical assessment
- Cognitive assessment
- Environmental assessment
- CMS OASIS Q&As can be accessed through the CMS OASIS web page

OASIS ITEM

(M2030)	**Management of Injectable Medications:** <u>Patient's current ability</u> to prepare and take <u>all</u> prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**
Enter Code ☐	0 Able to independently take the correct medication(s) and proper dosage(s) at the correct times. 1 Able to take injectable medication(s) at the correct times if: (a) individual syringes are prepared in advance by another person; <u>OR</u> (b) another person develops a drug diary or chart. 2 Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection 3 <u>Unable</u> to take injectable medication unless administered by another person. NA No injectable medications prescribed.

ITEM INTENT

- This item is intended to assess the patient's ability to take all injectable medications reliably and safely at on day of assessment.
- The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. These items address the patient's ability to safely manage injectable medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:

  - physical impairments (for example, limited manual dexterity);
  - emotional/cognitive/behavioral impairments (for example, memory deficits, impaired judgment, fear);
  - sensory impairments (for example, impaired vision, pain);
  - environmental barriers (for example, access to kitchen or medication storage area, stairs, narrow doorway.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- Excludes IV medications, infusions (for example, medications given via a pump), and medications given in the physician's office or other settings outside the home.
- Includes one-time injections administered in the home.
- Includes assessment of the patient's ability to obtain the medication from where it is routinely stored, draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly.
- Enter Response 0 if the patient sets up her/his own individual doses and is able to take the correct medication in the correct dosage at the correct time as a result of this.
- Enter Response 1 for a patient independent in injectable medication administration if another person must prepare individual doses and/or if another person must develop a drug diary or chart.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2030)

- Enter Response 2 if reminders to take medications are necessary, regardless of the whether the patient is independent or needs assistance in preparing individual doses and/or developing a drug diary or chart. (Reminders provided by a device that the patient can independently manage are not considered "assistance" or "reminders.")
- Enter Response 3 if the physician ordered the RN to administer an injection in the home.
- If the patient's ability to manage injectable medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.
- PRN injectables, ordered and included on POC, are to be considered when determining the patient's ability to manage injectable medications. If the PRN medication was not needed during the assessment timeframe, use clinical judgment and make an inference regarding the patient's ability by asking them to describe and demonstrate the steps for administration and needle disposal, considering the patient's cognitive and physical status as well as any other barriers.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is helpful in determining the most accurate response for this item. Observe patient preparing the injectable medications. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.
- For a patient residing in an assisted living facility where the facility holds and administers medications, M2030 should continue to report the patient's ability to administer all injectable medication(s) reliably and safely at the correct times. When medications are stored by the facility, use clinical judgment and make an inference regarding the patient's ability by asking the patient to describe and demonstrate the steps for administration and needle disposal, considering the patient's cognitive and physical status as well as any other barriers.

DATA SOURCES/RESOURCES

- Observation/demonstration is the preferred method
- Documentation of other agency staff
- Patient/caregiver interview
- Physical assessment
- Cognitive assessment
- Environmental assessment
- CMS OASIS Q&As can be accessed through the CMS OASIS web page
- Chapter 5 of this manual has a link to the OASIS Q&As

OASIS ITEM

SOC/ROC

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.

Enter Code	f. **Supervision and safety** (for example, due to cognitive impairment)
	    0 No assistance needed –patient is independent or does not have needs in this area
	    1 Non-agency caregiver(s) currently provide assistance
	    2 Non-agency caregiver(s) need training/ supportive services to provide assistance
	    3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance
	    4 Assistance needed, but no non-agency caregiver(s) available

Discharge

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.
Enter Code ☐	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	c. **Medication administration** (for example, oral, inhaled or injectable) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

ITEM INTENT

- Identifies ability and willingness of the caregiver(s) (other than home health agency staff) to provide categories of assistance needed by the patient.

TIME POINTS ITEM(S) COMPLETED

- Start of care
- Resumption of care
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- At SOC/ROC, report what is known on the day of assessment regarding ability and willingness of non-agency caregivers to provide help in the various categories of assistance for the upcoming episode of care. At Discharge, report what is known on the day of the discharge assessment regarding the ability and willingness of non-agency caregivers to provide assistance to the patient at the time of the discharge.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2102)

- For each row, enter one description of caregiver assistance.
- If patient needs assistance with any aspect of a category of assistance (such as needs assistance with some IADLs but not others), consider the aspect that represents the most need.
- If more than one response represents the non-agency caregiver's ability to provide assistance, select the response that represents the caregiver's greatest barrier to meet the need. For example, the caregiver provides assistance but also needs training or support. In this example, report that the caregiver needs training/supportive services to provide assistance, because it represents the caregiver's greatest barrier to meeting the patient's need.
- Enter Response 3 if:

    – Non-agency Caregiver(s) are not likely to provide care due to an unwillingness and/or inability on the part of the non-agency caregiver(s); and/or if there is a reluctance on the part of the non-agency caregiver(s) to provide care.

- Row a – ADLs include basic self-care activities such as the examples listed.
- Row c – Medication administration refers to any type of medication (prescribed or OTC) and any route of administration including oral, inhalant, injectable, topical, or administration via g-tube/j-tube, etc.
- Row d – Medical procedures/treatments include procedures/treatments that the physician or physician-designee has ordered for the purpose of improving health status. Some examples of these procedures/treatments include wound care and dressing changes, range of motion exercises, intermittent urinary catheterization, postural drainage, electromodalities, etc.
- Devices such as anti-embolism stockings, prosthetic devices, orthotic devices, or other supports that have a medical and/or therapeutic impact should be considered medical procedures/treatments, not as ADL/dressing items in Row a.
- Row f – Supervision and safety includes needs related to the ability of the patient to safely remain in the home. This category of assistance needs should focus on supervision and safety necessary due to cognitive or mental health issues. Such assistance may range from calls to remind the forgetful patient to take medications, to in-person visits to ensure that a patient with impaired decision making is safe, to the need for the physical presence of another person in the home to ensure that the patient doesn't wander, harm themselves or others or to monitor other safety risks related to cognitive/mental health concerns.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Review of previous health history

OASIS ITEM

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? **(Enter zero ["000"] if no therapy visits indicated.)**

(☐☐☐) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐ NA - Not Applicable: No case mix group defined by this assessment.

ITEM INTENT

- Identifies the total number of therapy visits (physical, occupational, or speech therapy combined) planned for the Medicare payment episode for which this assessment will determine the case mix group, and only applies to payers utilizing a payment model based on case mix group assignment.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- Therapy visits must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapist(s), and (b) be reasonable and necessary to the treatment of the patient's illness or injury. The Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.
- Enter a number that is "zero filled and right justified." For example, 11 visits should be reported as "011."
- Enter "000" if no therapy services are needed.
- Once patient eligibility has been confirmed and the Plan of Care contains physician orders for the qualifying service as well as other Medicare covered home health services, the qualifying service does not have to be rendered prior to the other Medicare covered home health services ordered in the Plan of Care.

  – The sequence of visits performed by the disciplines must be dictated by the individual patient's Plan of Care.
  – For example, an eligible patient in an initial 60-day episode that has both physical therapy and occupational therapy orders in the Plan of Care, the sequence of the delivery of the type of therapy is irrelevant as long as the need for the qualifying service is established prior to the delivery of other Medicare covered services and the qualifying discipline provides a billable visit prior to transfer or discharge in accordance with the Conditions of Participation.

- For multidisciplinary cases – Nursing and Therapy may collaborate to answer this item correctly. The PT, OT, and/or SLP are responsible to communicate the number of visits ordered by the physician to the RN completing this item. Coordination of patient care is specified in the Conditions of Participation.
- When a patient is discharged home from an inpatient facility admission in the last five days of a certification period (the requirement to complete a Resumption of Care assessment overlaps with the requirement to complete a Recertification assessment), CMS allows the agency to complete a single ROC assessment to meet the requirements of both time points. In such cases, the total number of therapy visits planned for the upcoming 60-day episode should be reported in M2200.

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2200)

- Answer "NA" (Not Applicable) when this assessment will not be used to determine a case mix group for Medicare, or other payers using a Medicare PPS-like model. Usually, the "NA" response will be checked for patients whose payment source is not Medicare fee-for-service (that is, M0150, Response 1 is not checked), or for an assessment that will not be used to determine a Medicare case mix group. However, payers other than the Medicare program may use this information in setting an episode payment rate. If the HHA needs a case mix code (HIPPS code) for billing purposes, a response other than "NA" – Not Applicable is required to generate the case mix code.

- Assessment strategies: When the assessment and care plan are complete, review the Plan of Care to determine whether therapy services are ordered by the physician. If not, enter "000." If therapy services are ordered, how many total visits are indicated over the 60-day payment episode? If the number of visits that will be needed is uncertain, provide your best estimate. As noted in item intent above, the Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.

DATA SOURCES/RESOURCES

- Physician's orders
- Referral information
- Plan of Care
- Clinical record

OASIS ITEM

(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]**

ITEM INTENT

- Identifies whether the patient was seen in a hospital emergency department. Responses to this item include the entire period at or since the most recent SOC/ROC assessment, including use of hospital emergency department that results in a qualifying hospital admission, necessitating Transfer OASIS data collection. This item includes current events.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- This item excludes urgent care services not provided in a hospital emergency department, including care provided at doctor's office, care provided by an ambulance crew, or care received in urgent care facilities. This item includes holding and observation only in the hospital emergency department setting.
    - An urgent care facility is defined as a freestanding walk-in clinic (not a department of a hospital) for patients in need of immediate medical care. Urgent care centers treat many problems that can be seen in a primary care physician's office, but urgent care centers offer some services that are generally not available in primary care physician offices. For example, X-ray facilities allow for treatment of minor fractures and foreign bodies, such as nail gun injuries. Most urgent care centers offer extended hours in evenings and on weekends for patients to receive treatment when their personal physician is not available.
- If a patient went to a hospital emergency department, regardless of whether the patient/caregiver independently made the decision to seek emergency department services or was advised to go the emergency department by the physician, home health agency, or other health care provider, then Response 1 or 2 should be entered depending on whether or not a hospital admission occurred.
- If a patient went to a hospital emergency department, was "held" at the hospital for observation, then released, the patient did receive emergent care. The time period that a patient can be "held" without admission can vary. "Holds" can be longer than 23 hours but emergent care should be reported regardless of the length of the observation "hold." An OASIS transfer assessment is not required if the patient was never actually admitted to an inpatient facility.
- If a patient went to a hospital emergency department and was subsequently admitted to the hospital, enter Response 2. An OASIS transfer assessment is required (assuming the inpatient stay was for 24 hours or longer, and for reasons other than diagnostic testing).

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2301)

- If a patient is admitted to the hospital for a stay requiring an OASIS Transfer, **Response 0 – No**, should only be entered if the patient was directly admitted to the hospital (was not treated or evaluated in the emergency room), and had no other emergency department visits at or since the most recent SOC/ROC assessment.
- Enter **Response 1- Yes, used hospital emergency department WITHOUT hospital admission** for a patient who, at the time of or at any time since the most recent SOC/ROC, accessed a hospital emergency department that did not result in an admission to the hospital.
- If a patient utilized a hospital emergency department more than once at the time of or at any time since the most recent SOC/ROC, enter **Response 2 - Yes, used hospital emergency with hospital admission** if any emergency department visit at or since the most recent SOC/ROC resulted in hospital admission. If no admission, enter Response 1.
- In Responses 1 and 2, "hospital admission" is defined as admission to a hospital where the inpatient stay is for 24 hours or longer, and for reasons other than diagnostic testing.
- A patient who dies in a hospital emergency department is considered to have been under the care of the emergency department, not the home health agency. In this situation, a Transfer assessment, not an assessment for "Death at Home," should be completed. For M2301, enter **Response 1 – Yes, used hospital emergency department WITHOUT hospital admission.**

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Clinical record
- Hospital emergency department discharge information
- Physician
- Hospital emergency department staff

OASIS ITEM

(M2310)   **Reason for Emergent Care:** For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)? **(Mark all that apply.)**

☐ 1   Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis

☐ 10   Hypo/Hyperglycemia, diabetes out of control

☐ 19   Other than above reasons

☐ UK   Reason unknown

ITEM INTENT

- Identifies the reasons for which the patient sought and/or received care in a hospital emergency department.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- This item **excludes** urgent care services not provided in a hospital emergency department, including care provided in a doctor's office, care provided by an ambulance crew, or care received in urgent care facilities.
- If more than one reason contributed to the hospital emergency department visit, mark all appropriate responses. For example, if a patient received care for a fall at home and was found to have medication side effects, mark both Response 19, Other than above reasons (for the fall), and Response 1 (for the medication side effects).
- If a patient seeks care in a hospital emergency department for a specific suspected condition, report that condition, even if the suspected condition was ruled out (for example, patient was sent to ED for suspected DVT but diagnostic testing and evaluation were negative for DVT – select Response 19 – Other than above reasons).
- If the reason is not included in the choices, select Response 19 - Other than above reasons.
- If the patient has received emergent care in a hospital emergency department multiple times since the most recent SOC/ROC, include the reasons for all visits.

DATA SOURCES/RESOURCES

- Patient/caregiver interview
- Clinical record
- Hospital emergency department discharge information
- Physician
- Hospital emergency department

OASIS ITEM

(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.

ITEM INTENT

- Identifies if specific interventions focused on specific problems were both included on the physician-ordered home health Plan of Care AND implemented as part of care provided at the time of or at any time since the most recent SOC/ROC assessment. "Included in the physician-ordered Plan of Care" means that the patient condition was discussed and there was agreement as to the Plan of Care between the home health agency staff and the patient's physician.
- The problem-specific interventions referenced in the item may or may not directly correlate to stated requirements in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- Select "Yes" if the physician-ordered Plan of Care includes the specified best practice interventions as specified in each row, at the time of or at any time since the most recent SOC/ROC assessment, and there is evidence of implementation in the clinical record. If orders are present and implemented, "Yes" may be selected even if the formal assessment was not conducted, or did not suggest a need for the particular intervention.
- Select "No" if the interventions are not on the Plan of Care OR if the interventions are on the Plan of Care but the interventions were not implemented by the time the Discharge or Transfer assessment was completed, unless "NA" applies.
- Select "NA" if the plans/interventions specified in the row are not applicable for this patient. See guidance on selecting "NA" for each row below.
- Interventions provided by home health agency staff, including the assessing clinician, may be reported by the assessing clinician in M2401. For example, if the RN finds a patient to be at risk for falls, and the physical therapist implements fall prevention interventions included on the Plan of Care prior to the end of the quality episode, the RN may select "Yes" for row b of M2401. The M0090 Date Assessment Completed should report the date the last information was gathered to complete the comprehensive assessment.
- For each row a-f, select one response.
- For rows b, c, e, and f, the intervention specified in the first column must be both on the physician-ordered Plan of Care AND implemented for "Yes" to be selected.
- For rows a and d, **BOTH** of the interventions specified in the first column must be both on the physician-ordered Plan of Care AND implemented for "Yes" to be selected.
- For rows b, c, d and e, the standardized, validated assessment that is referred to in the last column refers to a tool that has been scientifically tested on a population with characteristics similar to that of the patient being assessed (for example, community-dwelling elderly, noninstitutionalized adults with disabilities, etc.); and 2) includes a standard response scale (for example, a scale where patients rate pain from 0-10). The standardized, validated tool must be appropriately administered as indicated in the instructions and must be relevant for the patient's ability to respond.

  - For rows b and c, a formal assessment (as defined in the relevant OASIS item M1730, and M1910) must have been performed to select "NA."

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2401)

- Row a: If the physician-ordered Plan of Care contains both orders for a) monitoring the skin of the patient's lower extremities for evidence of skin lesions AND b) patient education on proper foot care, and the clinical record contains documentation that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "Yes." If the physician-ordered Plan of Care contains orders for only one of the interventions and/or only one type of intervention (monitoring or education) or no intervention is documented in the clinical record, select "No," unless "NA" applies. Select "NA" if the patient does not have a diagnosis of diabetes mellitus or is missing lower legs due to congenital or acquired condition (bilateral amputee).

- Row b: If the physician-ordered Plan of Care contains specific interventions to reduce the risk of falls and the clinical record contains documentation that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "Yes." Environmental modifications, strengthening exercises, and consultation with the physician regarding medication concerns are examples of possible falls prevention interventions. If the Plan of Care does not include interventions for fall prevention, and/or there is no documentation in the clinical record that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "No," unless "NA" applies. If all formal multi-factor falls risk assessments conducted at the time of or at any time since the most recent SOC/ROC assessment indicates the patient was not at risk for falls (if a single-threshold assessment is used), or at low, minimal, or no risk for falls (if a multi-threshold tool is used), select "NA" (unless orders for fall prevention are present and were implemented).

- Row c: If the physician-ordered Plan of Care contains interventions for evaluation or treatment of depression and the clinical record contains documentation that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "Yes."

- Interventions for depression may include new medications, adjustments to already-prescribed medications, psychotherapy or referrals to agency resources (for example, social worker). If the patient is already under physician care for a diagnosis of depression, interventions may include monitoring medication effectiveness, teaching regarding the need to take prescribed medications, etc. If the Plan of Care does not include interventions for treating depression and/or if no interventions related to depression are documented in the clinical record at the time of or at any time since the most recent SOC/ROC assessment, select "No," unless "NA" applies. If every standardized, validated assessment conducted at the time of or any time since the most recent SOC/ROC assessment indicates patient did not meet criteria for further evaluation of depression AND patient did not have diagnosis of depression, select "NA" (unless orders for further evaluation or treatment of depression are present and were implemented).

- Row d: If the physician-ordered Plan of Care contains interventions to monitor AND mitigate pain and the clinical record contains documentation that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "Yes." Medication, massage, visualization, biofeedback, and other intervention approaches have successfully been used to mitigate pain severity. If the physician-ordered Plan of Care contains orders for only one of the interventions (for example, pain medications but no monitoring plan) and/or only one type of intervention (for example, administering pain medications but no pain monitoring) or no interventions were documented at the time of or at any time since the most recent SOC/ROC assessment, select "No," unless "NA" applies. If every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment was negative for pain, select "NA" (unless orders for monitoring and mitigating pain are present and were implemented).

RESPONSE-SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2401)

- Row e: If the physician-ordered Plan of Care includes planned clinical interventions to reduce pressure on bony prominences or other areas of skin at risk for breakdown and the clinical record contains documentation that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "Yes." Planned interventions can include teaching on frequent position changes, proper positioning to relieve pressure, careful skin assessment and hygiene, use of pressure-relieving devices such as enhanced mattresses, etc. If the Plan of Care does not include interventions to prevent pressure ulcers and/or no interventions were documented in the clinical record at the time of or at any time since the most recent SOC/ROC assessment, select "No," unless "NA" applies. If 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, select "NA" (unless orders for interventions to reduce pressure on areas of skin at risk for breakdown are present and were implemented).

- Row f: If the physician-ordered Plan of Care contains orders for pressure ulcer treatments based on principles of moist wound healing (for example, moisture retentive dressings) and the clinical record contains documentation that these interventions were performed at the time of or at any time since the most recent SOC/ROC assessment, select "Yes." If the Plan of Care does not contain orders for pressure ulcer treatments based on principles of moist wound healing and/or no pressure ulcer treatments based on principles of moist wound healing were documented at the time of or at any time since the most recent SOC/ROC assessment, select "No," unless "NA" applies. If patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated per physician, select "NA" (unless orders for pressure ulcer treatments based on principles of moist wound healing are present and were implemented).

DATA SOURCES/RESOURCES

- Plan of Care
- Physician's orders
- Clinical record
- Clinical assessment
- Communication notes

OASIS ITEM

(M2410)	To which **Inpatient Facility** has the patient been admitted?
Enter Code ☐	1 Hospital 2 Rehabilitation facility 3 Nursing home 4 Hospice NA No inpatient facility admission **[*Omit "NA" option on TRN*]**

ITEM INTENT

- Identifies the type of inpatient facility to which the patient was admitted.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE-SPECIFIC INSTRUCTIONS

- If the patient was admitted to more than one facility, indicate the facility type to which the patient was admitted first (for example, the facility type that they were transferred to from their home).
- When a patient dies in a hospital emergency department, the RFA 7 – Transfer to an Inpatient Facility OASIS is completed. In this unique situation, clinicians are directed to enter Response 1 – Hospital for M2410, even though the patient was not admitted to the inpatient facility.
- Admission to a freestanding rehabilitation hospital, a certified distinct rehabilitation unit of a nursing home, or a distinct rehabilitation unit that is part of a short-stay acute hospital is considered a rehabilitation facility admission (Response 2).
- Admission to inpatient drug rehabilitation is considered an inpatient admission. Enter Response 1 – Hospital, whether it was a freestanding drug rehabilitation unit or a distinct drug rehabilitation unit that is part of a short-stay acute hospital.
- Admission to a skilled nursing facility (SNF), an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or a nursing facility (NF) is a nursing home admission (Response 3).
- When completing a Transfer, enter Response 1, 2, 3, or 4. "NA" should not be an active/available response at transfer.
- When completing a Discharge from Agency – Not to an Inpatient Facility, enter Response "NA."

DATA SOURCES/RESOURCES

- Patient family interview (for agency discharge)
- Telephone contact with caregiver or family if patient was transferred
- Facility

OASIS ITEM

(M2420)	**Discharge Disposition:** Where is the patient after discharge from your agency? **(Choose only one answer.)**
Enter Code ☐	1 Patient remained in the community (without formal assistive services) 2 Patient remained in the community (with formal assistive services) 3 Patient transferred to a non-institutional hospice 4 Unknown because patient moved to a geographic location not served by this agency UK Other unknown

ITEM INTENT

- Identifies where the patient resides after discharge from the home health agency.

TIME POINTS ITEM(S) COMPLETED

- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- Patients who are in assisted living or board and care housing are considered to be living in the community with formal assistive services.
- Formal assistive services refers to community-based services provided through organizations or by paid helpers. Examples: homemaking services under Medicaid waiver programs, personal care services provided by a home health agency, paid assistance provided by an individual, home-delivered meals provided by organizations like Meals-on-Wheels.

   - Therapy services provided in an outpatient setting would not be considered formal assistance.

- Informal services are provided by friends, family, neighbors, or other individuals in the community for which no financial compensation is provided. Examples: assistance with ADLs provided by a family member, transportation provided by a friend, meals provided by church members (specifically, meals not provided by the church organization itself, but by individual volunteers).
- Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not in an inpatient hospice facility.

DATA SOURCES/RESOURCES

- Patient/caregiver/family interview
- Physician
- Community resources

OASIS ITEM

(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient.

☐☐ / ☐☐ / ☐☐☐☐	
month day year	

ITEM INTENT

- Identifies the actual date of discharge, transfer, or death (at home), depending on the reason for assessment.

TIME POINTS ITEM(S) COMPLETED

- Transfer to an inpatient facility
- Death at home
- Discharge from agency – not to an inpatient facility

RESPONSE-SPECIFIC INSTRUCTIONS

- 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 for the year.
- The date of discharge is determined by agency policy or physician order.
- The transfer date is the actual date the patient was admitted to an inpatient facility.
- The death date is the actual date of the patient's death at home. Exclude death occurring in an inpatient facility or in an emergency department, as both situations would result in Transfer OASIS collection and would report the date of transfer. Include death that occurs while a patient is being transported to an emergency department or inpatient facility (before being seen in the emergency department or admitted to the inpatient facility).

DATA SOURCES/RESOURCES

- Agency policy or physician order
- Telephone contact with the family or medical service provider may be required to verify the date of transfer to an inpatient facility or death at home.

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

GG0100: Prior Functioning: Everyday Activities

GG0100. Prior Functioning: Everyday Activities: Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.	
Coding: **3. Independent** – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. **2. Needed Some Help** – Patient needed partial assistance from another person to complete activities. **1. Dependent** – A helper completed the activities for the patient. **8. Unknown** **9. Not Applicable**	↓ **Enter Codes in Boxes** ☐ **A.** **Self Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury. ☐ **B.** **Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury. ☐ **C.** **Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury. ☐ **D.** **Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Item Intent

This item identifies the patient's usual ability with everyday activities, prior to the current illness, exacerbation or injury.

Time Points Item(s) Completed

Start of care

Resumption of care

Response-Specific Instructions

Interview patient or family or review patient's clinical records describing patient's prior functioning with everyday activities.

Coding Instructions

- **Code 3, Independent**, if the patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
- **Code 2, Needed Some Help**, if the patient needed partial assistance from another person to complete activities.
- **Code 1, Dependent**, if the helper completed the activities for the patient.
- **Code 8, Unknown**, if the patient's usual ability prior to the current illness, exacerbation or injury is unknown.
- **Code 9, Not Applicable**, if the activity was not applicable to the patient prior the current illness, exacerbation or injury.

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

Coding Tips

If no information about the patient's ability is available after attempt to interview patient or family and after reviewing patient's clinical record, code 8, Unknown.

Examples

1. When to Code "Not Applicable"

Mr. S ambulates with a walker around his home, and uses a stair lift to negotiate the stairs to the second floor, where his bedroom is located.

Coding: GG0100C, Stairs, would be coded 9, Not Applicable.

Rationale: Mr. S is not able to go up and down stairs; he uses a stair lift. So, he did not perform this activity.

Data Sources/Resources

Patient interview

Family interview

Clinical record

GG0110: Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.		
↓ **Check all that apply**		
☐	A.	**Manual wheelchair**
☐	B.	**Motorized wheelchair and/or scooter**
☐	C.	**Mechanical lift**
☐	D.	**Walker**
☐	E.	**Orthotics/Prosthetics**
☐	Z.	**None of the above**

Item Intent

This item identifies the patient's use of devices and aids immediately prior to the current illness, exacerbation, or injury to align treatment goals.

Time Points Item(s) Completed

Start of care

Resumption of care

Response-Specific Instructions

Interview patient or family or review the patient's clinical record describing the patient's use of prior devices and aids.

Coding Instructions

- **Check all devices that apply.**

- **GG0110C - Mechanical lift,** any device a patient or caregiver requires for lifting or supporting the patient's bodyweight. Examples include, but are not limited to:
    - Stair lift
    - Hoyer lift
    - Bath tub lift
- **GG0110D - Walker,** All types of walkers. Examples include, but are not limited to:
    - Pick-up walker
    - Hemi-walker
    - Rolling walker
    - Platform walker
- **Check Z, None of the Above**, if the patient did not use any of the listed devices or aids immediately prior to the current illness, exacerbation or injury.
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

Examples

1. Mobilized Wheelchair and/or Scooter

Mrs. M is a bilateral lower extremity amputee and has multiple diagnoses including diabetes, obesity and peripheral vascular disease. She is unable to walk and did not walk prior to the current episode of care that started due to a pressure ulcer and respiratory infection. She used a motorized wheelchair to mobilize.

> **Coding:** GG0110B, Motorized wheelchair and/or scooter would be checked.

> **Rationale:** Mrs. M used a motorized wheelchair prior to the current illness/injury.

2. None of the Above

Mr. C has bilateral lower extremity neuropathy secondary to his diabetes. Prior to this current episode, he used a cane. Today, he is using a walker.

> **Coding:** GG0110Z, None of the above, would be checked.

> **Rationale:** A cane is not a device included as part of the item list above. Not all devices and aids are included in this item.

Data Sources/Resources

Patient interview

Family interview

Clinical record

GG0130 Self-Care

SOC/ROC

GG0130. Self-Care
Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).
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.   *Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.   10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)   88. **Not attempted due to medical conditions or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	☐☐	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.
☐☐	☐☐	**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower
☐☐	☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.

(continued)

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Follow-Up

GG0130. Self-Care
Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up, code the reason.
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. *Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury. 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 88. **Not attempted due to medical conditions or safety concerns**

4. Follow-Up Performance	
Enter Codes in Boxes	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

Discharge

GG0130. Self-Care
Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, code the reason.
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.   *Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.   10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)   88. **Not attempted due to medical conditions or safety concerns**

3. Discharge Performance ↓ Enter Codes in Boxes ▼	
☐☐	**A.** **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.
☐☐	**B.** **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C.** **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	**E.** **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	**F.** **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	**G.** **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	**H.** **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Item Intent

This item identifies the patient's ability to perform the listed self-care activities, and discharge goal(s).

Time Points Item(s) Completed

Start of care

Resumption of care

Follow-up

Discharge from agency – not to an inpatient facility

> **Note:** *This item, GG0130, includes* **Performance** *assessment and* **Discharge Goal***(s) at the SOC/ROC. Refer to sections for instructions, tips and examples for each.*

Response-Specific Instructions – *Performance Assessment* (SOC/ROC, FU and DC)

- Licensed clinicians may assess the patient's performance based on direct observation (preferred) as well as reports from the patient, clinicians, care staff, and/or family.

- When possible, CMS invites a multidisciplinary approach to patient assessment.

- Patients should be allowed to perform activities as independently as possible, as long as they are safe.

  - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

  - Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.

- Patients with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the patient's need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling).

Response-Specific Instructions – SOC/ROC Performance Assessment

- Code the patient's functional status based on a functional assessment that occurs at or soon after the patient's SOC/ROC. The SOC/ROC function scores are to reflect the patient's SOC/ROC baseline status and are to be based on observation of activities, to the extent possible. When possible, the assessment should occur prior to the start of therapy services to capture the patient's true baseline status. This is because therapy interventions can affect the patient's functional status.

- A patient's functional ability can be impacted by the environment or situations encountered in the home. Observing the patient in different locations and circumstances within the home is important for a comprehensive understanding of the patient's functional status.

> **DEFINITION**
>
> **ASSESSMENT TIMEFRAME**
> - The assessment timeframe is the maximum number of days within which to complete the comprehensive assessment.

  – If the patient's ability varies during the *assessment timeframe*, record their *usual ability* to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather the patient's usual performance; what is true greater than 50% of the assessment timeframe.

Response-Specific Instructions – SOC/ROC Discharge Goal(s)

> **DEFINITION**
>
> **USUAL PERFORMANCE, ABILITY**
> - A patient's usual performance is his/her ability greater than 50% of the assessment timeframe.

- For the Home Health (HH) Quality Reporting Program (QRP) a minimum of one self-care or mobility goal must be coded. However, agencies may choose to complete more than one self-care or mobility discharge goal. Code the patient's discharge goal(s) using the 6-point scale. Use of the activity not attempted codes (07, 09, 10 or 88) is permissible to code discharge goal(s). Use of a dash is permissible for any remaining self-care or mobility goals that were not coded.

- Discharge goal(s) may be the coded the same as SOC/ROC performance, higher than SOC/ROC performance or lower than SOC/ROC performance.

- If the SOC/ROC performance of an activity was coded using one of the activity not attempted codes (07, 09, 10 or 88) a discharge goal may be submitted using the 6-point scale if the patient is expected to be able to perform the activity by discharge.

- Licensed clinicians can establish a patient's discharge goal(s) at the time of SOC/ROC based on the patient's prior medical condition, SOC/ROC assessment, self-care and mobility status, discussions with the patient and family, professional judgment, the profession's practice standards, expected treatments, patient motivation to improve, anticipated length of stay, and the discharge plan. Goals should be established as part of the patient's care plan.

Response Specific Instructions – Follow-Up and Discharge Performance

- *Follow-up Performance:* Clinicians should code the patient's functional status based on a functional assessment that occurs within the assessment timeframe.

- *Discharge Performance:* The discharge *time period under consideration* includes the last 5 days of care. This includes the date of the discharge visit plus the four preceding calendar days. Code the patient's functional status based on a functional assessment that occurs at or close to the time of discharge.

> **DEFINITION**
>
> **TIME PERIOD UNDER CONSIDERATION**
> The time period under consideration is the span of time for data collection and assessment. For most OASIS items this is the day of assessment. For other items, item wording or related guidance will specify the time period under consideration, such as, since the most recent SOC/ROC.

Coding Instructions for SOC/ROC Performance and Discharge Goal(s), and Follow-up and Discharge Performance

Code 06, Independent, if the patient completes the activity by him/herself with no assistance from a helper.

Code 05, Setup or Clean-up Assistance, if the helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the patient requires assistance cutting up food or opening container, or requires setup of hygiene item(s) or assistive device(s).

Code 04, Supervision or Touching Assistance, if the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided 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 assistance during the activity.

Code 03, Partial/Moderate Assistance, if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

Code 02, Substantial/Maximal Assistance, if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

Code 01, Dependent, if the helper does ALL of the effort. Patient does none of the effort to complete the activity; or the assistance of two or more helpers is required for the patient to complete the activity.

Code 07, Patient Refused, if the patient refused to complete the activity.

Code 09, Not Applicable, if the patient did not attempt to perform the activity and did not perform this activity prior to the current illness, exacerbation, or injury.

Code 10, Not Attempted Due to Environmental Limitations, if the patient did not attempt this activity due to environmental limitations. Examples include lack of equipment, weather constraints

Code 88, Not Attempted Due to Medical Condition or Safety Concerns, if the activity was not attempted due to medical condition or safety concerns.

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

Coding Tips

GG0130A. Eating

Patient uses a gastrostomy tube (G-Tube) or total parenteral nutrition (TPN):

- Assistance with tube feedings or TPN is not considered when coding the item eating.

- If the patient does not eat or drink by mouth and relies **solely** on nutrition and liquids through tube feedings or TPN due to a **new (recent-onset) medical condition,** code GG0130A as 88, Not attempted due to medical condition or safety concerns.

- If the patient **does not** eat or drink by mouth at the time of the assessment, and the patient did not eat or drink by mouth **prior to the current** illness, injury or exacerbation, code GG0130A as 09, Not applicable.

- If the patient eats and drinks by mouth, *and* **relies partially** on obtaining nutrition and liquids via tube feedings or TPN, code eating based on the amount of assistance the patient requires to eat and drink by mouth.

GG0130B. Oral Hygiene

- If a patient does not perform oral hygiene during home visit, determine the patient's abilities based on the patient's performance of similar activities during the assessment, or on patient and/or caregiver report.

Examples – Performance

1. Eating – Food Consistency

Mrs. H does not have any food consistency restrictions, but often needs to swallow two or three times so that the food clears her throat due to difficulty with pharyngeal peristalsis. She requires verbal cues to use the compensatory strategy of extra swallows to clear the food.

> **Coding**: GG0130A, Eating, would be coded 04, Supervision or touching assistance.

> **Rationale**: Mrs. H swallows all types of food consistencies and requires verbal cueing (supervision) from the helper. Code based on assistance from the helper. The coding is not based on whether the patient had restrictions related to food consistency.

2. Eating – Visual Deficit

Mrs. V has difficulty seeing on her left side since her stroke. During meals, a helper must remind her to scan the entire plate to ensure she has seen all the food.

> **Coding:** GG0130A, Eating, would be coded 04, Supervision or touching assistance.

> **Rationale:** The helper provides verbal cueing assistance as Mrs. V completes the activity of eating. Supervision, such as reminders, may be provided throughout the activity or intermittently.

3. Eating – G-tube

Mr. R is unable to eat or drink by mouth since he had a stroke 1 week ago. He receives nutrition and hydration through a G-tube, which is administered by a helper.

> **Coding:** GG0130A, Eating, would be coded 88, Not attempted due to medical condition or safety concerns.

> **Rationale:** The patient does not eat or drink by mouth at this time due to a recent-onset medical condition (his recent-onset stroke). This item includes eating and drinking by mouth only.

4. Oral Hygiene – Assistance to and from the Bathroom

The helper provides steadying assistance to Mr. S as he walks to the bathroom. The helper applies toothpaste onto Mr. S's toothbrush. Mr. S then brushes his teeth at the sink in the bathroom without physical assistance or supervision. Once Mr. S is done brushing his teeth and washing his hands and face, the helper returns and provides steadying assistance as the patient walks back to his bed.

> **Coding:** GG0130B, Oral hygiene, would be coded 05, Setup or clean-up assistance.

> **Rationale:** The helper provides setup assistance (putting toothpaste on the toothbrush) before Mr. S brushes his teeth. Do not consider assistance provided to get to or from the bathroom to score Oral hygiene.

Examples - SOC/ROC Performance

1. SOC/ROC Performance When the Activity Did Not Occur at the Time of the Assessment, Nor Prior to the Current Illness, Injury or Exacerbation

Ms. J cannot swallow any food or liquids secondary to ALS. She has a J-tube and has been on tube feedings for several years. She is being admitted to skilled home health care for treatment of a sacral pressure injury. Her treatment includes TPN to support wound healing.

> **Coding:** GG0130A1, Eating, **SOC Performance** would be coded, 09, Not Applicable. GG0130A2, Eating, **Discharge Goal,** would be coded 09, Not Applicable.

> **Rationale:** Mr. J does not eat or drink by mouth at the time of assessment, and did not eat or drink by mouth prior to the current illness, injury or exacerbation. And, Mr. J is not expected to eat or drink by mouth by discharge.

2. SOC/ROC Performance When the Activity Did Not Occur at the Time of the Assessment, but Did Occur Prior to the Current Illness, Injury or Exacerbation

Mr. B has been prescribed bowel rest for pancreatitis, and he is not to eat or drink anything for one week, after which the home health nurse will support advancing back to a regular diet. TPN has been prescribed, and he is being admitted to home care for TPN teaching and management.

> **Coding:** GG0130A1, Eating, **SOC Performance,** would be coded 88, Not attempted due to medical condition or safety concerns.

Examples – Establish Discharge Goal(s) at SOC/ROC

3. Discharge Goal Code is Higher than SOC/ROC Performance Code

During SOC/ROC functional assessment, Mr. M states he prefers to bathe himself rather than depending on helpers or his wife to perform this activity. The clinician assesses Mr. M's SOC/ROC performance for Shower/Bathe self, and determines the helper performs more than half the effort. The assessing clinician, using professional judgement, available information and collaboration as allowed anticipates that by discharge Mr. M will require a helper for less than half of the activity Shower/Bathe self.

> **Coding:** GG0130E1, Shower/Bathe self, **SOC Performance,** would be coded 02, Substantial/maximal assistance. GG0130E2 Shower/Bathe self, **Discharge Goal**, would be coded 03, Partial/moderate assistance.

> **Rationale:** At SOC/ROC assessment, Mr. M participates in the activity Shower/bathe self, but a helper performs more than half the activity, the definition of substantial/maximal assistance. The assessing clinician expects Mr. M has the potential to improve in performance of this activity, to the extent that a helper needs to assist for less than half the activity, the definition for partial/moderate assistance.

4. Discharge Goal Code is the Same as SOC/ROC Performance Code

During the SOC/ROC assessment, Mrs. E states she prefers to participate in her oral hygiene twice daily. On assessment, the clinician identifies that Mrs. E's caregiver completes more than half of this activity. Mrs. E has severe arthritis, Parkinson's disease, diabetic neuropathy, and renal failure. These conditions result in multiple impairments, including limited endurance, weak hand grasp, slow movements and tremors. The assessing clinician, using professional judgment, all available information and collaboration as allowed, determines that Mrs. E is not expected to progress to a higher level of functioning during the episode of care. However, the clinician anticipates that Mrs. E will be able to maintain her SOC/ROC performance level. The clinician discusses functional goals with Mrs. E and they agree maintaining functioning is a reasonable goal.

> **Coding:** GG0130B1 Oral Hygiene, **SOC/ROC Performance,** would be coded 02, Substantial/maximal assistance. GG0130B2, Oral Hygiene, **Discharge Goal,** would be coded 02, Substantial/maximal assistance.

> **Rationale:** Performance assessment revealed Mrs. E's caregiver completes more than half the activity, Oral Hygiene, which matches Code 02, substantial/maximal assistance. Mrs. E's condition in this example makes it unlikely that her performance of this activity will improve, but that maintenance of her current level of function is possible, so the discharge goal is coded the same as admission performance.

5. Discharge Goal Code is Lower than SOC/ROC Performance Code

Mrs. T has a progressive neurological illness that affects her strength, coordination, and endurance. Mrs. T prefers to use the bedside commode for as long as possible rather than using incontinence undergarments. The helper currently supports Mrs. T while she is standing so that Mrs. T can pull down her underwear before sitting onto the bedside commode. When Mrs. T has finished voiding, she wipes her perineal area. Mrs. T then requires the helper to support her trunk while Mrs. T pulls up her underwear. The assessing clinician, using professional judgment, all available information and collaboration as allowed anticipates that Mrs. T will weaken further by discharge, and while she will still be able to use the bedside commode, she will need the helper to assist with all toileting hygiene.

> **Coding:** GG0130C1, Toileting hygiene, **SOC/ROC Performance**, would be coded 03, Partial/moderate assistance. GG0130C2, Toileting hygiene, **Discharge Goal**, would be coded 02, substantial/maximal assistance.

> **Rationale:** Assessment of SOC/ROC performance of toileting hygiene demonstrated that the helper provided less than half the effort for Mrs. T's toileting hygiene. The assessing clinician expects that by discharge, Mrs. T will need the helper to assist with more than half the effort of toileting hygiene.

6. Discharge Goal Code Is Established for a Patient Where the Activity Was 09 – Not Applicable at SOC/ROC

Mrs. D has been unable to eat or drink by mouth for several weeks, due to a large, cancerous lesion on the soft palate. A week ago, the lesion worsened becoming very painful and required surgical removal. At the SOC, she remains restricted from any oral intake, with the expected goal of progressing to small sips of water and soft foods by mouth with supervision by discharge from home health.

> **Coding:** GG0130A1, Eating, **SOC Performance,** would be coded 09, Not Applicable. GG0130A2, Eating, **Discharge Goal,** would be coded 04, Supervision or Touching Assistance.

> **Rationale:** Mrs. D does not eat or drink by mouth at the time of the SOC assessment, and did not eat or drink by mouth prior to the current illness, injury or exacerbation (the recent worsening necessitating surgery). The assessing clinician expects that by discharge, Mrs. D will be able to manage at least some food and drink by mouth, with supervision.

GG0170 Mobility

SOC/ROC

GG0170. Mobility
Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).
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. *Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury. 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 88. **Not attempted due to medical conditions or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to 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.
☐☐	☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**G.** **Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	☐☐	**I.** **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb)*
☐☐	☐☐	**J.** **Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	☐☐	**K.** **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐☐	☐☐	**L.** **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	**M.** **1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
☐☐	☐☐	**N.** **4 steps:** The ability to go up and down four steps with or without a rail. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
☐☐	☐☐	**O.** **12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐	**P.** **Picking up object**: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	☐	**Q.** **Does patient use wheelchair and/or scooter?** **0. No** → Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1. **1. Yes** → Continue to GG0170R, Wheel 50 feet with two turns.
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐	**RR1.** Indicate the type of wheelchair or scooter used. 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S.** **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐	**SS1.** Indicate the type of wheelchair or scooter used. 1. **Manual** 2. **Motorized**

Follow-Up

GG0170. Mobility
Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up code the reason.
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.
Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

4. Follow-Up Performance	
↓ **Enter Codes in Boxes**	
☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	C. **Lying to sitting on side of bed:** The ability to 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.
☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Follow-Up performance is coded 07, 09, 10 or 88 → skip to GG0170M, 1 step (curb).*
☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	L. **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.

(continued)

4. Follow-Up Performance		
↓ Enter Codes in Boxes		
[ ][ ]	*M.*	**1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If Follow-up performance is coded 07, 09, 10 or 88, skip to GG0170Q, Does patient use wheelchair and/or scooter?*
[ ][ ]	N.	**4 steps:** The ability to go up and down four steps with or without a rail.

[ ]		**Q. Does patient use wheelchair and/or scooter?**
		    0. No →Skip GG0170R
		    1. Yes → Continue to GG0170R, Wheel 50 feet with two turns.

[ ][ ]	R.	**Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

Discharge

GG0170. Mobility
Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, code the reason.
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. *Activities 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 and/or touching/steadying and/or contact guard 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** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury. 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 88. **Not attempted due to medical conditions or safety concerns**

3. Discharge Performance		
↓ Enter Codes in Boxes		
[ ][ ]	A.	**Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.

(continued)

3. Discharge Performance		
Enter Codes in Boxes ↓		
☐☐	**B.**	**Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C.**	**Lying to sitting on side of bed:** The ability to 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.
☐☐	**D.**	**Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E.**	**Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F.**	**Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**G.**	**Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	**I.**	**Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb).*
☐☐	**J.**	**Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	**K.**	**Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐☐	**L.**	**Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	**M.**	**1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
☐☐	**N.**	**4 steps:** The ability to go up and down four steps with or without a rail. *If Discharge performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
☐☐	**O.**	**12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	**P.**	**Picking up object**: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
☐		**Q. Does patient use wheelchair and/or scooter?** **0. No** → Skip to J1800 Any falls since SOC/ROC, whichever is more recent. **1. Yes** → Continue to GG0170R, Wheel 50 feet with two turns.
☐☐	**R.**	**Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
☐		**RR3. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**
☐☐	**S.**	**Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
☐		**SS3. Indicate the type of wheelchair or scooter used.** **1. Manual** **2. Motorized**

Item Intent

This item identifies the patient's ability to perform the listed mobility activities, and discharge goal(s).

Time Points Item(s) Completed

Start of care

Resumption of care

Follow-up

Discharge from agency – not to an inpatient facility

Note: This item, GG0170, includes **Performance** assessment and **Discharge Goal(s)** at SOC/ROC. Refer to sections for instructions, tips and examples for each.

Response-Specific Instructions – Performance Assessment (SOC/ROC, FU and DC)

- Licensed clinicians may assess the patient's performance based on direct observation (preferred) as well as reports from patient, clinicians, care staff, and/or family.

- When possible, CMS invites a multidisciplinary approach to patient assessment.

- Patients should be allowed to perform activities as independently as possible, as long as they are safe.

  – If helper assistance is required because the patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

  – Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.

- Patients with cognitive impairments/limitations may need physical assistance and/or verbal assistance when completing an activity. Code based on the patient's need for assistance to complete an activity safely

Response-Specific Instructions – SOC/ROC Performance Assessment

- Code the patient's functional status based on a functional assessment that occurs at or soon after the patient's SOC/ROC. The SOC/ROC function scores are to reflect the patient's SOC/ROC baseline status, and are to be based on observation of activities, to the extent possible. When possible, the assessment should occur prior to the start of therapy services to capture the patient's true baseline status. This is because therapy interventions can affect the patient's functional status.

- A patient's functional ability can be impacted by the environment or situations encountered in the home. Observing the patient in different locations and circumstances within the home is important for a comprehensive understanding of the patient's functional status.

  – If the patient's ability varies during the *assessment timeframe,* record their *usual ability* to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather the patient's usual performance; what is true greater than 50% of the assessment timeframe.

> **DEFINITION**
>
> **ASSESSMENT TIMEFRAME**
> - The assessment timeframe is the maximum number of days within which to complete the comprehensive assessment.

> **DEFINITION**
>
> **USUAL PERFORMANCE, ABILITY**
> - A patient's usual performance is his/her ability greater than 50% of the assessment timeframe.

Response-Specific Instructions – SOC/ROC Discharge Goal(s)

- For the Home Health (HH) Quality Reporting Program (QRP) a minimum of one self-care or mobility discharge goal must be coded. However, agencies may choose to complete more than one self-care or mobility discharge goal. Code the patient's discharge goal(s) using the 6-point scale. Use of the activity not attempted codes (07, 09, 10 or 88) is permissible to code discharge goal(s). Use of a dash is permissible for any remaining self-care or mobility goals that were not coded.

- Discharge goal(s) may be coded the same as SOC/ROC performance, higher than SOC/ROC performance, or lower than SOC/ROC performance (See Examples).

- If the SOC/ROC performance of an activity was coded using one of the activity not attempted codes (07, 09, 10 or 88), a discharge goal may be submitted using the 6-point scale if the patient is expected to be able to perform the activity by discharge.

- Licensed clinicians can establish a patient's discharge goal(s) at the time of SOC/ROC based on the patient's prior medical condition, SOC/ROC assessment, self-care and mobility status, discussions with the patient and family, professional judgment, the profession's practice standards, expected treatments, patient motivation to improve, anticipated length of stay, and the discharge plan. Goals should be established as part of the patient's care plan.

Response-Specific Instructions – Follow-Up and Discharge Performance

- **Follow-up Performance:** Clinicians should code the patient's functional status based on a functional assessment that occurs within the assessment timeframe.

- **Discharge Performance:** The discharge *time period under consideration* includes the last 5 days of care. This includes the date of the discharge visit plus the four preceding calendar days. Code the patient's functional status based on a functional assessment that occurs at or close to the time of discharge.

> **DEFINITION**
>
> **TIME PERIOD UNDER CONSIDERATION**
> - The time period under consideration is the span of time for data collection and assessment. For most OASIS items this is the day of assessment. For other items, item wording or related guidance will specify the time period under consideration, such as, since the most recent SOC/ROC.

Coding Instructions

Code 06, Independent, if the patient completes the activity by him/herself with no assistance from a helper.

Code 05, Setup or clean-up assistance, if the helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the patient requires placement of a bed rail to facilitate rolling, or requires setup of a leg lifter or other assistive devices.

Code 04, Supervision or touching assistance, if the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. For example, the patient requires verbal cueing, coaxing, or general supervision for safety to complete the activity, or patient may require only incidental help such as contact guard or steadying assistance during the activity.

Code 03, Partial/moderate assistance, if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. For example, the patient requires assistance such as partial weight-bearing assistance, but HELPER does LESS THAN HALF the effort.

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

Code 01, Dependent, if the helper does ALL of the effort. Patient does none of the effort to complete the activity, or the assistance of two or more helpers is required for the patient to complete the activity.

Code 07, Patient refused, if the patient refused to complete the activity.

Code 09, Not applicable, if the patient did not attempt to perform the activity and did not perform this activity prior to the current illness, exacerbation, or injury.

Code 10, Not attempted due to environmental limitations, if the patient did not attempt this activity due to environmental limitations. Examples include lack of equipment, weather constraints, etc.

Code 88, Not attempted due to medical condition or safety concerns, if the activity was not attempted due to medical condition or safety concerns.

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

Coding Tips and Examples

General Coding Tips

- If a patient does not attempt the activity and a helper does not complete the activity, and the patient's usual status cannot be determined based on patient or caregiver report, code the reason the activity was not attempted:

  - Code 07 if the patient refused to attempt the activity
  - Code 10 if the activity was not attempted due to environmental limitations
  - Code 09 if the patient could not perform an activity at the time of assessment, and also <u>could not</u> perform the activity prior to the current illness, exacerbation or injury
  - Code 88 if the patient could not perform an activity at the time of the assessment, but <u>could</u> perform the activity prior to the current illness, exacerbation or injury

- If the only help a patient needs to complete an activity is for a helper to retrieve an assistive device or adaptive equipment, such as a cane for walking, or a tub bench for bathing then enter code 05, Setup or clean-up assistance.
- If two or more helpers are required to assist the patient to complete the activity, code as 01 Dependent.
- A dash (–) indicates "No information." Do not use a dash if the reason that the item was not assessed was because the patient refused (code 07), the item is not applicable (code 09), the activity was not attempted due to environmental limitations (code 10), or the activity was not attempted due to medical condition or safety concerns (code 88).

Coding Tips and Examples GG0170A, Roll Left and Right

- The activity includes the patient rolling to both the left and to the right while in a lying position,
- If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, but <u>could</u> perform this activity prior to the current illness, exacerbation or injury, code 88, Not attempted due to medical condition or safety concerns.

- For example, if a clinician determines that a patient's new medical need requires that the patient sit in an upright sitting position rather than a slightly elevated position, then code GG0170A, Roll left and right as 88, Not attempted due to medical or safety concerns.
- If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, and could <u>not</u> perform the activity prior to the current illness, exacerbation or injury, code 09, Not applicable.
- For GG0170A, Roll left and right, clinical judgment should be used to determine what is considered a "lying" position for the patient. For example, a clinician could determine that a patient's preferred slightly elevated resting position is "lying" for that patient.

1. GG0170A, Roll Left and Right

At SOC, the physical therapist helps Mr. R turn onto his right side by instructing him to bend his left leg and roll to his right side. He then instructs him how to position his limbs to return to lying on his back and then to repeat a similar process for rolling onto his left side and then return to lying on his back. Mr. R completes the activity without physical assistance from a helper. Mr. R was moving about in bed without difficulty prior to hospitalization. The therapist expects Mr. R will roll left and right by himself by discharge.

> **Coding:** GG0170A, Roll left and right, **SOC Performance** would be coded 04, Supervision or touching assistance. **Discharge Goal** would be coded 06, Independent.

> **Rationale:** At SOC, the physical therapist provides verbal cues (i.e., instructions) to Mr. R as he rolls from his back to his right side and returns to lying on his back. The physical therapist does not provide any physical assistance. After assessment and considering his current condition, the therapist expects Mr. R will be independently rolling left and right at discharge.

Coding Tips and Examples GG0170B, Sit to Lying

- The activity includes the ability to move from sitting on side of bed to lying flat on the bed.
- If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, but could perform this activity prior to the current illness, exacerbation or injury, code 88, Not attempted due to medical condition or safety concerns.
  - For example, if a clinician determines that a new patient medical need requires that the patient sit in an upright sitting position rather than a slightly elevated position, then code GG0170B, Sit to lying as 88, Not attempted due to medical or safety concerns.

- If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, and could not perform the activity prior to the current illness, exacerbation or injury, code 09, Not applicable.
- For GG0170B, Sit to lying, clinical judgment should be used to determine what is considered a "lying" position for the patient. For example, a clinician could determine that a patient's preferred slightly elevated resting position is "lying" for that patient.

2. GG0170B, Sit to Lying

Mr. A suffered multiple vertebral fractures due to a fall off a ladder. At SOC, he requires assistance from a therapist to get from a sitting position to lying flat on the bed because of significant pain in his lower back. The therapist supports his trunk and lifts both legs to assist Mr. A from sitting at the side of the bed to lying flat on the bed. Mr. A assists himself a small amount by raising one leg onto the bed and then bending both knees while transitioning into a lying position.

> **Coding:** GG0170B, Sit to lying **SOC Performance** would be coded 02, Substantial/maximal assistance.

> **Rationale:** The therapist provided more than half the effort for the patient to complete the activity of sit to lying.

At SOC, Mrs. H requires assistance from two helpers to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on her right side, obesity, and cognitive limitations. One of the helpers explains to Mrs. H each step of the sitting to lying activity. Mrs. H is then fully assisted to get from sitting to a lying position on the bed. Mrs. H makes no attempt to assist when asked to perform the incremental steps of the activity.

> **Coding:** GG0170B, Sit to lying, **SOC Performance** would be coded 01, Dependent.

> **Rationale:** The patient does none of the effort to complete the activity, and the assistance of two helpers is needed to complete the activity of sit to lying. If two or more helpers are required to assist the patient to complete an activity, code as 01, Dependent.

Coding Tips and Examples GG0170C, Lying to Sitting on Side of Bed

- The activity includes patient transitions from lying on his/her back to sitting on the side of the bed with feet flat on the floor and sitting upright on the bed without back support.
- If a patient's feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment (if applicable), or a foot stool is required to accommodate foot placement on the floor/footstool.
- Back support refers to an object or person providing support of the patient's back.
- If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, but could perform this activity prior to the current illness,

exacerbation or injury, code 88, Not attempted due to medical condition or safety concerns.

- If a clinician determines that a new patient medical need requires that the patient sit in an upright sitting position rather than a slightly elevated position, then code GG0170C, Lying to sitting on side of bed as 88, Not attempted due to medical or safety concerns,
- If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, and could not perform the activity prior to the current illness, exacerbation or injury, code 09, Not applicable.
- For GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a "lying" position for the patient. For example, a clinician could determine that a patient's preferred slightly elevated resting position is "lying" for that patient.

3. GG0170C, Lying to Sitting on Side of Bed

Ms. H is recovering from a spinal fusion. At SOC, she rolls to her right side and pushes herself up from the bed to get from a lying to a seated position. The therapist provides needed verbal cues to guide Ms. H as she safely uses her hands and arms to support her trunk and avoid twisting as she raises herself from the bed. Ms. H then safely maneuvers to the edge of the bed, finally lowering her feet to the floor to complete the activity without hands-on assistance.

> **Coding:** GG0170C, Lying to sitting on side of bed **SOC Performance** would be coded 04, Supervision or touching assistance.

> **Rationale:** The therapist provides verbal cues only as Ms. H safely moves from a lying to sitting position on the side of the bed with her feet on the floor.

> **Coding Tips and Examples, GG0170D, Sit to Stand**

- The activity includes the patient coming to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
- If the only help a patient needs to complete the sit to stand activity is for a helper to retrieve an assistive device or adaptive equipment, such as a walker or ankle foot orthosis, then enter code 05, Setup or clean-up assistance.

4. GG0170D, Sit to Stand

Mr. B is being admitted to home health for pressure ulcer care. He has complete tetraplegia from an injury one year ago and has been unable to bear weight in standing since the injury. At SOC, using a patient lift that does not require him to come to standing, he is transferred from his bed into a wheelchair with assistance.

> **Coding:** GG0170D, Sit to stand **SOC Performance** would be coded 09, Not applicable.

Rationale: The activity was not attempted at admission and the patient did not perform this activity prior to the current illness, exacerbation or injury (the pressure ulcer) due to the diagnosis of complete tetraplegia.

Coding Tips and Examples GG0170E, Chair/Bed-to-Chair Transfer

- The activity begins with the patient sitting (in a chair, wheelchair, or at the edge of the bed) and transferring to sitting in a chair, wheelchair, or at the edge of the bed.
- Sit to lying and lying to sitting are not assessed as part of GG0170E.
- If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer and two helpers are needed to assist with a mechanical lift transfer, then code 01, Dependent, even if the patient assists with any part of the chair/bed-to-chair transfer.

5. GG0170E, Chair/Bed-to-Chair Transfer

Mr. L had a stroke and uses a wheelchair for mobility. When Mr. L gets out of bed at SOC, the therapist moves the wheelchair into the correct position and locks the brakes so that Mr. L can transfer into the wheelchair safely. Mr. L transfers into the wheelchair by himself without the need for supervision or assistance during the transfer. The family reports that Mr. L does transfer safely without the need for supervision, once the wheelchair is placed and locked. The nurse does not expect Mr. L's mobility status to change by discharge.

Coding: GG0170E, Chair/bed-to-chair transfer, **SOC Performance** would be coded 05, Setup or clean-up assistance. **Discharge Goal** would be coded 05, Setup or clean up assistance.

Rationale: A helper must provide setup assistance only. Once set up is provided, Mr. L transfers safely and does not need supervision or physical assistance during the transfer. The nurse expects Mr. L will continue to need wheelchair setup assistance for this transfer at discharge.

Coding Tips and Examples GG0170F, Toilet Transfer

- The activity includes the patient getting on and off a toilet or commode.
- Use of assistive device(s) and adaptive equipment (for instance a grab bar or elevated toilet) required to complete the toilet transfer should not affect coding of the activity.
- If the only help a patient needs to complete the toilet transfer activity is for a helper to retrieve and place the toilet seat riser, and remove it after patient use, then enter code 05, Setup or clean-up assistance.
- Toileting hygiene and clothing management are not considered part of the toilet transferring activity.
- If the patient requires assistance from two or more helpers to get on and off the toilet or commode, then enter code 01, Dependent.

6. GG0170F, Toilet Transfer

The assessing clinician notes that the home health aide visit note (documented on the afternoon visit on the SOC date) stated that the aide needed to steady Mrs. Z with a light contact when the patient lowers her underwear and then transfers onto the toilet. After voiding, Mrs. Z cleanses herself. She then stands up supporting her own weight as the aide steadies her. Mrs. Z pulls up her underwear as the aide steadies her to ensure Mrs. Z does not lose her balance.

> **Coding:** GG0170F, Toilet transfer, **SOC Performance** would be coded 04, Supervision or touching assistance.

> **Rationale:** The aide provides steadying assistance only as the patient transfers on and off the toilet. Assistance with managing clothing and cleansing is coded under item GG0130C, Toileting hygiene, and is not considered when rating the Toilet transfer item.

At SOC, Mrs. S is on bedrest due to a new medical complication. She uses a bedpan for bladder and bowel management. The assessing clinician expects the patient will return to independent use of the bathroom toilet once the current condition resolves.

> **Coding:** GG0170F, Toilet transfer **SOC Performance** would be coded 88, Not attempted due to medical condition or safety concerns. **Discharge Goal** would be coded 06 Independent.

> **Rationale:** At SOC, the patient does not transfer onto or off a toilet due to being on bedrest because of a new medical condition, but was able to perform this activity prior to the current medical condition. It is expected that the patient will be independent in the activity at discharge.

Coding Tips and Examples GG0170G, Car Transfer

- The activity includes transferring in and out of a car or van on the passenger side.
- Does not include opening or closing the car door, or fastening seat belt.
- If the patient is not able to attempt car transfers (for example because no car is available, or there are weather or other environmental constraints), and the patient's usual status cannot be determined based on patient or caregiver report, enter code 10 Not attempted due to environmental limitations.
- If at the time of the assessment the patient is unable to attempt car transfers, and could not perform the car transfers prior to the current illness, exacerbation or injury, code 09, Not applicable.

7. GG0170, Car Transfer

Mrs. W uses a wheelchair and ambulates for only short distances. At SOC, Mrs. W requires the physical therapist to lift most of her weight to get from a seated position in the wheelchair to a standing position. The therapist provides trunk support when Mrs. W takes several steps during the transfer turn. Mrs. W lowers herself into the car seat with steadying assistance from the

therapist. Mrs. W-moves her legs into the car as the therapist lifts the weight of her legs from the ground.

> **Coding:** GG0170G, Car transfer **SOC Performance** would be coded 02, Substantial/maximal assistance.

> **Rationale:** The therapist completed more than half the effort to transfer Mrs. W into the car by providing significant lifting assistance from the wheelchair, trunk support when taking steps toward the car seat, steadying when lowering into the car seat and lifting support when moving legs into the car. Mrs. W contributes less than half of the effort to complete the activity.

The day after being admitted to home health, Mrs. N works with an occupational therapist on transfers in and out of the passenger side of a car. When reviewing the therapist's evaluation, the assessing clinician reads that when performing car transfers, Mrs. N required verbal reminders for safety and contact guarding assistance from the OT for guidance and direction. The therapist instructed the patient on strategic hand placement while Mrs. N transitioned to sitting into the car seat. Documentation showed that the therapist opened and closed the car door.

> **Coding:** GG0170G, Car transfer **SOC Performance** would be coded 04, Supervision or touching assistance.

> **Rationale:** The therapist provides touching assistance only as the patient transfers in the passenger seat of the car. Assistance with opening and closing the car door is not included in the definition of this item and is not considered when coding this item.

Coding Tips and Examples GG0170I, Walk 10 Feet

- Starting from standing, the activity includes walking at least 10 feet in a room, corridor, or similar space.
- Use of assistive device(s) and adaptive equipment (for instance a cane or leg brace) required to complete the walking activity should not affect coding of the activity.
- If the only help a patient needs to complete the walking activity is for a helper to retrieve and place the walker and/or put it away after patient use, then enter code 05, Setup or clean-up assistance.

8. GG0170I, Walk 10 Feet

Mr. L had bilateral amputations 3 years ago, and prior to this HH admission he used a wheelchair and did not walk. At SOC, Mr. L does not use prosthetic devices and only uses a wheelchair for mobility. Mr. L's care plan includes assisting with fitting and use of bilateral lower extremity prostheses. The therapist's care plan goal is for Mr. L to walk distances of 30 feet with supervision within his home and then discharge to outpatient therapy.

> **Coding:** GG0170I, Walk 10 feet, **SOC Performance** would be coded 09, Not applicable. **Discharge Goal** would be coded 04, Supervision or touching assistance.

Rationale: When assessing the resident for GG0170I, Walk 10 feet, consider the patient's status prior to the current illness, exacerbation or injury. Use code 09, Not applicable, because Mr. L could not perform the activity of walking at SOC, and did not perform the activity of walking prior to the current episode of care. The therapist expects Mr. L will be walking more than 10 feet with supervision by discharge.

Coding Tips and Examples GG0170J, Walk 50 Feet with Two Turns

- Starting from standing, the activity includes walking 50 feet and making two turns.
- The turns are 90 degree turns and may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the right and one 90 degree turn to the left).
- The 90 degree turns should occur at the patient's ability level (i.e., not jeopardizing patient safety), and can include the use of an assistive device (for example walker or crutches) without affecting coding of the activity.

9. GG0170, Walk 50 Feet with Two Turns

At SOC, Mr. B is recovering from a recent stroke and now has difficulty walking. Even with assistance, he is able to walk only 30 feet. Mr. B's care plan includes muscle strengthening and gait training. The therapist expects Mr. B will be able to walk 50 feet with two turns safely with the assistance of a caregiver for verbal cues and contact guard for steadying on the turns at discharge.

Coding: GG0170J, Walk 50 feet with two turns, would be coded 88, Not attempted due to medical condition or safety concerns. **Discharge Goal** would be 04 Supervision or touching assistance.

Rationale: Mr. B is ambulatory but was not able to walk the entire distance because of his new medical condition (stroke). Since the patient is unable to complete the activity at SOC, but was completing the activity prior to the recent stroke, Code 88 is appropriate. Although not able to complete the activity at SOC, the therapist anticipates Mr. B will be able to walk 50 feet with two turns safely with the assistance of a caregiver for verbal cues and contact guarding at discharge.

Coding Tips and Examples GG0170K, Walk 150 Feet

- Starting from standing, the activity includes walking 150 feet in a corridor, or similar space.
- If the patient's environment does not accommodate a walk of 150 feet without turns, but the patient demonstrates the ability to walk with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale.
- Use of assistive device(s) and adaptive equipment (for instance a rolling walker or quad cane) required to complete the walking activity should not affect coding of the activity.

- If the only help a patient needs to complete the walking activity is for a helper to retrieve and place the assistive device and/or put it away after patient use, then enter code 05, Setup or clean-up assistance.

10. GG0170K, Walk 150 Feet

Mr. R has recent endurance limitations due to an exacerbation of heart failure and is only walking about 30 feet before he tires, loses strength and must sit and rest. He reports he was walking 150 feet or more with his cane prior to this exacerbation of his heart failure.

Coding: GG0170K, Walk 150 feet would be coded 88, Activity not attempted due to medical or safety concerns.

Rationale: The activity was not attempted due to Mr. R's recent endurance limitations and current medical condition, but he was able to complete the activity prior to the recent exacerbation of his condition.

Coding Tips and Examples GG0170L, Walking 10 Feet on Uneven Surfaces

- Once standing, the activity includes walking 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
- If the patient is not able to attempt walking on uneven surfaces (for example because no uneven surfaces are available, or there are weather or other environmental constraints limiting access), and the patient's usual status for walking 10 feet on uneven surfaces cannot be determined based on patient or caregiver report, enter code 10 Not attempted due to environmental limitations.
- Use of assistive device(s) and adaptive equipment (for instance a rolling walker or quad cane) required to complete the walking activity should not affect coding of the activity.

11. GG0170L, Walking 10 Feet on Uneven Surfaces

Mrs. N has severe joint degenerative disease and is recovering from sepsis. When walking on the uneven driveway was attempted yesterday when Mrs. N came home from the hospital, she reports that her neighbor had to hold her belt and help lift her a little during a few steps. The neighbor also provided help to advance the walker across the gravel driveway as the patient walked.

Coding: GG0170L, Walking 10 feet on uneven surfaces would be coded 03, Partial/moderate assistance.

Rationale: Per patient report, Mrs. N requires help provide some weight-bearing support, and assist in advancing the walker as she walked 10 feet on uneven surfaces. The helper does less than half the effort for walking 10 feet on uneven surfaces.

Coding Tips and Examples GG0170M, 1 Step (curb)

- The activity includes the patient going up and down a curb and/or one step.

- Use of assistive device(s) and adaptive equipment (for instance a railing or cane) required to complete the activity should not affect coding of the activity.

12. GG0170M, 1 Step (curb)

Mrs. Z had a stroke and needs to learn how to step up and down one step to enter and exit her home. At SOC, the physical therapist provides needed verbal cueing as Mrs. Z uses her quad cane to aid her balance in stepping up and back down one step. The therapist does not provide any physical assistance.

Coding: GG0170M, 1 step would be coded 04, Supervision or touching assistance.

Rationale: The patient needs only verbal cueing to complete the activity of stepping up and down one step.

Coding Tips and Examples GG0170N, 4 Steps

- The activity includes the patient going up and down four steps with or without a rail.
- Use of assistive device(s) and adaptive equipment (for instance a railing or cane) required to complete the activity should not affect coding of the activity.
- If at the time of the assessment the patient is unable to complete the activity due to a physician prescribed restriction (for instance, no stair climbing for 2 weeks), but could perform this activity prior to the current illness, exacerbation or injury, code 88, Not attempted due to medical condition or safety concern.

13. GG0170N, 4 Steps

At SOC, Mr. J has lower body weakness and the physical therapist provides light touching assistance when he ascends 4 steps. While descending 4 steps, the physical therapist faces the patient and descends the stairs providing minimal trunk support, with one hand on the patient's hip and the other holding the gait belt, as Mr. J holds the stair railing.

Coding: GG0170N, 4 steps would be coded 03, Partial/moderate assistance.

Rationale: The therapist provides touching assistance as Mr. J ascends 4 steps. The therapist provides minimal trunk support when he descends the 4 steps, providing less than half the effort to complete the activity. The patient requires partial/moderate assistance to up and down 4 steps.

Coding Tips and Examples GG0170O, 12 Steps

- The activity includes the patient going up and down 12 steps with or without a rail.
- Use of assistive device(s) and adaptive equipment (for instance a railing or cane) required to complete the activity should not affect coding of the activity.
- If at the time of the assessment the patient is unable to complete the activity due to a physician prescribed restriction (for instance, no stair climbing for 2 weeks), but could perform this activity prior to the current illness, exacerbation or injury, code 88, Not attempted due to medical condition or safety concern.

14. GG0170O, 12 Steps

At SOC, Ms. Y is recovering from a stroke and has 12 stairs with a railing and she needs to use these stairs to enter and exit her home. The physical therapist uses a gait belt around her trunk and at times is required to support much of the patient's weight as Ms. Y ascends and then descends 12 stairs.

Coding: GG0170O, 12 steps would be coded 02, Substantial/maximal assistance.

Rationale: The therapist provides more than half the effort in providing the necessary support for Ms. Y as she ascends and descends 12 stairs by intermittently supporting much of her weight using a gait belt.

Mrs. D is returning home after a hip replacement. She is restricted from stair climbing until she is seen for her follow-up MD appointment. Just prior to her surgery, she was able to climb her flight of 12 stairs with stand-by assist of her niece.

Coding: GG0170O, 12 steps would be coded 88 – Not attempted due to medical condition or safety concerns.

Rationale: At the SOC, the patient is unable to complete the activity of going up and down 12 steps due to a temporary physician-ordered activity restriction. Prior to the recent surgery, Mrs. D was able to complete that activity with assistance so code 88 is appropriate.

Coding Tips and Examples GG0170P, Picking up Object

- The activity includes the patient bending/stooping from a standing position to pick up a small object, such a spoon, from the floor.
- Use of assistive device(s) and adaptive equipment (for instance a cane to support standing balance and a reacher to pick up the object) required to complete the activity should not affect coding of the activity.
- If at the time of the assessment the patient is unable to complete the activity (for instance is unable to stand), and <u>could</u> not stand to perform this activity prior to the current illness, exacerbation or injury, code 09, Not applicable.

15. GG0170P, Picking up Object

Mr. P has a neurologic condition that has resulted in coordination and balance problems. At SOC, he reports he and his wife worked with the OT in the SNF on picking things off the floor. He demonstrates how he stoops to pick up a pencil from the floor as his wife provides the right amount of verbal cues for safety and stands by, ready to help in case he loses his balance.

Coding: GG0170P, Picking up object would be coded 04, Supervision or touching assistance.

Rationale: A caregiver is needed to provide verbal cues and stand-by assistance when Mr. P picks up an object due to his coordination issues.

Ms. C has recently undergone a hip replacement. At SOC, she walks with a walker without assistance. When she drops a hair brush from her walker basket, she asks her daughter to locate her long-handled reacher and bring it to her. Using the reacher, Mrs. C is able to bend slightly, and safely pick up the hair brush with the reacher, without need of additional assistance or verbal cues.

Coding: GG0170P, Picking up object would be coded 05, Set-up or clean-up assistance.

Rationale: The daughter provides set-up assistance only by retrieving the reacher and then the patient is able use the device to pick up the hairbrush safely.

Coding Tips and Examples GG0170Q, Does the Patient Use a Wheelchair/Scooter?

- The intent of the wheelchair mobility item is to assess the ability of patients who are learning how to self-mobilize using a wheelchair or patients who used a wheelchair prior to admission.
- Use clinical judgment to determine if the patient's use of a wheelchair is for self-mobilization due to the patient's medical condition or safety.
- If the patient is ambulatory and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport within a larger living facility (assisted living facility or apartment complex), or for community mobility outside the home (for instance to a physician appointment or to dialysis), enter code 0 – No for GG0170Q Does the patient use a wheelchair/scooter, and skip all remaining wheelchair questions.

Coding Tips and Examples GG0170R, Wheel 50 Feet with Two Turns, and GG0170RR, Indicate the Type of Wheelchair or Scooter Used

- Once seated in the wheelchair or scooter, the activity includes wheeling at least 50 feet and making two turns.
- Indicate whether the wheelchair or scooter used is manual or motorized.
- The turns are 90 degree turns and may be in the same direction (two 90 degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the right and one 90 degree turn to the left).
- The 90 degree turns should occur at the patient's ability level (i.e., not jeopardizing patient safety).

16. **GG0170R, Wheel 50 Feet with Two Turns, and GG0170RR, Indicate the Type of Wheelchair or Scooter Used**

At SOC, Mrs. M is unable to bear any weight on her right leg due to a recent fracture. The nurse observes as the certified nursing assistant in the assisted living facility provides steadying assistance when transferring Mrs. M from the bed into her manual wheelchair. Once in her wheelchair, Mrs. M propels herself safely about 60 feet down the hall using her left leg and safely makes two turns without any necessary physical assistance or supervision.

Coding: GG0170R, Wheel 50 feet with two turns would be coded 06, Independent.

Rationale: Mrs. M wheels herself more than 50 feet safely without need for supervision or physical assistance. Assistance provided with the transfer is not considered when scoring Wheel 50 feet with two turns. Score assistance with bed to chair transfer in GG0170E.

Indicate the type of wheelchair/scooter used: In the above example Mrs. M used a manual wheelchair.

Coding: GG0170RR, Indicate the type of wheelchair/scooter used would be coded 1, Manual.

Rationale: Mrs. M uses a manual wheelchair to self-mobilize.

Once seated in the manual wheelchair, Ms. R wheels about 10 feet, including around one corner to the hallway. Due to shoulder pain, she asks her son to push the wheelchair the additional 40 feet around another corner and into her bathroom.

Coding: GG0170R, Wheel 50 feet with two turns would be coded 02, Substantial/maximal assistance.

Rationale: The helper provides more than half the effort to assist the patient to complete the activity.

Indicate the type of wheelchair/scooter used: In the above example Ms. R used a manual wheelchair.

Coding: GG0170RR, Indicate the type of wheelchair/scooter used would be coded 1, Manual.

Rationale: Ms. R used a manual wheelchair.

Coding Tips and Examples GG0170S, Wheel 150 Feet and GG0170SS, Indicate the Type of Wheelchair/Scooter Used

- Once seated in the wheelchair or scooter, the activity includes wheeling at least 150 feet in a corridor or similar space.
- Indicate whether the wheelchair or scooter used is manual or motorized.
- If the patient's environment does not accommodate wheelchair/scooter use of 150 feet without turns, but the patient demonstrates the ability to mobilize the wheelchair/scooter with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale.

17. GG0170S, Wheel 150 Feet and GG0170SS, Indicate the Type of Wheelchair/Scooter Used

Mr. N uses a below-the-knee prosthetic limb. Mr. N has peripheral neuropathy and limited vision due to complications of diabetes. Via observation and patient report, the assessing clinician

determines that Mr. N's usual performance is that a helper is needed to provide verbal cues for safety due to vision deficits, and the patient mobilizes his manual wheelchair a distance of 150 within his home.

> **Coding:** GG0170S, Wheel 150 feet would be coded 04, Supervision or touching assistance.

> **Rationale:** Mr. N requires the helper to provide verbal cues for his safety when using a wheelchair for 150 feet.

Indicate the type of wheelchair/scooter used: In the above example Mr. N used a manual wheelchair.

> **Coding:** GG0170SS, Indicate the type of wheelchair/scooter used would be coded 1, Manual.

> **Rationale:** Mr. N used a manual wheelchair.

SECTION J: HEALTH CONDITIONS

J1800: Any Falls Since SOC/ROC, whichever is more recent

J1800.	**Any Falls Since SOC/ROC,** whichever is more recent

Enter Code
 ☐
	Has the patient **had any falls since SOC/ROC,** whichever is more recent**?**
	      0. **No** → Skip J1900
	      1. **Yes** → Continue to J1900, Number of Falls Since SOC/ROC, whichever is more recent

Item Intent

This item identifies if the patient had any witnessed or unwitnessed falls since the most recent SOC/ROC.

Time Points Item(s) Completed

Transfer to an inpatient facility

Death at home

Discharge from agency – not to an inpatient facility

Response-Specific Instructions

Review home health clinical record, incident reports and any other relevant clinical documentation (for example, fall logs)

Interview patient and/or caregiver about occurrence of falls

Coding Instructions

- **Code 0, No**, if the patient has not had any fall since the most recent SOC/ROC.
- **Code 1, Yes**, if the patient has fallen since the most recent SOC/ROC.
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

DEFINITION

FALL
- Unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (such as a bed or chair). The fall may be witnessed or unwitnessed, reported by the patient or an observer, or identified when a patient is found on the floor or ground. Falls are not a result of an overwhelming external force (such as, a person pushes a patient).
- An **intercepted fall** occurs when the patient would have fallen if he or she had not caught him/herself or had not been intercepted by another person— this is still considered a fall.
- CMS understands that **challenging a patient's balance** and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

Examples

1. Unwitnessed Fall

The discharging RN reviews the clinical record and interviews the patient and caregiver, Mrs. K and her daughter Susan, determining that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit in which Susan reported her mother slipped from her wheelchair to the floor the previous day.

> **Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.

> **Rationale:** This item addresses unwitnessed as well as witnessed falls.

2. Intercepted Fall

An incident report describes an event in which Mr. S appeared to slip on a wet spot on the floor during a home health aide bath visit. He lost his balance and bumped into the wall, but was able to steady himself and remain standing.

> **Coding:** J1800, Any Falls since SOC/ROC, would be coded 1, Yes.

> **Rationale:** An intercepted fall is considered a fall.

3. Balance Training – Challenge Balance

A patient is participating in balance retraining activities during a therapy visit. The therapist is intentionally challenging patient's balance, anticipating a loss of balance. The patient has a loss of balance to the left due to hemiplegia and the physical therapist provides minimal assistance to allow the patient to maintain standing.

> **Coding:** J1800, Any Falls since SOC/ROC, would be coded 0, No.

> **Rationale:** The patient's balance was intentionally being challenged by the physical therapist, so a loss of balance is anticipated. When assistance is provided to a patient to allow him/her to maintain standing during an anticipated loss of balance during a supervised therapeutic intervention, this is not considered a fall or intercepted fall.

4. Unanticipated Fall During Therapy

A patient is ambulating with a walker with the help of the physical therapist. The patient stumbles and the therapist has to bear some of the patient's weight in order to prevent a fall.

> **Coding:** J1800, Any Falls since SOC/ROC would be coded 1, Yes.

> **Rationale:** The patient's stumble was not anticipated by the therapist. The therapist intervened to prevent a fall. An intercepted fall is considered a fall.

Data Sources/Resources

Patient report

Caregiver report

Patient record

Incident reports

Relevant clinical documentation, such as fall logs

J1900: Number of Falls Since SOC/ROC, whichever is more recent

J1900.	**Number of Falls Since SOC/ROC,** whichever is more recent	
CODING:	**↓ Enter Codes in Boxes**	
0. None 1. One 2. Two or more	☐	**A.** **No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B.** **Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C.** **Major injury:** Bone **fractures**, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Item Intent

This item identifies the number of falls a patient had since the most recent SOC/ROC, and fall-related injury.

Time Points Item(s) Completed

Transfer to an inpatient facility

Death at home

Discharge from agency – not to an inpatient facility

Response-Specific Instructions

Review the home health clinical record, incident reports and any other relevant clinical documentation, such as fall logs.

Interview the patient and/or caregiver about occurrence of falls.

Determine the number of falls that occurred since the most recent SOC/ROC, and, code the level of fall-related injury for each.

Code falls no matter where the fall occurred.

Code each fall only once.

If the patient has multiple injuries in a single fall, code the fall for the highest level of injury.

DEFINITIONS

INJURY RELATED TO A FALL
Any documented or reported injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

NO INJURY
No evidence of any injury noted on assessment; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall.

INJURY (EXCEPT MAJOR)
Includes skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the patient to complain of pain.

MAJOR INJURY
Includes bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

Coding Instructions for J1900A, No Injury

- **Code 0, None**, if the patient had no injurious falls since the most recent SOC/ROC.
- **Code 1, One**, if the patient had one non-injurious fall since the most recent SOC/ROC.
- **Code 2**, **Two or more**, if the patient had two or more non-injurious falls since the most recent SOC/ROC.
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

Coding Instructions for J1900B, Injury, Except Major

- **Code 0, None**, if the patient had no falls with injury, except major, since the most recent SOC/ROC.
- **Code 1, One**, if the patient had one fall with injury, except major, since the most recent SOC/ROC.
- **Code 2, Two or more**, if the patient had two or more falls with injury, except major, since the most recent SOC/ROC.
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

Coding Instructions for J1900C, Major Injury

- **Code 0, None**, if the patient had no falls with major injury since the most recent SOC/ROC.
- **Code 1, One**, if the patient had one fall with major injury since the most recent SOC/ROC.
- **Code 2, Two or more**, if the patient had two or more falls with major injury since the most recent SOC/ROC.
- **A dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

Examples

1. One Fall Since Most Recent SOC/ROC, with No Injury

The discharging RN reviews the clinical record and interviews Mrs. K and her daughter Susan, the patient and caregiver, determining that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit in which Susan reported that her mother slipped from her wheelchair to the floor the previous day. Susan contacted the EMTs for help returning Mrs. K to her wheelchair; the EMT assessment at that time identified no injury. Documentation of the RN assessment during the home visit details no injury identified related to the fall.

Coding:

J1900A, No injury would be coded 1, one non-injurious fall since the most recent SOC/ROC.

J1900B, Injury (except major), would be coded 0, no falls with injury, except major, since the most recent SOC/ROC.

J1900C, Major injury would be coded 0, no falls with major injury since the most recent SOC/ROC.

Rationale: Only one fall is identified since the most recent SOC/ROC, and the patient sustained no injury in the fall.

2. One Fall Since Most Recent SOC/ROC with Injury (not major)

Review of the clinical record and incident reports, and, patient and caregiver report, identify that a single fall occurred since the most recent SOC/ROC. The fall is documented on a clinical note from an RN home visit that describes the patient Mr. R's report of a fall that occurred between visits, in which he tripped on the dog, fell against the wall and banged his elbow, sustaining a skin tear that he treated himself. Documentation of the RN assessment during the home visit details the healing skin tear, and no other injury or symptom identified related to the fall.

Coding:

J1900A. No injury, would be coded 0, no non-injurious falls since the most recent SOC/ROC.

J1900B. Injury (except major), would be coded 1, one injurious (except major) fall since the most recent SOC/ROC.

J1900C. Major injury, would be coded 0, no falls with major injury since the most recent SOC/ROC.

Rationale: Documentation of only one fall since the most recent SOC/ROC is identified. A laceration is considered an injury (except major).

3. One Fall Since the Most Recent SOC/ROC, with Major Injury

Review of the patient record and incident reports, and, patient and caregiver report identify that a single fall occurred since the most recent SOC/ROC. The fall is documented on an incident report that describes a telephone call received from the patient, Mrs. B's, daughter Mary, in which Mary reported Mrs. B fell at home and hit her head, and was transported via ambulance to the emergency room. Examination and testing revealed a subdural hematoma. Mrs. B was held in observation stay and received treatment, returning home in stable condition after 48 hours.

Coding:

J1900A, No injury, would be coded 0, no non-injurious falls since the most recent SOC/ROC.

J1900B, Injury (except major), would be coded 0, no falls with injury (except major) since the most recent SOC/ROC.

J1900C, Major injury, would be coded 1, one fall with major injury since the most recent SOC/ROC.

Rationale: Documentation of only one fall since the most recent SOC/ROC is identified. Subdural hematoma is considered a major injury.

4. Two Falls Since the Most Recent SOC/ROC, One with Injury (except major), One with No Injury

Review of the patient record, incident reports and patient and caregiver report identify that two falls occurred since the most recent SOC/ROC. The falls are documented on clinical notes. The first describes an event during which Mr. G tripped on the bathroom rug and almost fell, but caught himself against the sink. The RN assessment identified no injury. The second describes an event during which Mr. G, while coming up the basement stairs with the laundry, fell against the stair and sustained a bruise and laceration on his left knee.

Coding:

J1900A, No injury, would be coded 1, one non-injurious fall since the most recent SOC/ROC.

J1900B, Injury (except major), would be coded 1, one injurious (except major) fall since the most recent SOC/ROC.

J1900C, Major injury, would be coded 0, no falls with major injury since the most recent SOC/ROC.

Rationale: The first fall is an intercepted fall, which is considered a fall. The patient sustained no injury as a result of this fall. The second fall resulted in a laceration and bruising, considered injury, but not major injury.

5. One Fall Since the Most Recent SOC/ROC, with Multiple Injuries

Review of the patient record, incident reports and patient and caregiver report identify that a single fall occurred since the most recent SOC/ROC. The fall is documented on an incident report, which describes an event during which Mrs. J fell while walking from her bedroom to the bathroom and was transported to the emergency room via ambulance. Examination and testing revealed a skin tear on Mrs. J's left hand, bruising on both knees, and a fractured left hip.

Coding:

J1900A, No injury, would be coded 0, no non-injurious falls since the most recent SOC/ROC.

J1900B, Injury (except major), would be coded 0, no injurious (except major) falls since the most recent SOC/ROC.

J1900C, Major injury, would be coded 1, one fall with major injury since the most recent SOC/ROC.

Rationale: Documentation of only one fall since the most recent SOC/ROC was identified. The patient sustained multiple injuries in the fall. When multiple injuries are sustained in a single fall, code the injury of highest severity.

Data Sources/Resources

Patient report

Caregiver report

Patient record

Incident reports

Relevant clinical documentation, such as fall logs

CHAPTER 4   PAGE INTENTIONALLY LEFT BLANK

CHAPTER 5   RESOURCES, LINKS TO GENERAL SOURCES, PUBLICATIONS, AND WEB SITES

This chapter provides information on print and electronic resources available to support you in OASIS accuracy, quality, safety and best practices.

Disclaimer

The links are valid at the time this document is being prepared but cannot be expected to remain unchanged indefinitely. CMS does not control the content of the websites that are not listed as CMS. The opinions expressed may or may not match those of CMS policy.

Home Health Quality Help Desk

Home Health Quality Help Desk: homehealthqualityquestions@cms.hhs.gov
Questions related to: Home Health Quality Measures including, but not limited to: quality manuals, quality measures, measure calculation (OBQI, OBQM, PBQI, Quality of Patient Care Stars, Home Health Compare), risk adjustment, public reporting, and Quality Assessment Only (QAO)/Pay for Reporting (P4R). EXCLUDES ALL INQUIRIES FOR HHVBP.

CMS Websites

e-Rulemaking: Electronic Comments on CMS Regulations – instructions for viewing documents open for public comment, submitting public comments and reviewing public comments received on regulations
https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html

Home Health Agency (HHA Center)
https://www.cms.gov/center/provider-Type/home-Health-Agency-HHA-Center.html

Enrollment, Participation & Certification	Policies/Regulations
Billing/Payment	Educational Resources
CMS Manuals & Transmittals	Demonstrations
Initiatives (Quality Initiative, Home Health Compare, etc.)	Research & Analysis

The Medicare Learning Network®
http://www.cms.hhs.gov/MLNGenInfo/

National Provider Identifier (NPI) Registry
https://npiregistry.cms.hhs.gov/

Outcome and Assessment Information Set (OASIS)
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html

Background & Regulations	Automation Coordinators
iHAVEN	OASIS PPS
Data Set	Home Health Agency Q&A
Data Specifications	Reports
User Manual	Training
Education Coordinators	Archives

Measures Management System (MMS)
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/index.html

Guidelines and Best Practices

Home Health Best Practice Intervention Packages (BPIPs), Home Health Quality Improvement National Campaign Includes packages for cardiovascular health, immunization and infection prevention, medication management, underserved populations, patient self-management, reducing hospitalizations, management of oral medications, fall prevention, and cross setting care (transitions, disease management, telehealth, and care delivery changes). Registration is required.
http://www.homehealthquality.org/Education/Best-Practices.aspx

National Guideline Clearinghouse (NGC)
http://www.guideline.gov

Vaccination Guidelines

Influenza Vaccine Guidelines
https://www.cdc.gov/flu/professionals/vaccination/vaccine_safety.htm

Pneumococcal vaccine recommendations
https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html

Wound Care

The National Pressure Ulcer Advisory Panel – NPUAP: Educational and Clinical Resources
http://www.npuap.org/resources/educational-and-clinical-resources/

International Skin Tear Advisory Panel (ISTAP)
http://www.skintears.org/education/tools/

Wound, Ostomy and Continence Nurses Society's Guidance on OASIS-C2 Integumentary Items: Best Practice for Clinicians
http://c.ymcdn.com/sites/www.wocn.org/resource/resmgr/publications/WOCN_Guidance_on_OASIS-C2_In.pdf

Healthcare Technology

National Quality Forum and Health Information Technology
http://www.qualityforum.org/HealthIT/

Office of the National Coordinator for Health Information Technology (ONC)
Home Page   http://www.healthit.gov
About ONC   https://www.healthit.gov/topic/about-onc

Healthcare Information and Management Systems Society (HIMSS)
http://www.himss.org/

Healthcare Information Technology Standards Panel
http://www.hitsp.org/news.aspx

ICD-10-CM Official Guidelines for Coding and Reporting

ICD-10-CM Release
https://www.cdc.gov/nchs/icd/icd10cm.htm#icd
https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-CM-Coding-Guidelines.pdf

Clinical Resources

Medications

Institute of Safe Medication Practices (ISMP) *List of High-Alert Medications in Community/Ambulatory Healthcare*
https://www.ismp.org/recommendations/high-alert-medications-community-ambulatory-list

MEDLINE
http://www.nlm.nih.gov/medlineplus/druginformation.html

Activities of Daily Living: Definition and History
http://aspe.hhs.gov/daltcp/reports/guide.htm

Diabetes
http://www.diabetes.org
https://www.niddk.nih.gov/health-information/diabetes

Diabetic Foot Care
http://www.niddk.nih.gov/health-information/health-topics/Diabetes/prevent-diabetes-problems/Pages/index.aspx

Caregivers
https://www.aarp.org/home-family/caregiving/caregiving-tools/

http://www.nextstepincare.org/

Mental Health Resources

Alzheimer's
http://www.alz.org

National Alzheimer's and Dementia Resource Center (NADRC)
https://nadrc.acl.gov/

Brief Interview for Mental Status (BIMS) – Assessment Tool

MDS 3.0 Report	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS30FinalReport-Appendices.zip
Journal Article	*Nursing Home Assessment of Cognitive Impairment: Development and Testing of a Brief Instrument on Mental Status* http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2008.01944.x/abstract
CAM Assessment	https://www.hospitalelderlifeprogram.org/delirium-instruments/

Depression Recognition & Assessment in Older Home Care Patients

Online Training	http://www.geriu.org/uploads/applications/DepressionInHomecare/DinHomecare.html
Journal Article	*Training Nursing Staff to Recognize Depression in Home Healthcare.* Full text link: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3684961/

Cognitive Assessment

Clock Drawing Test   http://alzheimers.about.com/od/testsandprocedures/a/The-Clock-Drawing-Test.htm
MMSE   https://www.mountsinai.on.ca/care/psych/on-call-resources/on-call-resources/mmse.pdf

Risk Assessment Tools

Depression: Patient Health Questionnaire Resources

Agency for Healthcare Research & Quality (AHRQ) PHQ2
https://innovations.ahrq.gov/qualitytools/patient-health-questionnaire-phq-2

Screen for Obesity – BMI

National Heart, Lung, and Blood Institute
https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

Anxiety

SAMHSA-HRSA Center for Integrated Health Solutions link
https://www.integration.samhsa.gov/clinical-practice/screening-tools#anxiety

Pain

Wong-Baker FACES®
http://wongbakerfaces.org

Brief Pain Inventory
https://www.mdanderson.org/research/departments-labs-institutes/departments-divisions/symptom-research/symptom-assessment-tools/brief-pain-inventory.html

Fall Risk

MAHC 10 – Fall Risk Assessment Tool
https://www.homecaremissouri.org/projects/falls/documents/Oct2012FINALValidatedFallriskassessmenttool.pdf

Professional Organizations

American Nurses Association (ANA)	http://www.nursingworld.org/
American Occupational Therapy Association (AOTA)	http://www.aota.org/
American Physical Therapy Association (APTA)	http://www.apta.org/
American Speech-Language-Hearing Association (ASHA)	https://www.asha.org/

Quality Resources

Agency for Healthcare Research and Quality (AHRQ)
https://www.ahrq.gov/

AHRQ's Health Care Innovations Exchange Web site
(Innovations and Quality Tools classified by disease or clinical category, patient population, stage of care, setting of care, and more.)
https://innovations.ahrq.gov/

AHRQ's Quality Measures Database
National Quality Measures Clearinghouse (NQMC)
https://www.qualitymeasures.ahrq.gov/

Institute for Clinical Systems Improvement
https://www.icsi.org/
https://www.icsi.org/guidelines__more/find_guidelines/

Institute for Healthcare Improvement
http://www.ihi.org/Pages/default.aspx

Institute of Medicine
http://www.nationalacademies.org/hmd/

Crossing the Quality Chasm
https://www.nap.edu/catalog/10027/crossing-the-quality-chasm-a-new-health-system-for-the

Patient Safety and Quality: An Evidence-Based Handbook for Nurses
Chapter 13 Patient Safety and Quality in Home Health Care:
https://www.ncbi.nlm.nih.gov/books/NBK2631/

Care Transitions

Transitional Care Model
https://www.nursing.upenn.edu/ncth/transitional-care-model/

Care Transitions Intervention
http://www.caretransitions.org

A Home Health Model of Care Transitions, Alliance for Home Care Quality
http://ahhqi.org/images/uploads/AHHQI_Care_Transitions_Tools_Kit_r011314.pdf

National Transitions of Care Coalition (NTOCC)
http://www.ntocc.org/

Agency for Healthcare Research and Quality

PSNET Patient Safety Network
http://www.psnet.ahrq.gov/

TeamSTEPPS
http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/index.html

VA National Center for Patient Safety
http://www.patientsafety.va.gov/

The Joint Commission
http://www.jointcommission.org/accreditation/home_care_accreditation_requirements.aspx

APPENDIX A: OASIS AND THE COMPREHENSIVE ASSESSMENT

OASIS Elements Incorporated into the Comprehensive Assessment. What is the association between the Comprehensive Assessment and the OASIS data sets?

Since 1999, the Home Health Agency (HHA) Conditions of Participation (CoPs) have required that each patient receive a patient-specific comprehensive assessment. A revised CoP for comprehensive assessment went into effect January 13, 2018. The majority of requirements were retained. A new standard "Content of the comprehensive assessment" was established, incorporating much of the previous standard and adding new requirements.

Users are encouraged to refer directly to the HHA CoPs for complete, current information:

- The Medicare & Medicaid Program Conditions of Participation for Home Health Agencies Rule published by the Centers for Medicare & Medicaid Services in the Federal Register on 1/13/17. https://www.federalregister.gov/documents/2017/01/13/2017-00283/medicare-and-medicaid-program-conditions-of-participation-for-home-health-agencies.

- HHAs must incorporate the current version of the OASIS items into the comprehensive assessment for adult, non-maternity patients. The HHAs are free to rearrange OASIS item sequence in a way that permits logical ordering within their own forms as long as the actual item content, skip patterns, and OASIS number remain the same.

- OASIS data elements form a substantial portion of the comprehensive assessment. However, the data items in OASIS alone do not constitute a thorough comprehensive assessment. For example, the OASIS items do not include vital signs, assessment of breath sounds, or collection of data on fluid intake, which are part of a more complete patient assessment.

- OASIS data collection and reporting is not required for non-Medicare or Medicaid payers, however, all home health patients who receive skilled care are required to have a comprehensive assessment regardless of payer source per the requirements. Patients who receive non-skilled home health services such as homemaker, chore, or companion services are not required by the CoPs to have a comprehensive assessment.

APPENDIX B: OASIS DATA ACCURACY

1. DATA ACCURACY

Medicare Home Health Care Conditions of Participation Standard: Accuracy of Encoded OASIS Data (See the link for Home Health CoP at the CMS.gov Home Health Agency Center https://www.cms.gov/center/provider-Type/home-Health-Agency-HHA-Center.html) stipulates that the encoded OASIS data must accurately reflect the patient's status at the time the information is collected. Before transmission, the HHA must ensure that data items on its own clinical record match the encoded data that are sent to CMS. Once the qualified skilled professional (specifically, RN, PT, SLP/ST, or OT) completes the assessment, the HHA should develop means to ensure that the OASIS data input into the computer and transmitted to the CMS exactly reflect the data collected by the skilled professional. In addition, the State survey process for HHAs may include review of OASIS data collected versus data encoded and transmitted to the CMS.

2. DATA QUALITY AUDITS

Data-driven systems, such as OASIS data collection and outcome measurement, depend on the accuracy of source data describing patient health status. It follows that minimizing data errors that could affect accuracy of clinical data or outcome analyses is a necessary condition. This function is the responsibility of the agency since, ultimately, agency-level outcome reports reflect the data agencies input into the system. Internal staff development and training must focus on data accuracy not only at the start-up of OASIS data collection, but on a continuing basis. We recommend that data quality audits be conducted in agencies on a routine basis. Some data audit activities should be conducted monthly, while others can be conducted at less frequent intervals, such as quarterly.

The following guidelines provide a method for monitoring the quality of data in an agency. Types of audits, their recommended frequency, and categories of staff members (to conduct data audit activities and summarize findings) are suggested. If problems are identified, it is also recommended that the agency develop and implement a plan to correct data quality problems. Table B.1 displays the data quality audit approaches discussed and summarizes the purpose, frequency, and procedures for each.

Table B.1: Data Quality Audits

Audit Type	Purpose	Frequency	Overview of Procedure	Performed By
Clinical Record Audit	To verify accuracy of OASIS patient status items compared to other related patient documentation	Monthly	Review at least five SOC records and five discharge records. Compare OASIS items to other documentation from the SOC or discharge visits and from other visits surrounding SOC or discharge.	QI coordinator or clerical staff
Data Entry Audit	To verify accuracy of OASIS data entry and the data in the clinical record (or using double data entry)	Monthly	Either: Obtain a hardcopy of OASIS data that were entered for five patients. Compare to OASIS items in clinical record; or Data enter OASIS information for five patients twice. Compare data entered the first time to data entered the second time for each patient.	QI coordinator, IS/IT coordinator, or data entry staff
Clinical Audit Visits	To verify accuracy of OASIS assessment data (that is, evaluate assessment methodology and assessment skills of clinical staff)	Quarterly	For at least three or four patients, a supervisor or peer auditor attends the SOC visit. The auditor completes OASIS items while the care provider conducts the assessment and completes SOC paperwork. OASIS items are compared for consistency between auditor and care provider.	QI coordinator, clinical supervisor, or clinical staff

a.   **Monthly Audit Activities**

Clinical Record Audits: Clinical record audits allow an agency to monitor the validity of OASIS data. The quality check assesses the congruence of OASIS data with other patient status information found in the clinical record. This audit allows an agency to check for systematic bias in describing patient status. Most often, this will take the form of exaggerating illness or disability at start of care to enhance the justification for providing services and, under prospective payment, to maximize payment. There may also be a concomitant bias in the opposite direction for a discharge assessment, driven by a desire to make patient outcomes appear in a more favorable light or simply as a justification for discharge (for example, the goal of reaching a certain level of functioning has been met).

To conduct a clinical record audit, an abbreviated record review can be conducted for at least five new admissions and five patients discharged from the agency (but not due to an inpatient facility admission). Records should be randomly selected, in order to evaluate data quality for a cross-section of patients and care providers. The selection process might be as follows:

1. Choose a standing date for record selection (for example, the first Tuesday of every month). On that day each month, alphabetically compile a list of all skilled care patients admitted to the agency for the previous month. For example, if the record selection date for February falls on February 3rd, compile a list of all patients admitted to the agency from January 3rd to February 2nd.
2. Count the number of patients on the list. Divide that number by five, rounding down to the nearest whole number. For example, if there are 42 patients on the list, $42 \div 5 = 8.4$, which would be rounded to 8. This number, n, will be used to select records. Divide this number by 2 to obtain the starting point, m, for selecting records.
3. Count from the first patient alphabetically, select the mth patient, and select every n^{th} patient after that. Using the above example, you would select the 4th person and then every 8th person on the list for record review.
4. The same procedure should be used to select records for discharged patients. Compile a list of patients discharged from the agency within the previous month. Divide the number of patients by five, and use that number (n) to select patients for record review.
5. In the event that you have fewer than five patients admitted to or discharged from your agency, review all records. It should be noted that many agencies choose to audit a larger sample and some audit 100% of records.

Procedure for Clinical Record Audits: For new admissions, review the start of care (SOC) OASIS items and compare to other admission documentation and two or three subsequent visit notes, if they occur within the first week after SOC. In addition, if care providers from two disciplines perform assessments on the patient within one week of SOC (for example, registered nurse conducts comprehensive assessment visit and completes OASIS items; the physical therapist visits two days later and evaluates the patient), the documentation should be compared. Reviewers should evaluate whether any discrepancies between the SOC OASIS assessment and the other documentation are sufficiently significant to indicate a data quality problem. For example, if the SOC OASIS items indicate that the patient is fully independent in ambulation, but other documentation indicates that the patient needs assistance when walking, a data quality problem may exist. Assess for any discrepancies between sociodemographic items (for example, patient ID number or age) in addition to discrepancies in clinical assessments (ICD-10-CM codes, all clinical assessment OASIS items).

The records for discharged patients should be reviewed in the same manner. All discharge OASIS patient status items should be compared to other discharge information as well as to the previous two or three visit notes (if those visits occur within the same week of discharge). If there are large differences in descriptions of the patient, a potential data quality problem exists.

If differences are found that cannot be explained by other documentation in the clinical record, the care provider who completed the OASIS should be contacted to determine if the discrepancies were real (for example, the patient did change significantly between the SOC visit and a visit the next day) or if an error was made when recording OASIS data. If data quality problems exist, the problems can be corrected. If clinical documentation must be amended, this should be done according to agency policy. Any corrections to OASIS data in the clinical record must also be reflected in the OASIS database maintained by the agency, and if data submission has already occurred, a correction must be transmitted to CMS.

Data Entry Audits: Data entry audits allow agencies to monitor the accuracy of data entry. Data entry errors in fields such as birth date or health insurance number are often detected through other agency procedures (for example, billing – if the data entry software communicates with other agency systems), while patient status data are not typically subjected to such verification. Such errors, however, can affect outcome analyses and should be monitored. This type

of audit may not be relevant for agencies using electronic health records, as data entry occurs concurrently with the clinical assessment.

To conduct a data entry audit, a small sample of Medicare and/or Medicaid (skilled care) patient records should be checked at monthly intervals. In this evaluation, the clinical documentation is compared to the OASIS data that was entered to assess for data entry errors. This can be done by visual inspection or by double data entry, where the same record is data entered twice.

Procedure for Data Entry Audits: From the monthly list of Medicare and Medicaid patients admitted to the agency, select at least five records. The sample records need not be randomly selected, but if more than one person is responsible for data entry, some records entered by each staff member should be assessed. These may be the same records you use for the clinical audit. Obtain a printout of the information that was data entered or view the data online (the procedure for doing this will vary, depending upon the software you choose). Compare the response to each OASIS item in the clinical documentation with the computer printout or screen display of entered data. An alternative method is to have two staff conduct data entry of the same records independently and to compare the data records item by item.[1]

If discrepancies exist between the data that were entered and the OASIS items in the clinical record or between the OASIS items that were data entered twice, it is important to follow up with appropriate personnel. The agency database should be corrected and if necessary a correction should be transmitted to CMS. If data entry errors appear to be pervasive, a plan of action to remedy the problems should be developed and implemented.

b.   Quarterly Audit Activities

Clinical Audit Visits: Clinical audit visits provide an opportunity to verify the quality of patient status data collected by clinicians. It is recommended that each quarter agencies conduct supervisory (or peer) audit visits to at least three to four patients. These audit visits should occur at the admission comprehensive assessment visit. Within a one-year period, each clinical staff member of an average-sized agency thus can receive an audit visit. The supervisor or peer auditor should complete the SOC OASIS items while observing the care provider conducting the SOC visit. The care provider and auditor should not discuss OASIS items between themselves during the visit. The QI coordinator (or designated person) then compares each item on the SOC OASIS items completed by the care provider to the OASIS items completed by the auditor. Discrepancies should be noted. Any differences between OASIS items should be discussed jointly by the care provider and auditor to determine the reasons for the differences and to ensure that care providers fully understand the OASIS items. It is not necessary to select a random sample of patients for the audit visits, but the QI coordinator or QI team should ensure that a variety of patients and care providers are represented.

3.   SUMMARIZING AUDIT ACTIVITIES

a.   Documentation

Agencies should summarize findings from all audit activities as they are completed. Because these audit activities will be an ongoing quality monitoring activity, it may be helpful to include summaries of findings in quarterly QI reports. If data quality problems are identified from the audit activities, investigations should be conducted into the cause(s) of the problems, and action plans developed and implemented to resolve the problems. Approaches to assure that accurate patient-level data are utilized to describe patient status and to compute outcome measures increase the likelihood that agency-level outcome reports accurately describe the effectiveness of patient care.

b.   Making Corrections to OASIS Data

For information about making corrections to OASIS data, refer to 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).

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[1]   The exact mechanism for accomplishing double data entry will depend on the data entry software your agency uses. For example, jHAVEN does not directly support double data entry. However, a separate installation of jHAVEN could be used for the second data entry. The assessments could then be exported from their respective jHAVEN installations, and the exported data could be compared for consistency.

APPENDIX C: OASIS-D ITEMS, TIME POINTS, AND USES

This table can be used in identifying the time points and potential uses for each OASIS-D data item.

The following key should be used for the Item Uses column:

A   =   Administrative
Q   =   Quality Measure
PRA   =   Potential Quality Measure Risk Adjustment
$ =   Payment

The following key should be used for the Time Points columns:

S   =   Start of Care (SOC)
R   =   Resumption of Care (ROC)
F   =   Follow-Up (FU)
T   =   Transfer (TRF)
D   =   Discharge (DC)
H   =   Death at Home (DAH)

Items		Time Points						Item Uses
Item #	Item Description	SOC	ROC	FU	TRF	DC	DAH	
M0010	**CMS Certification Number**	S	-	-	-	-	-	A
M0014	**Branch State**	S	-	-	-	-	-	A
M0016	**Branch ID Number**	S	-	-	-	-	-	A
M0018	**National Provider Identifier (NPI)**	S	-	-	-	-	-	A
M0020	**Patient ID Number**	S	-	-	-	-	-	A
M0030	**Start of Care Date**	S	-	-	-	-	-	$, Q
M0032	**Resumption of Care Date**	-	R	-	-	-	-	Q
M0040	**Patient Name**	S	-	-	-	-	-	A
M0050	**Patient State of Residence**	S	-	-	-	-	-	A
M0060	**Patient ZIP Code**	S	-	-	-	-	-	A
M0063	**Medicare Number**	S	-	-	-	-	-	A
M0064	**Social Security Number**	S	-	-	-	-	-	A
M0065	**Medicaid Number**	S	-	-	-	-	-	A
M0066	**Birth Date**	S	-	-	-	-	-	PRA
M0069	**Gender**	S	-	-	-	-	-	PRA
M0080	**Discipline of Person Completing Assessment**	S	R	F	T	D	H	A
M0090	**Date Assessment Completed**	S	R	F	T	D	H	A, Q
M0100	**This Assessment is Currently Being Completed for the Following Reason**	S	R	F	T	D	H	Q, PRA
M0102	**Date of Physician-ordered Start of Care (Resumption of Care)**	S	R	-	-	-	-	Q
M0104	**Date of Referral**	S	R	-	-	-	-	Q
M0110	**Episode Timing**	S	R	F	-	-	-	$, PRA

Items		Time Points						Item Uses
Item #	Item Description	SOC	ROC	FU	TRF	DC	DAH	
M0140	**Race/Ethnicity**	S	-	-	-	-	-	**A**
M0150	**Current Payment Sources for Home Care**	S	-	-	-	-	-	**A, PRA**
M0906	**Discharge/Transfer/ Death Date**	-	-	-	T	D	H	**Q**
M1000	From which of the following **Inpatient Facilities** was the patient discharged within the past 14 days?	S	R	-	-	-	-	**Q, PRA**
M1005	**Inpatient Discharge Date**	S	R	-	-	-	-	**A, Q**
M1021	**Primary Diagnosis,** ICD-10-CM and Symptom Control Rating	S	R	F	-	-	-	**$, PRA**
M1023	**Other Diagnoses**, ICD-10-CM and Symptom Control Rating	S	R	F	-	-	-	**$, PRA**
M1028	**Active Diagnoses – Comorbidities and Co-existing Conditions**	S	R	-	-	-	-	**PRA**
M1030	**Therapies** the patient receives at home	S	R	F	-	-	-	**$, PRA**
M1033	**Risk for Hospitalization**	S	R	-	-	-	-	**PRA**
M1041	**Influenza Vaccine Data Collection Period**	-	-	-	T	D	-	**Q**
M1046	**Influenza Vaccine Received**	-	-	-	T	D	-	**Q**
M1051	**Pneumococcal Vaccine**	-	-	-	T	D	-	**Q**
M1056	**Reason Pneumococcal Vaccine not received**	-	-	-	T	D	-	**Q**
M1060	**Height and Weight**	S	R	-	-	-	-	**PRA**
M1100	**Patient Living Situation**	S	R	-	-	-	-	**PRA**
M1200	**Vision**	S	R	F	-	-	-	**$, PRA**
M1242	**Frequency of Pain Interfering** with patient's activity or movement	S	R	F	-	D	-	**$, Q, PRA**
M1306	Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher or** designated as Unstageable?	S	R	F	-	D	-	**Q, PRA**
M1307	The **Oldest Stage 2 Pressure Ulcer** that is present at discharge	-	-	-	-	D	-	**Q**
M1311	**Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage**	S	R	F	-	D	-	**$, Q, PRA**
M1322	**Current Number of Stage 1 Pressure Injuries**	S	R	F		-	-	**$, PRA**
M1324	**Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable**	S	R	F	-	D	-	**$, Q**
M1330	Does this patient have a **Stasis Ulcer?**	S	R	F	-	D	-	**$, PRA**
M1332	**Current Number of Stasis Ulcer(s) that are Observable**	S	R	F	-	-	-	**$, PRA**
M1334	**Status of Most Problematic Stasis Ulcer that is Observable**	S	R	F	-	D	-	**$, Q, PRA**
M1340	Does this patient have a **Surgical Wound?**	S	R	F	-	D	-	**Q, PRA**
M1342	**Status of Most Problematic Surgical Wound that is Observable**	S	R	F	-	D	-	**$, Q, PRA**
M1400	When is the patient dyspneic or noticeably **Short of Breath**?	S	R	F	-	D	-	**$, Q, PRA**

Items		Time Points						Item Uses
Item #	Item Description	SOC	ROC	FU	TRF	DC	DAH	
M1600	Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?	S	R	-	-	D	-	Q
M1610	**Urinary Incontinence or Urinary Catheter Presence**	S	R	F	-	-	-	$, PRA
M1620	**Bowel Incontinence Frequency**	S	R	F	-	D	-	$, Q, PRA
M1630	**Ostomy for Bowel Elimination**	S	R	F	-	-	-	$
M1700	**Cognitive Functioning**	S	R	-	-	D	-	Q, PRA
M1710	**When Confused (Reported or Observed Within the Last 14 Days)**	S	R	-	-	D	-	Q, PRA
M1720	**When Anxious (Reported or Observed Within the Last 14 Days)**	S	R	-	-	D	-	Q, PRA
M1730	**Depression Screening**	S	R	-	-	-	-	Q, PRA
M1740	**Cognitive, behavioral, and psychiatric symptoms** that are demonstrated at least once a week **(Reported or Observed)**	S	R	-	-	D	-	Q, PRA
M1745	**Frequency of Disruptive Behavior Symptoms (Reported or Observed)**	S	R	-	-	D	-	PRA
M1800	**Grooming**	S	R	-	-	D	-	Q, PRA
M1810	**Ability to Dress Upper Body**	S	R	F	-	D	-	$, Q, PRA
M1820	**Ability to Dress Lower Body**	S	R	F	-	D	-	$, Q, PRA
M1830	**Bathing: Excludes grooming (washing face, washing hands, and shampooing hair).**	S	R	F	-	D	-	$, Q, PRA
M1840	**Toilet Transferring**	S	R	F	-	D	-	$, Q, PRA
M1845	**Toileting Hygiene**	S	R	-	-	D	-	Q, PRA
M1850	**Transferring**	S	R	F	-	D	-	$, Q, PRA
M1860	**Ambulation/Locomotion**	S	R	F	-	D	-	$, Q, PRA
M1870	**Feeding or Eating**	S	R	-	-	D	-	Q, PRA
M1910	**Falls Risk Assessment**	S	R	-	-	-	-	Q, PRA
M2001	**Drug Regimen Review**	S	R	-	-	-	-	Q, PRA
M2003	**Medication Follow-up**	S	R	-	-	-	-	Q
M2005	**Medication Intervention**	-	-	-	T	D	H	Q
M2010	**Patient/Caregiver High-Risk Drug Education**	S	R	-	-	-	-	-
M2016	**Patient/Caregiver Drug Education Intervention**	-	-	-	T	D	-	Q
M2020	**Management of Oral Medications: Excludes injectable and IV medications**	S	R	-	-	D	-	Q, PRA
M2030	**Management of Injectable Medications: Excludes IV medications**	S	R	F	-	-	-	$, PRA
M2102	**Types and Sources of Assistance**	S	R	-	-	D	-	Q, PRA
M2200	**Therapy Need**	S	R	F	-	-	-	$, PRA
M2301	**Emergent Care**	-	-	-	T	D	-	Q
M2310	**Reason for Emergent Care**	-	-	-	T	D	-	Q
M2401	**Intervention Synopsis**	-	-	-	T	D	-	Q

Items		Time Points						Item Uses
Item #	**Item Description**	**SOC**	**ROC**	**FU**	**TRF**	**DC**	**DAH**	
M2410	To which **Inpatient Facility** has the patient been admitted?	-	-	-	**T**	**D**	-	**Q**
M2420	**Discharge Disposition**	-	-	-	-	**D**	-	**Q**
GG0100	**Prior Functioning: Everyday Activities**	**S**	**R**	-	-	-	-	**PRA**
GG0110	**Prior Device Use**	**S**	**R**	-	-	-	-	**PRA**
GG0130	**GG0130A. Eating**	**S**	**R**	**F**	-	**D**	-	**Q, PRA**
	GG0130B. Oral Hygiene	**S**	**R**	**F**	-	**D**	-	**Q, PRA**
	GG0130C. Toileting Hygiene	**S**	**R**	**F**	-	**D**	-	**Q, PRA**
	GG0130E. Shower/bathe self	**S**	**R**	-	-	**D**	-	**PRA**
	GG0130F. Upper body dressing	**S**	**R**	-	-	**D**	-	**PRA**
	GG0130G. Lower body dressing	**S**	**R**	-	-	**D**	-	**PRA**
	GG0130H. Putting on/taking off footwear	**S**	**R**	-	-	**D**	-	**PRA**
GG0170	**GG0170A. Roll left and right**	**S**	**R**	**F**	-	**D**	-	**PRA**
	GG0170B. Sit to lying	**S**	**R**	**F**	-	**D**	-	**Q, PRA**
	GG0170C. Lying to sitting	**S**	**R**	**F**	-	**D**	-	**Q, PRA**
	GG0170D. Sit to stand	**S**	**R**	**F**	-	**D**	-	**Q, PRA**
	GG0170E. Chair/bed-to-chair transfer	**S**	**R**	**F**	-	**D**	-	**Q, PRA**
	GG0170F. Toilet transfer	**S**	**R**	**F**	-	**D**	-	**Q, PRA**
	GG0170G. Car transfer	**S**	**R**	-	-	**D**	-	**PRA**
	GG0170I. Walk 10 feet	**S**	**R**	**F**	-	**D**	-	**PRA**
	GG0170J. Walk 50 feet with two turns	**S**	**R**	**F**	-	**D**	-	**Q, PRA**
	GG0170K. Walk 150 feet	**S**	**R**	-	-	**D**	-	**Q, PRA**
	GG0170L. Walking 10 feet on uneven surfaces	**S**	**R**	**F**	-	**D**	-	**PRA**
	GG0170M. 1 step (curb)	**S**	**R**	**F**	-	**D**	-	**PRA**
	GG0170N. 4 steps	**S**	**R**	**F**	-	**D**	-	**PRA**
	GG0170O. 12 steps	**S**	**R**	-	-	**D**	-	**PRA**
	GG0170P. Picking up object	**S**	**R**	-	-	**D**	-	**PRA**
	GG0170Q. Does patient use wheelchair and/or scooter?	**S**	**R**	**F**	-	**D**	-	**Q, PRA**
	GG0170R. Wheel 50 feet with two turns	**S**	**R**	**F**	-	**D**	-	**Q, PRA**
	GG0170RR: Type of wheelchair or scooter	**S**	**R**	-	-	**D**	-	**Q, PRA**
	GG0170S. Wheel 150 feet	**S**	**R**	-	-	**D**	-	**Q, PRA**
	GG0170SS. Type of wheelchair or scooter	**S**	**R**	-	-	**D**	-	**Q, PRA**
J1800	**Any Falls Since SOC/ROC**	-	-	-	**T**	**D**	**H**	**Q, PRA**
J1900	**Number of Falls Since SOC/ROC**	-	-	-	**T**	**D**	**H**	**Q, PRA**
TOTAL	**Total items per timepoint**	**99**	**84**	**46**	**16**	**72**	**7**	

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APPENDIX E: DATA REPORTING REGULATIONS

The Balanced Budget Act of 1997 authorized the Secretary of the Department of Health and Human Services (HHS) to require that home health agencies (HHAs) submit any information that the Secretary considers necessary to develop a reliable case mix system for the purposes of implementing a prospective payment system for HHAs. To fulfill this mandate, CMS implemented a regulation requiring electronic reporting of OASIS data for Medicare and Medicaid patients to a centralized data submission system maintained by CMS as a Condition of Participation for HHAs. This rule provides guidelines for HHAs for the electronic transmission of the OASIS data as well as responsibilities of the provider in collecting and transmitting this information to CMS. Rules concerning the privacy of patient identifiable information generated by the OASIS were also set forth.

CONDITION OF PARTICIPATION: REPORTING OASIS INFORMATION

Encoding OASIS Data

Once the comprehensive assessment has been completed and OASIS data collected, HHAs not already utilizing electronic capture of their OASIS data would enter the OASIS information into the computer system, referred to as "encoding." All the time points of the OASIS assessments have a uniform time frame of thirty days from the date the assessment is completed (M0090 – Date Assessment Completed) for encoding and submitting the data. Once the OASIS data are encoded (in software available from CMS, or other software that conforms to the CMS standard data submission specifications), the agency will review each assessment and edit it for transmission to a centralized data submission system. During this preparation period, the HHA must run a software application that subjects each patient data set to the CMS edit specifications and makes it transmission-ready. The agency must correct any information that does not pass the CMS-specified edits (e.g., data is missing, incorrect, or inconsistent). If errors are identified or suspected, staff entering data or preparing for submission may need to contact the qualified clinician who was responsible for completing the comprehensive assessment document, allowing necessary corrections to be made per agency policy. Delaying data entry or submission may impact the assessing clinician's recall, and the resulting data accuracy.

HHAs have flexibility in the method used to encode their data. Data can be encoded directly by the skilled professional who conducts the assessment into a laptop, hand-held, or tablet computer, by a clerical staff member from a hard copy of the completed assessment, or by a data entry operator or service with whom the HHA may contract to enter the data. Any of these are acceptable methods of meeting the regulatory reporting requirements for OASIS. However, the HHA is ultimately responsible for meeting the reporting requirements as well as maintaining patient confidentiality.

Once the OASIS data are encoded, HHAs use their software to review and edit the data prior to data submission. When editing the data prior to transmission, it is important to remember that the edits include an electronic safety net to preclude the transmission of erroneous or inconsistent information and enforce the required formatting for the data set items. When transmitted, the patient assessment data are stabilized at the time point of the assessment, preventing the override of current assessment information with future or past information.

Accuracy of Encoded OASIS Data

The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Before transmission, the HHA must ensure that data items on its own clinical record match the encoded data that are sent to the centralized data submission system. We expect that once the qualified skilled professional (specifically, RN, PT, SLP/ST, or OT) completes the assessment, the HHA will develop a means to ensure that the OASIS data input into the computer and transmitted to a centralized data submission system exactly reflect the data collected by the skilled professional. Appendix B contains recommendations for conducting data quality audits on a routine basis. In addition, the State survey process for HHAs may include review of OASIS data collected versus data encoded and transmitted.

Transmission of OASIS Data

CMS requires that the HHA electronically transmit the accurate, completed, and encoded OASIS data to a centralized data submission system within 30 days of the completion of the assessment (M0090 Date Assessment Completed). As long as the submission time frame is met, HHAs are free to develop schedules for transmitting the data that best suit their needs. Data must be transmitted in a format that meets the requirements specified in the data format standard (i.e., conforming to the CMS standard electronic record layouts, edit specifications, and data dictionary). HHAs that are required to submit OASIS data must do so using a secure connection to a network maintained by CMS or its contractor.

Final Validation Report

Once transmitted, the data submission is validated and feedback is provided to the HHA via the OASIS Final Validation Report or OASIS Submitter Final Validation Report as to whether the submission file(s) has been accepted or rejected and whether each submitted record meets the data format and edit requirements. An entire submission or individual records may be rejected for a variety of reasons. The HHA must make corrections and resubmit the data for any assessments that are rejected. If an assessment record causes non-fatal warning messages to be generated, the HHA may elect to submit a corrected assessment record but is not required to do so.

HHAs must use a CMS-assigned branch identification number (where applicable) to identify branch-specific assessment information in a uniform fashion nationwide. This procedure finalized a process that began in January 2004, uniquely identifying every branch of every HHA certified to participate in the Medicare home health program. The system links the parent to the branch HHA and gives CMS the capability of monitoring the quality of care delivered by agencies down to the HHA branch level.

Centers for Medicare & Medicaid Services

For Medicare fee-for-service patients, the transmitted OASIS data also are utilized for billing. The HHA can submit a Request for Anticipated Payment (RAP) to their Medicare Administrative Contractor (MAC) when all of the four following conditions are met:

- After the OASIS assessment is complete, locked or export ready, or there is an agency-wide internal policy for establishing that the OASIS data is finalized for transmission to the centralized data submission system,
- A physician's verbal orders for home care have been received and documented,
- A plan of care has been established and sent to the physician, and
- The first service visit under that plan has been delivered.

An episode will be opened on Common Working File (CWF) with the receipt and processing of the RAP. RAPs, or in special cases claims, must be submitted for initial HH PPS episodes, subsequent HH PPS episodes, or in transfer situations to start a new HH PPS episode when another episode is already open at a different agency. HHAs should submit the RAP as soon as possible after care begins to assure they are established as the primary HHA for the beneficiary.

Data Format

To meet the data format requirements, HHAs may use software developed by CMS (the most recent version of which is jHAVEN) or other vendor's software that conforms to CMS standardized electronic record formats, edit specifications, and data dictionaries. The CMS software can be used for several purposes. HHAs can use CMS software to encode OASIS data, maintain agency and patient-specific OASIS information, and create export files to submit OASIS data. The CMS software provides comprehensive on-line help to users in encoding, editing, and transmitting these data sets. The CMS software can also be used as a core program by HHAs and software vendors for developing their own software that supports OASIS reporting requirements, while also supporting or developing programs that meet other agency needs. Additionally, CMS maintains a toll-free help line to support this software product. For questions, please call the help desk at 800-339-9313 or you can email questions to "help@QTSO.com."

The CMS software alerts the individual who is encoding the data to use the correct screens for the specific type of assessment record required. HHAs using paper copies of assessment instruments must differentiate among the various subsets of OASIS data set, i.e., specialized forms for particular assessment time points. HHAs are cautioned that the CMS software provides only the minimum requirements to encode data, apply mandatory edits, and prepare data files for transmission. CMS will support these functions and applications. However, CMS does not intend to provide any other applications related to care planning, financial information, durable medical equipment, medications, personnel, or claims submission. Software developers are encouraged to use the CMS software to meet minimum requirements until they can ensure that their own software will accommodate CMS specifications and other applications useful for HHAs. If the HHA uses software other than software developed by CMS, it must conform to CMS standardized electronic data submission specifications.

> **The current OASIS Data Set and Manuals can be found on the Home Health Quality Reporting Requirements page, at** https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html.

HHAs can download the required OASIS data set documents by clicking on "OASIS User Manuals," and then go to Downloads for the OASIS Guidance Manual. In Chapter 2 of the Guidance Manual, there is one document that

includes all items in the data set, and additional documents for each data collection time point: start of care; resumption of care following an inpatient facility stay; follow-up; discharge (not to an inpatient facility); transfer to inpatient facility (with or without agency discharge); and death at home.

In addition, CMS provides OASIS data entry and data management software. The software can be downloaded at no charge to HHAs and used to encode OASIS data and create data files ready for submission to CMS. Data submission specifications, data dictionaries, the HHA data submission manual, contact information for each state's OASIS Automation Coordinator, and a link to the QIES Technical Support Office (QTSO) for OASIS Questions and Answers are located at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html. Other educational materials for HHAs will be posted on the website. The site is intended to provide direct access for HHAs, State agencies, CMS contractors, software vendors, professional organizations, and consumers. Vendors and agencies are encouraged to regularly review the website for information related to the computerization of OASIS and other CMS-related home health issues. CMS will continue to promote processes for ensuring accuracy in the software.

Condition of Participation: Release of Patient Identifiable OASIS Information

The HHA or an agent acting on behalf of the HHA must ensure that all protected health (patient-identifiable) information in the clinical record, including OASIS data, remains confidential and is not released to the public. The data must be secured and controlled, whether in hard copy or in electronic format. In addition to the provisions of this Condition of Participation, all HHAs must adhere to the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to ensure patient confidentiality and the security of patient information. (Further information on these requirements is provided on-line at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/.)

CMS specifies that the HHA who chooses to secure the services of an agent to complete the OASIS regulatory reporting requirements must secure a written contract between the HHA and the agent to not use or disclose the information. The agent may only release data to the extent the HHA itself is permitted to do so. It is believed that this CoP will act as a safeguard against the unauthorized use of a patient's clinical record information, regardless of the form or storage method.

State Agency Responsibilities for OASIS Collection

Under section 1891(b) of the Social Security Act, the Secretary of the Department of Health and Human Services must assure that processes are in place to protect the health and safety of individuals under the care of an HHA and to promote the effective and efficient use of public monies. Section 1864 of the Act authorizes the use of State health agencies to determine a provider's compliance with the CoPs. State responsibilities in ensuring compliance with the CoPs are set forth at Part 488, Survey, Certification, and Enforcement Procedures.

The State Agency must ensure that access to data is restricted (except for the transmission of data and reports to CMS) to the State Agency component that conducts surveys for purposes related to this function, and to other entities if authorized by CMS. The State Agency must ensure that patient identifiable OASIS data are released only to the extent permitted under the Privacy Act of 1974 and the Administrative Simplification provision of the HIPAA Act of 1996. The System of Records supports the HHA/OASIS database.

The State Agency provides technical support for HHAs. The State Agency or other entity designated by CMS must instruct each HHA on the administration of and integration of the OASIS data set into the facility's own record keeping system; instruct each HHA on the use of software to encode and transmit OASIS data to the centralized data submission system; monitor each HHA's ability to transmit OASIS data; and provide ongoing technical assistance and general support to HHAs in implementing the OASIS reporting requirements specified in the Conditions of Participation for HHAs.

Privacy Act System of Records Notice

The Privacy Act of 1974, requires records described in the System of Records Notices (SORNs) to be published in the Federal Register and posted to the internet.[1] Each SORN describes legal authority for data collection and maintenance and describes the types of information in the records.[2] In the group of Centers for Medicare & Medicaid Services (CMS) SORNs, there is a specific SORN for HHA OASIS. The OASIS data set is the assessment information collected

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[1]   U. S. Department of Health and Human Services, Privacy Act. https://www.hhs.gov/foia/privacy/index.html

[2]   U. S. Department of Health and Human Services, HHS System of Records Notices(SORNs)
       https://www.hhs.gov/foia/privacy/sorns/index.html

in the SOR. For additional details on categories of individuals covered, categories of records captured in the system, authority for maintenance of the system, and general purpose, please see the HHA OASIS SORN 09-79-9522.[3]

Deficit Reduction Act of 2005 Requirement for Reporting Quality Data and Public Reporting for Quality Measures

The requirements for reporting quality data and public reporting for quality measures are addressed in two rules:

- In the ***Deficit Reduction Act (DRA) of 2005***, Section 5201(c) (2)[4], the rule addresses adjustments, submission of data and public availability of data.
- In the ***Social Security Act, Prospective Payment for Home Health Services***, Section 1895 1895(B)(3) (ii) (V) specifies the manner in which CMS determines whether an HHA is in compliance.[5]

HHAs are required to submit OASIS assessments and Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey (HH CAHPS) data to meet the quality reporting requirements of section 1895(b)(3)(B)(v) of the Deficit Reduction Act. Additional information related to Home Health Quality Reporting is available on the CMS Home Health Quality Initiatives website.

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[3]   U. S. Department of Health and Human Services, SORN 09-70-0522: Home Health Agency (HHA) Outcome and Assessment Information Set (OASIS). https://www.hhs.gov/foia/privacy/sorns/09700522/index.html

[4]   Deficit Reduction Act of 2005. https://www.gpo.gov/fdsys/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf (pg. 46).

[5]   Social Security Act, Prospective Payment for Home Health Services. https://www.ssa.gov/OP_Home/ssact/title18/1895.htm

APPENDIX F: OASIS AND QUALITY IMPROVEMENT

OVERVIEW

The OASIS instrument was introduced nationally in 1999. Its initial purpose was to provide a standardized home health item set and standardized quality measures for use in quality improvement activities within individual home health agencies. The uses for OASIS data quickly expanded beyond quality measurement to also include determining reimbursement under Medicare Prospective Payment System (PPS). The uses for OASIS data have continued to evolve over the years with significant quality and payment implications tied to OASIS data. The current uses for OASIS-based measures include: 1) Home Health Agency Medicare-certification surveys, 2) the measures on the consumer-focused Home Health Compare website, 3) the measures used in the Home Health Quality of Patient Care Star Ratings, 4) the measures used in the Centers for Medicare & Medicaid Services (CMS) Home Health Value-Based Purchasing (HHVBP) Model, and 5) the Quality Assessment Only (QAO) Metric used in home health pay-for-reporting (P4R). The OASIS instrument is also expected to play a pivotal role in post-acute care quality improvement as advances are made related to the mandates of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act).

HISTORY OF OASIS AND OUTCOME-BASED QUALITY IMPROVEMENT (OBQI)

In the early 2000s, CMS developed and began to promote a quality improvement process that used OASIS-based measures as the foundation for home health quality improvement activities. This process was known as Home Health Outcome-Based Quality Improvement, or OBQI. CMS, through their contracts with state Quality Improvement Organizations (QIOs), provided training to home health agencies nationally on OBQI. Agency training and use of OBQI to improve quality was a preparatory step for the upcoming home health public reporting of quality measures.

In 2002, CMS announced plans for public reporting of home health quality measures. In the fall of 2003, CMS launched the Home Health Compare website (www.Medicare.gov). This initiative encouraged consumers to use publicly available home health quality measures when selecting a home health agency. The launch of Home Health Compare was also a catalyst for agency quality-improvement activities as well as the marketing and promotion of quality of care by individual agencies. The OASIS-based measures created the foundation for these early activities and advances in home health quality improvement.

UNDERSTANDING QUALITY & QUALITY IMPROVEMENT

What is quality? The term "quality" in healthcare may have many different meanings. However, standard definitions are required to be able to measure quality and to then improve quality. The OASIS-based quality measures provide the home health industry with a framework for defining quality in terms of what matters to a patient and their caregivers. The home health quality measures have included many measures of activities of daily living (ADLs), patient status, and home health agency care processes. These include the measures of "Improvement in Ambulation-Locomotion" "Stabilization in Grooming," "Improvement in Pain Interfering with Activity," etc. These measures are important to patients as they symbolized quality of life and independence in a home setting. They are also important measures to home health clinicians as clinicians could implement best practice interventions to assist patients to improve or to stabilize in the measures that were most meaningful to the individual patients. The definition of quality for home health also includes measures of agency best practices that are expected to impact quality of care such "Drug Regimen Review Conducted with Follow-Up for Identified Issues."

On an agency-wide scale, agencies can then measure their overall progress in each quality measure to determine if they are improving in the measure, worsening in the measure, or remaining unchanged. Through the Certification and Survey Provider Enhanced Report (CASPER) system, agencies can compare, or benchmark, their current performance on the individual quality measures to their prior performance for each individual measure and can also compare their performance to a national reference rate. A subset of all quality measures is available to the public on Home Health Compare.

OUTCOME AND PROCESS MEASURES

The initial OASIS-based quality measures were risk adjusted outcome measures. Shortly after the 2010 implementation of OASIS-C, agencies were introduced to the first standardized process measures which were derived from OASIS data.

OUTCOME MEASURES

An **outcome** is a health status change that occurs over time, where the change is intrinsic to the patient. **Outcome of care measures** are one tool for examining changes in patient status that may be impacted by home health care services. Thus, a change in the patient's environment, such as the provision of a walker or handrails in the patient's residence, is not considered an outcome according to this definition—such changes are services or processes of care. Because the nature of the change can be positive, negative, or neutral, the actual change in patient health status can correspond to improvement, decline, or stabilization (i.e., no change) in patient condition or functioning.

The definition of an outcome does not include a presumed direction; therefore, any deviation (or non-deviation) in health status between the initial time point and the follow-up time point constitutes an outcome. For example, did the patient's ability to walk and move around improve by the time they finished working with the home health agency? A rate of 88% for that measure means that 88% of the time, the agency improved their patients' ability to walk and move around.

An **end-result outcome** is a change in patient health status, such as physiologic, functional, cognitive, emotional, or behavioral health, between two or more time points. Examples of end-result outcomes are: Improvement in Ambulation/Locomotion and Stabilization in Bathing.

A **utilization outcome** is a type of health care utilization (or non-utilization) that reflects (typically a substantial) change in patient health status over time. Examples of utilization outcomes include quality measures that address hospital admission, use of hospital emergency department services, and discharge to the community. Utilization measures were initially computed using only OASIS data; however, there are currently utilization measures that are computed using OASIS data and utilization measures computed using Medicare fee-for-service (FFS) claims data. A complete list of quality measures and measure descriptions are available on the CMS Home Health Quality Initiative website.

MEASURE EXCLUSIONS FOR OUTCOME MEASURES

Some patients are excluded from the improvement or the stabilization computations. Any patient whose status at start (or resumption) of care is optimal for the health attribute under consideration is excluded from the improvement computation. Such a case is excluded because the patient could not possibly show improvement, since he/she is as "good" as they can possibly be for this attribute. All the patients included in the improvement computation had the potential to show improvement; the percentage (and the actual number of cases) listed at the end of the bar actually did improve.

Similar to exclusions from the improvement measures, some cases are excluded from the stabilization computation. Any patient whose status at start (or resumption) of care is at the most severely impaired level for the health attribute under consideration is excluded from the stabilization computation. This patient could not possibly show worsening, and therefore is excluded.

EXAMPLES – OUTCOME MEASURES

Measure Name	Consumer Language (on Home Health Compare)	Measure Description	Measure Focus (Numerator)	OASIS Items Used in Measure Calculation
Improvement in Ambulation-Locomotion	How often patients got better at walking or moving around.	Percentage of home health episodes of care during which the patient improved in ability to ambulate.	Number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in ambulation/locomotion at discharge than at start (or resumption) of care	Items Used to Compute Change: (M1860) Ambulation/ Locomotion Items Used to Compute Exclusions: (M1700) Cognitive Functioning (M1710) When Confused (M1720) When Anxious
Stabilization in Grooming	NA – This measure is not publicly reported.	Percentage of home health episodes of care during which patients improved or stayed the same in ability to groom self.	Number of home health episodes of care where the value recorded on the discharge assessment indicates the same or less impairment in grooming themselves at discharge than at start (or resumption) of care.	Items Used to Compute Change: (M1800) Grooming. Items Used to Compute Exclusions: (M1700) Cognitive Functioning (M1710) When Confused (M1720) When Anxious

PROCESS MEASURES

Process quality measures evaluate the rate of home health agency use of specific evidence-based processes of care. The standardized home health quality process measures focus on high-risk, high-volume, problem-prone areas for home health care. These include measures pertaining to all or most home care patients, such as timeliness of home care admission/resumption of care and immunizations.

Process items represent actions taken by home health care providers that are designed to improve patient outcomes. An example of a process measure is the percentage of home health quality episodes during which patients received the influenza immunization for the current flu season. An agency rate of 72% for that measure means that the agency's process of caring for patients included the recommended practice in 72% of the included quality episodes. The process items in OASIS have been carefully developed to represent "evidence-based" practice.

MEASURE EXCLUSIONS FOR PROCESS MEASURES

The majority of the OASIS-based process measures have measure-specific exclusions. Exclusions are specific to each measure. For example, the process measure of "Influenza Immunization Received for Current Flu Season" excludes quality episodes in which no care was provided during October 1–March 31, or the patient died, or the patient does not meet age/condition guidelines for influenza vaccine. Quality episodes that are excluded are not counted favorably or unfavorably toward the measure calculation.

EXAMPLE – PROCESS MEASURES

Measure Name	Consumer Language (on Home Health Compare)	Measure Description	Measure Focus (Numerator)	OASIS Items Used in Measure Calculation
Influenza Immunization Received for Current Flu Season	How often the home health team made sure that their patients have received a flu shot for the current flu season.	Percentage of home health episodes of care during which patients received influenza immunization for the current flu season.	Number of home health episodes of care during which the patient a) received vaccination from the HHA or b) had received vaccination from HHA during earlier episode of care, or c) was determined to have received vaccination from another provider	Items Used to Compute Care Processes: (M0030) Start of Care Date (M0032) Resumption of Care Date (M0906) Discharge/Transfer/ Death Date (M1046) Influenza Vaccine Received Items Used Compute Exclusions: (M1041) Influenza Vaccine Data Collection Period (M1046) Influenza Vaccine Received (M0906) Discharge/Transfer/ Death Date

HOME HEALTH QUALITY IMPROVEMENT

Soon after the introduction of OASIS-based quality reports, CMS provided home health agencies with a quality improvement model: Outcome-Based Quality Improvement (OBQI). As home health quality initiatives have evolved over the years, the OBQI process has also evolved. Today, agencies may select to use other quality improvement methodologies in addition to or in place of OBQI. These may include Six Sigma, Lean Methodology, PDSA (Plan, Do, Study, Act), etc., or agencies may choose to use a combination or variation of methodologies to meet their individual quality improvement needs.

Although agencies may not choose to use the original OBQI process, many of the steps within OBQI are relevant to home health quality improvement today. A cyclical and ongoing quality improvement process may include the following steps:

1. Review Quality Measure Reports
2. Select Quality Measures—for focused quality improvement activities
3. Investigate Care Processes (related to measures selected for quality improvement)
4. Develop a Plan of Action (a.k.a. Quality Improvement Plan)
5. Implement the Plan
6. Monitor the Plan
7. Revise/Update the Plan – as needed

OASIS items provide the basis for the majority of home health quality measures today. In addition to the OASIS-based quality measures, there are also home health quality measures that are derived from claims data and Home Health CAHPS® (Consumer Assessment of Healthcare Providers and Systems) data. Some agencies may have access to additional quality measures through their health system or payer affiliations, through other programs, or quality reports generated from their health records. Home health agencies are encouraged to use any of these information sources in systematic efforts to continuously monitor and improve the care provided to their patients. However, CMS cannot provide guidance on data, analysis, or reports from software or data benchmarking from other sources such as software vendors or data benchmarking companies.

QUALITY EPISODES

Quality episodes are used in the calculation of the quality measures. Quality episodes are not the same as payment, or Prospective Payment System (PPS) episodes. A quality episode begins with either a start of care or resumption of care assessment and ends with a transfer or discharge assessment. A quality episode does not include recertification(follow-up) assessments and may span payment episodes.

> A quality episode is measured from:
> Start of Care to the Transfer OR
> Start of Care to the Discharge/Death OR
> Resumption of Care to the Transfer OR
> Resumption of Care to the Discharge/Death.

For example, let's look at a patient who was admitted on 1/1/15 and transferred to an inpatient facility on 1/15/15, then had a resumption of care on 1/20/15 and was discharged from the agency on 2/1/15. In this example, this patient had two quality episodes. The first quality episode began with the start of care on 1/1/15 and ended with the transfer to an inpatient facility on 1/15/15. The second quality episode began with the resumption of care on 1/20/15 and ended with the discharge on 1/31/15.

CALCULATING QUALITY MEASURES

Measuring quality first begins at the patient-level. Outcome measures indicate the change in patient status from one point in time to another point in time. For the OASIS-based measures, we use the OASIS items for this calculation. To calculate quality measures, we also need to understand the measure definition. The measure tables include the measure numerator, denominator, and measure exclusions.

EXAMPLE: IMPROVEMENT IN DYSPNEA

Measure Definition: The "Improvement in Dyspnea" measure is the "Percentage of home health episodes of care during which the patient became less short of breath or dyspneic."

OASIS Item(s) Used in Measure Calculation: The measure is calculated using the OASIS item: (M1400) When is the patient dyspneic?

> **(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)

Measure Exclusions: The first step in calculating measures is to determine the patients that are eligible for the measure. In this example, this measure excludes home health quality episodes of care for which the patient, at start/resumption of care, was not short of breath at any time, and also excludes quality episodes that end with inpatient facility transfer or death. Therefore, for this measure, all patients who at start of care or resumption of care are scored a "0 – Patient is not short of breath" on OASIS are excluded from this measure because the patient cannot improve. If the patient cannot improve, then Improvement in Dyspnea is not computed. Quality episodes that end with death are also excluded and quality episodes that end with a transfer to an inpatient facility are excluded. Quality episodes that are excluded are not counted favorably or unfavorably toward the measure calculation.

Improvement: To improve in this measure, a patient must move from a higher numeric score on the OASIS response scale at start of care or resumption of care to a lower numeric score at discharge (e.g., M1400 start of care score of "3" and discharge score of "2" would be an improvement). The following table depicts how an individual

patient's score at the beginning of a quality episode (start of care or resumption of care) and at the end of a quality episode (discharge for this measure) would be calculated for the Improvement in Dyspnea measure:

OASIS RESPONSES & MEASURE CALCULATION FOR IMPROVEMENT IN DYSPNEA MEASURE

Start of Care OR Resumption of Care	Discharge	Calculation
0	0–4	Excluded
1	0	Improved
1	1–4	Did Not Improve
2	0–1	Improved
2	2–4	Did Not Improve
3	0–2	Improved
3	3–4	Did Not Improve
4	0–3	Improved
4	4	Did Not Improve

Agency "Improvement in Dyspnea" Observed Rate: In determining the agency rate for each outcome measure, we also need to understand the definitions for the measure numerator and denominator.

The numerator for this measure is the number of cases where improvement occurred. In the "Improvement in Dyspnea" measure, the numerator is number of home health quality episodes of care where the discharge assessment indicates less dyspnea at discharge than at start (or resumption) of care.

The denominator is the entire population (i.e., patients who improved and who did not improve) for the measure. Therefore, the denominator is every patient in the reporting period that is not excluded from the measure. In the "Improvement in Dyspnea" measure, the denominator is the number of home health quality episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions. (Remember that for the "Improvement in Dyspnea" measure, home health quality episodes of care for which the patient, at start/resumption of care, was not short of breath at any time, are excluded from this measure as are quality episodes that end in transfer to an inpatient facility or death.

Sample Agency Calculation: If an agency had 100 patients during the reporting period that were discharged from the agency, and 10 of these patients scored "0" at start of care/resumption of care on M1400 (and therefore were excluded) and 70 of the remaining 90 patients improved in dyspnea (moved from a higher numeric score on M1400 to a lower numeric score), then 70/90 (or 0.777) which equals 77.77% scored favorably or improved in dyspnea.

MEASURING STABILIZATION

In our example, we noted that with improvement in OASIS-based measures, the patient's status moved from a higher numeric score (at start of care or resumption of care) on the OASIS response scale to a lower numeric score (at discharge). A number of OASIS-based measures are calculated for "improvement" and/or "stabilization." For example, there is a measure for "Improvement in Bathing" and there is also a measure for "Stabilization in Bathing." How then is "stabilization" measured? For the OASIS-based measures, stabilization is calculated as all patients who did not worsen for the measure. Stabilization includes all patients who remain numerically the same on the OASIS response scale (i.e., "stabilized") from start of care or resumption of care to discharge AND all patients who improved (moved from a higher numeric score to a lower numeric score).

As the stabilization measures include all patients who have stabilized AND all patients who have improved, the measure rates for the stabilization measures are much higher than the corresponding improvement measure rates. For example, the current "Improvement in Bathing" national reference rate is approximately 76%. However, the

current "Stabilization in Bathing" national reference rate is approximately 98% as the stabilization rate includes patients who numerically stay the same for OASIS M1830 AND patients who numerically improve in the OASIS M1830 score.

OASIS & QUALITY MEASURE REPORTS

CMS provides several quality measure reports that are generated from OASIS data. Home health agencies can obtain their OASIS-based quality measure reports from CASPER reports. Information on obtaining OASIS-based quality reports can be found on CMS's QIES Technical Support Office (QTSO) website https://www.qtso.cms.gov/hhatrain.html.

Report Title	Report Description	Report Uses
1. Agency Patient-Related Characteristics (Case Mix) Report	The average value of each OASIS patient-related characteristics (patient attributes or circumstances) measure for episodes of care that ended during a specified period for the agency, along with national observed values for the same period.	Agencies can use this report as a companion to their Outcome Report and their Process Measures Report.
2. Outcome Report	End Results Outcome measures, Utilization Outcome measures, and Claims Based Outcome measures are reported; End Results Outcomes are computed only for episodes of care ending with a discharge to the community (RFA = 09); OASIS-based utilization Outcomes are computed for episodes of care ending with a transfer to an inpatient facility (RFA = 06 or 07) or a discharge to the community (RFA = 09); Claims Based Outcomes are calculated based upon the Episode Begin Date; Significance levels are presented for each measure when the sample size corresponding to the measure is at least 10. If the agency had nine or fewer patients on whom the outcome measure could be computed validly, statistical significance is not provided.	Agencies can use this report to monitor their outcome measures. Agencies are encouraged to review this report no less frequently than quarterly and may choose to review monthly for optimal monitoring of quality measures.
3. Potentially Avoidable Event Report	Lists each of the Potentially Avoidable Event Measures and statistics for each measure; Significance levels are presented for each measure when the sample size; corresponding to the measure is at least 10. If the agency had nine or fewer patients on whom the outcome measure could be computed validly, statistical significance is not provided.	Agencies are encouraged to review this report no less frequently than quarterly and may choose to review monthly for optimal monitoring of quality measures.
4. Potentially Avoidable Event: Patient Listing Report	Lists each of the Potentially Avoidable Event Measures, statistics for each, and the patients who experienced those events for a select agency during a specified period.	Agencies are encouraged to review this report no less frequently than quarterly and may choose to review monthly for optimal monitoring of quality measures.

Report Title	Report Description	Report Uses
5. Process Measures Report	Provides the number and percentage of each OASIS process quality measure followed for episodes of care that ended during a specified period for the agency, along with national observed values for the same period: Significance levels are presented for each measure when the sample size; Corresponding to the measure is at least 10. If the agency had nine or fewer patients on whom the outcome measure could be computed validly, statistical significance is not provided.	Agencies can use this report to monitor their OASIS-based process measures. Agencies are encouraged to review this report no less frequently than quarterly and may choose to review monthly for optimal monitoring of quality measures.
6. Agency Patient-Related Characteristics (Case Mix) Tally Report	Details the patient-related characteristics of each episode of care that ended during a specified period for the agency.	Agencies can use this report to drill-down to the individual patient-level to identify cases that triggered for each of the indicators on the Agency-Patient -Related Characteristics (Case Mix) Report.
7. Outcome Tally Report	Details the episodes of care that ended during a specified period for a select agency and were used to calculate the Outcome Reports.	Agencies can use this report to drill-down to the individual patient-level to identify cases that triggered for each of the measures on the Outcome Report. Agencies may find this report useful in investigating unfavorable OASIS- based outcome measures.
8. Process Tally Report	Details the episodes of care that ended during a specified period for a select agency and were used to calculate the Process Measures Reports.	Agencies can use this report to drill-down to the individual patient-level to identify cases that triggered for each of the measures on the Process Measures Report. Agencies may find this report useful in investigating unfavorable OASIS-based process measures.
9. Home Health Compare Provider Preview Report	This report is a preview of the agency's Home Health Compare data.	This report is placed in the agency's CASPER folders no less than 3 months prior to the Home Health Compare update to allow the agency to preview their Home Health Compare data and contact CMS with any potential data issues.
10. Quality of Patient Care Star Ratings Provider Preview Report	This report is a preview of the agency's Quality of Patient Care Star Rating and includes a score-card for each of the measures used to compute the Quality of Patient Care Star Rating.	This report is placed in the agency's CASPER folders no less than 3 months prior to the Home Health Compare update to allow the agency to preview their date and contact CMS with any potential data issues.
11. Quality Assessment Only (QAO) Performance Reports	CMS provides both a quarterly, interim Quality Assessments Only (QAO) Performance Report as well as a year-end Historical Quality Assessments Only (QAO) Performance Report. This QAO Performance Report is based on OASIS assessments submitted by an HHA during the applicable reporting period as it relates to compliance and Annual Payment Update (APU).	Agencies can use these reports to monitor their compliance with Home Health pay-for-reporting requirements.

Report Title	Report Description	Report Uses
12. Home Health Review and Correct Reports	These reports are available quarterly and updated weekly to provide confidential agency-level performance for quarterly and cumulative performance rates for the OASIS-based publicly reported quality measures.	Agencies can use these reports in conjunction with the other CASPER quality measure reports to determine if they have any data submission errors that may affect agency-level performance for one or more of the quality measures.

RISK ADJUSTMENT OF QUALITY MEASURES

Change in health status over a time interval during which care is provided (e.g., a quality episode) can occur either as a result of the care provided or the natural progression of disease and disability. The challenge in outcome analysis is to attempt to somehow separate changes due to care from those due to natural progression. Statistical **risk adjustment** refers to a collection of analytic methods designed to separate the relationships of outcomes with care provided from the relationship of outcomes with natural progression of disease and disability, which is critical to accurate outcome analysis. One of the major purposes of OASIS is to provide data items needed for risk adjustment. In essence, the general intent of risk adjustment is to compensate or adjust for differences in case mix or risk factors (between agency and a comparison sample) that should be taken into consideration if outcomes are to be compared validly. *Risk adjustment compensates or controls for the potential influence of case mix variables (i.e., risk factors) that can affect outcomes.*

The OASIS-based quality measures are calculated using items from the OASIS assessments from Medicare FFS, Medicare Advantage, Medicaid and Medicaid Managed care. For a set of these quality measures a logistic regression prediction model is created. Hundreds of risk factors are tested in development of the prediction models. Risk models are measure specific. A rigorous, multi-step process is followed that includes clinical review of the scientifically identified risk factors. Hence, the result of applying this prediction model for any episode of care is, in fact, the predicted value based on this logistic regression equation. This value could be described as the probability of obtaining a positive outcome (expected value) given the patient's clinical and functional status at the start of care.

Risk adjustment for home health agencies takes two forms depending upon whether the results are presented to the agency via their private CASPER reports or the results are publicly reported via Home Health Compare. Risk adjustment of an agency's observed outcome scores was first tested in the mid-1990's. These risk adjusted values have been reported to HHAs via their CASPER reports beginning in the late 1990's. Public reporting of home health quality outcomes on Home Health Compare began in August 2003. Because the purpose of these publicly reported results is to provide the public with the ability to compare performance across HHAs rather than within a particular HHA, the HHA's observed value for an outcome measure is adjusted by the difference between the national and the agency's predicted values. There are no plans to change the methodology of applying the results from the prediction models for each quality measure to risk adjust the outcome measures for HHAs.

Risk adjusted outcome and utilization measures are reported on the CASPER Outcome Reports and on Home Health Compare. Risk adjustment is based on statistical prediction models estimated on a national sample of home health agency patients to predict the likelihood of individual patient outcomes based on patient health status and other attributes at admission to home health care and other attributes. The method used to risk adjust home health agency outcome measures is as follows:

- The observed outcome rate for the agency is calculated for all eligible patients receiving care from the agency during the most recent 12 month period: $Agency_{obs}$= (# of patients achieving outcome)/(# of patients eligible for outcome).

- For each of the same patients, a predicted outcome probability is calculated based on the statistical risk model and the patient's condition at admission to home health care.

- Predicted outcome probabilities are averaged across all of the patients served over a 12 month period, to yield a predicted outcome rate for the agency: Agencypred= (sum of predicted probability)/(# of patients eligible for outcome).

- National observed and predicted rates are calculated in the same manner for the same 12 month period, by aggregating across all patients served by any home health agency in the United States.

- The agency rate is risk adjusted by adding to the observed agency rate the difference between the national predicted rate and the agency predicted rate, using the following formula: Agencyra = Agencyobs + (National¬pred – Agencypred).

If applying the risk adjustment formula results in a number less than zero the risk adjusted rate is set to zero. Similarly, if the result is greater than 100%, it is set to 100%.

On the CASPER reports that home health agencies receive, the observed agency outcome rate is reported and the national reference rate is risk adjusted for those OASIS-based outcome measures that are risk adjusted. This is done using the same method as for Home Health Compare, but the following formula is used: National¬ra = National¬obs + (Agencypred – National¬pred).

A subset of the OASIS-based outcome measures are risk adjusted. The OASIS-based process measures are not risk adjusted.

Additional information on home health risk adjustment methodology is available on the CMS Home Health Quality Initiative website and on the Home Health Compare website.

APPENDIX G: DESCRIPTION OF CHANGES FROM OASIS-C2 TO OASIS-D

Table G.1 presents an overview of changes made to the OASIS items and Guidance Manual for the transition from OASIS-C2 to OASIS-D. The table columns and headings are explained below.

1. **OASIS-C2 item number**: Item number in the OASIS-C2. If an NA appears, this indicates a corresponding item did not exist in OASIS C2.

2. **OASIS-D item number**: Item number in the OASIS-D. If the word "Removed" appears, this indicates the item was removed and not carried forward into OASIS D.

3. **Item Description**: A brief description of the item.

4. **Item Change**: Provides an at a glance categorization of the changes in the categories explained below.

   - New Item – if a new item is added, "X" will appear in this column.
   - Time Point Versions – If the item has different time point versions an "X" will appear in this column.
   - Item Text – if the item text is changed, "X" will appear in this column.
   - Response Option(s) – if the response option(s) is changed, "X" will appear in this column.
   - (-) Dash is a valid response – if the dash (-) value is a valid response for this item; "X" will appear in this column.
   - Skip Patterns - If the skip instructions (for example, [Go to M2401]) have changed, "X" will appear in this column.

5. **Change Description:** This column contains a brief description of the changes that have been made to each item.

6. **Guidance Manual Change**: provides an at a glance categorization of the changes in the Guidance Manual using the 5 categories explained below.

   - Item Intent- if the Guidance Manual text includes wording changes to the item intent, "X" will appear in this column.
   - Time Points Collected – if the specific time point at which this item is collected has changed (either it is collected at a new time point or it is no longer collected at a specific time point) "X" will appear in this column.
   - Response Specific Instructions – if the Guidance Manual text for the item includes changing the instructions for how to select a response, "X" will appear in this column.
   - Examples - If new examples were added or examples were updated, an "X" will appear in this column.
   - Data Sources and Resources – if the Guidance Manual text for the item includes changes to data sources and resources the clinician can use to answer the item "X" will appear in this column.

Table G.1: Description of Changes from OASIS-C2 to OASIS-D

Item Information			Item Change						Item Change Description	Guidance Manual Change				
OASIS-C2 Item #	OASIS-D Item #	Item Description	New Item	Time Point Versions	Item Text	Response Option(s)	(-) Dash is a Valid Response	Skip Pattern	Change(s)	Item Intent	Time Points Collected	Response Specific Instructions	Examples	Data Sources and Resources
M0080	M0080	Discipline of Person Completing Assessment										X		X
M0090	M0090	Date Assessment Completed										X		
M0102	M0102	Date of Physician-ordered SOC/ROC*								X		X		
M1000	M1000	Inpatient Facilities						X	Skip pattern changed due to M1017 item removal					
M1011	Removed	Inpatient Diagnosis												
M1017	Removed	Diagnoses, Treatment Regimen Change												
M1018	Removed	Conditions Prior												
M1021	M1021	Primary Diagnosis										X		
M1023	M1023	Other Diagnoses										X		
M1025	Removed	Optional Diagnoses												
M1028	M1028	Active Diagnoses				X	X		Added "none of the above" response option	X		X	X	
M1034	Removed	Overall Status												
M1036	Removed	Risk Factors												
M1046	M1046	Influenza Vaccine Received										X		
M1051	M1051	Pneumococcal Vaccine						X	Skip Pattern changed due to M1501, M1230 item removals					

Item Information			Item Change						Item Change Description	Guidance Manual Change				
OASIS-C2 Item #	OASIS-D Item #	Item Description	New Item	Time Point Versions	Item Text	Response Option(s)	(-) Dash is a Valid Response	Skip Pattern	Change(s)	Item Intent	Time Points Collected	Response Specific Instructions	Examples	Data Sources and Resources
M1056	M1056	Reason Pneumococcal Vaccine not received										X		
M1060	M1060	Height and Weight										X		
M1210	Removed	Ability to Hear												
M1220	Removed	Understanding Verbal Content												
M1230	Removed	Speech and Oral Expression												
M1240	Removed	Pain Assessment												
M1300	Removed	PU* Assessment												
M1302	Removed	Risk of Developing PUs*												
M1306	M1306	Unhealed Pressure Ulcer/Injury at Stage 2 or Higher			X				Added the words "injury/ Injuries" Changed "excludes healed Stage 2" to "excludes…all healed PUs "	X		X		
M1307	M1307	Oldest Stage 2 PU										X		

Item Information			Item Change						Item Change Description	Guidance Manual Change				
OASIS-C2 Item #	OASIS-D Item #	Item Description	New Item	Time Point Versions	Item Text	Response Option(s)	(-) Dash is a Valid Response	Skip Pattern	Change(s)	Item Intent	Time Points Collected	Response Specific Instructions	Examples	Data Sources and Resources
M1311	M1311	Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage		X	X		X	X	Different versions of this item available for SOC/ROC*, FU* and DC* Added "injury/injuries"; added "device" to non-removable dressing; removed "suspected…in evolution" from deep tissue injury Dash is a valid response for **discharge time point only** Modified skip language to "Go to"	X		X	X	
M1313	Removed	Worsening in PU Status												
M1320	Removed	Status of Most Problematic PU												
M1322	M1322	Current Number of Stage 1 Pressure Injuries			X				Replaced "ulcers" with "injuries"	X	X	X		
M1324	M1324	Stage of Most Problematic Unhealed Pressure Ulcer/Injury			X				Added the word "injury"	X		X		
M1332	M1332	Current Number of Stasis Ulcer(s)									X			
M1334	M1334	Status Most Problematic Stasis Ulcer										X		X

Item Information			Item Change						Item Change Description	Guidance Manual Change				
OASIS-C2 Item #	OASIS-D Item #	Item Description	New Item	Time Point Versions	Item Text	Response Option(s)	(-) Dash is a Valid Response	Skip Pattern	Change(s)	Item Intent	Time Points Collected	Response Specific Instructions	Examples	Data Sources and Resources
M1340	M1340	Surgical Wound?						X	Skip pattern changed due to M1350 item removal			X		
M1342	M1342	Status Most Problematic Surgical Wound										X		X
M1350	Removed	Skin Lesion or Open Wound												
M1410	Removed	Respiratory Treatments												
M1501	Removed	Symptoms in Heart Failure Patients												
M1511	Removed	Heart Failure Follow-up												
M1610	M1610	Urinary Incontinence or Urinary Catheter						X	Skip pattern no longer required due to M1615, M1620 item removals		X			
M1615	Removed	When does Urinary Incontinence occur?												
M1730	M1730	Depression Screening								X		X		
M1750	Removed	Psychiatric Nursing Services												
M1800	M1800	Grooming										X		
M1810	M1810	Dress Upper Body										X		
M1820	M1820	Dress Lower Body										X		
M1830	M1830	Bathing										X		
M1840	M1840	Toilet Transferring										X		
M1845	M1845	Toileting Hygiene										X		
M1850	M1850	Transferring										X		

Item Information			Item Change						Item Change Description	Guidance Manual Change				
OASIS-C2 Item #	OASIS-D Item #	Item Description	New Item	Time Point Versions	Item Text	Response Option(s)	(-) Dash is a Valid Response	Skip Pattern	Change(s)	Item Intent	Time Points Collected	Response Specific Instructions	Examples	Data Sources and Resources
M1860	M1860	Ambulation/Loco-motion										X		
M1870	M1870	Feeding or Eating										X		
M1880	Removed	Ability to Plan and Prepare Light Meals												
M1890	Removed	Ability to Use Telephone												
M1900	Removed	Prior Functioning												
M1910	M1910	Falls Risk Assessment								X		X		
M2001	M2001	Drug Regimen Review					X		Skip Pattern changed due to M2040 item removal	X		X	X	X
M2003	M2003	Medication Follow-up								X		X	X	
M2005	M2005	Medication Intervention								X		X	X	X
M2010	M2010	High-risk drug education								X				X
M2016	M2016	Patient/Caregiver Drug Education								X		X		
M2020	M2020	Management of Oral Medications								X				X
M2030	M2030	Management of Injectable Medications								X	X			X
M2040	Removed	Prior Medication Management												

Item Information			Item Change						Item Change Description	Guidance Manual Change				
OASIS-C2 Item #	OASIS-D Item #	Item Description	New Item	Time Point Versions	Item Text	Response Option(s)	(-) Dash is a Valid Response	Skip Pattern	Change(s)	Item Intent	Time Points Collected	Response Specific Instructions	Examples	Data Sources and Resources
M2102	M2102	Types and Sources of Assistance		X		X			Different versions of this item available for SOC/ROC and DC Removed rows: (b) "IADL* assistance" (e) "Management of Equipment" (g) "Advocacy or facilitation"			X		
M2110	Removed	How Often does the patient receive ADL* or IADL assistance												
M2250	Removed	Plan of Care Synopsis												
M2301	M2301	Emergent Care								X				
M2310	M2310	Reason for Emergent Care				X			Removed 15 of 19 response options			X		
M2401	M2401	Intervention Synopsis								X		X		X
M2410	M2410	Inpatient Facility						X	Skip pattern no longer required due to M2430, M0906 item removals					
M2420	M2420	Discharge Disposition						X	Skip pattern no longer required due to M2430 item removal					
M2430	Removed	Reason for Hospitalization												
M0903	Removed	Date of Last Home Visit												

Item Information			Item Change						Item Change Description	Guidance Manual Change				
OASIS-C2 Item #	OASIS-D Item #	Item Description	New Item	Time Point Versions	Item Text	Response Option(s)	(-) Dash is a Valid Response	Skip Pattern	Change(s)	Item Intent	Time Points Collected	Response Specific Instructions	Examples	Data Sources and Resources
NA	GG0100	Prior Functioning	X				X			X	X	X	X	NA
NA	GG0110	Prior Device Use	X				X			X	X	X	X	NA
NA	GG0130	Self-Care	X	X			X		Different versions of this item available for SOC/ROC, FU and DC	X	X	X	X	NA
NA	GG0170	Mobility	X	X			X		Different versions of this item available for SOC/ROC, FU and DC	X	X	X	X	NA
NA	J1800	Any Falls	X				X			X	X	X	X	NA
NA	J1900	Number of Falls	X				X			X	X	X	X	NA

*Notes: SOC - Start of Care; ROC - Resumption of Care; PU/PUs - Pressure Ulcer, Pressure Ulcers; FU - Follow-up; DC - Discharge; IADL - Instrumental Activity of Daily Living; ADL - Activity of Daily Living; NA - not applicable