Outcome and Assessment Information Set

OASIS-C2

Guidance Manual

Effective January 1, 2017

Centers for Medicare & Medicaid Services

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 quality-related 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 several 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.

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.

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Chapter 1 OASIS Item Guidance Introduction

The Outcome and Assessment Information Set (OASIS) is a group of standard data elements developed, tested, and refined over 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. Outcome measures are the basis for outcome-based quality improvement (OBQI) efforts that home health agencies (HHAs) can employ to assess and improve the quality of care they provide to patients. CMS provides HHAs with a) process quality, b) risk-adjusted outcome, and c) potentially avoidable event reports. In addition, HHAs can access patient-related characteristic reports 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 in assessment, care planning, education, prevention and clinical intervention to improve patient outcomes. Outcome measures include end-result functional and physical health improvement/stabilization, health care utilization measures (hospitalization and emergency department use), 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, OASIS data are used to adjust per-episode payment rates for patient conditions that affect care needs.

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 – Contains partial sample clinical record forms for OASIS data collection time points.

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

Appendices – Include additional contextual information, including sections on OBQI, 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 with assessment item sets for other post-acute care (PAC) settings and to enable calculation of standardized, cross-setting quality measures, pursuant to the provisions of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. There have been additional minor updates to bring the Manual current for OASIS-C2 (See Appendix G Change Table).

What's New?

This OASIS version incorporates three new items, modification to item wording, numbering or responses options in several existing items, and formatting changes. Many item changes are the result of standardization to report information that supports calculation of a cross-setting IMPACT quality measures. More detail is available in Appendix G.

Collecting OASIS Data

Techniques for collecting OASIS data have not changed. 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 inpatient facility
Discharge from home care
Death at home

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

Who Completes OASIS?

As identified in (M0080) Discipline of Person Completing Assessment, the comprehensive assessment and OASIS data collection should be conducted by 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 complete OASIS assessments.

In cases involving nursing, the RN must complete the comprehensive assessment at SOC. 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 (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). 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 congruency between documentation of findings from the comprehensive assessment and the Plan of Care. As specified in the Medicare Conditions of Participation for Home Health (see link to the Conditions of Participation above and in Chapter 5 of this manual), the Plan of Care should be updated to reflect revised care orders and current diagnoses throughout the period the patient is receiving home health care services.

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 and care planning interventions such as: a) whether the patient was assessed to be at risk for certain conditions like pain, falls risk, or pressure ulcer risk, and b) whether interventions to address the conditions were incorporated into the Plan of Care. These items refer to assessments that were completed and orders included in the Plan of Care 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 (see example in Table 1). Specific instructions about review periods are included in item guidance for the relevant OASIS questions.

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.

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

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

based on "Frequently Asked Questions" sent to CMS. (A link to Frequently Asked Questions is provided in Chapter 5). It may not be 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 or Discharge assessment) to be considered a complete care 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, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. CMS expects dash use to be a rare occurrence.

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

7. Combine observation, interview, and other relevant strategies to complete OASIS data items as needed (for example, it is acceptable to review the hospital discharge summary to identify inpatient procedures and diagnoses at Start of Care, or to examine the care notes to determine if a physician-ordered intervention was implemented at Transfer or Discharge). 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 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 updates. CMS may post updates to the guidance manual up to twice per year, and releases OASIS Q&As quarterly.

13. Only one clinician may take responsibility for accurately completing a comprehensive assessment. However, for selected items, collaboration is appropriate. These exceptions are noted in the 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 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 to produce 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.

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] Encoding OASIS Data, Transmittal of OASIS Data, and Data Format, 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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2 http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=1c743ade23ae8533ee0732689c166e31&r=PART&n=42y5.0.1.1.3#se42.5.484_120

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://www.qtso.com/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/Downloads/OASIS-C2-Data-Submission-Specs-v2-20-0-Draft.zip.
- **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: / /
month day year ☐ **NA - Not Applicable**

(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 ----------	M0010-M0030, M0040-M0150, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Start of care—further visits planned	
Resumption of Care ----------	M0032, M0080-M0110, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Resumption of care (after inpatient stay)	
Follow-Up ----------	M0080-M0100, M0110, M1011, M1021-M1023, M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
Recertification (follow-up) assessment	
Other follow-up assessment	
Transfer to an Inpatient Facility ----------	M0080-M0100, M1041-M1056, M1501, M1511, M2005, M2016, M2301-M2410, M2430, M0903, M0906
Transferred to an inpatient facility—patient not discharged from an agency	
Transferred to an inpatient facility—patient discharged from agency	
Discharge from Agency — Not to an Inpatient Facility	
Death at home ----------	M0080-M0100, M2005, M0903, M0906
Discharge from agency ----------	M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1501-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906

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 M0903*]**
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 M1017*]**

(M1005) Inpatient Discharge Date (most recent):

☐☐ / ☐☐ / ☐☐☐☐
month day year

☐ UK - Unknown

(M1011) List each **Inpatient Diagnosis** and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Inpatient Facility Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (patient was not discharged from an inpatient facility) ***[Omit "NA" option on SOC, ROC]***

(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Changed Medical Regimen Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

☐ 1 - Urinary incontinence
☐ 2 - Indwelling/suprapubic catheter
☐ 3 - Intractable pain
☐ 4 - Impaired decision-making
☐ 5 - Disruptive or socially inappropriate behavior
☐ 6 - Memory loss to the extent that supervision required
☐ 7 - None of the above
☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
☐ UK - Unknown

(M1021/1023/1025) **Diagnoses, Symptom Control, and Optional Diagnoses**: 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. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses - Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment.

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.

Column 3: (OPTIONAL) There is no requirement that HHAs enter a diagnosis code in M1025 (Columns 3 and 4). Diagnoses reported in M1025 will not impact payment.

Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition . An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1021) Primary Diagnosis & (M1023) Other Diagnoses		(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)	
Column 1	**Column 2**	**Column 3**	**Column 4**
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	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM
(M1021) Primary Diagnosis a. _____	**V, W, X, Y codes NOT allowed** a. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** a. _____ (☐☐☐.☐☐☐☐)	**V, W, X, Y, Z codes NOT allowed** a. _____ (☐☐☐.☐☐☐☐)
(M1023) Other Diagnoses b. _____	**All ICD-10–C M codes allowed** b. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** b. _____ (☐☐☐.☐☐☐☐)	**V, W, X, Y, Z codes NOT allowed** b. _____ (☐☐☐.☐☐☐☐)
c. _____	c. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	c. _____ (☐☐☐.☐☐☐☐)	c. _____ (☐☐☐.☐☐☐☐)
d. _____	d. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	d. _____ (☐☐☐.☐☐☐☐)	d. _____ (☐☐☐.☐☐☐☐)
e. _____	e. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	e. _____ (☐☐☐.☐☐☐☐)	e. _____ (☐☐☐.☐☐☐☐)
f. _____	f. ☐☐☐.☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	f. _____ (☐☐☐.☐☐☐☐)	f. _____ (☐☐☐.☐☐☐☐)

(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)

(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

(M1034) Overall Status: Which description best fits the patient's overall status?	
Enter Code ☐	0 The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 1 The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 2 The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death. 3 The patient has serious progressive conditions that could lead to death within a year. UK The patient's situation is unknown or unclear.

(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome: **(Mark all that apply.)**

- ☐ 1 - Smoking
- ☐ 2 - Obesity
- ☐ 3 - Alcohol dependency
- ☐ 4 - Drug dependency
- ☐ 5 - None of the above
- ☐ UK - Unknown

(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 M1501 at TRN; Go to M1230 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.)**

	Availability of Assistance				
Living Arrangement	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 can 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.

(M1210) Ability to Hear (with hearing aid or hearing appliance if normally used):	
Enter Code ☐	0 Adequate: hears normal conversation without difficulty. 1 Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly. 2 Severely Impaired: absence of useful hearing. UK Unable to assess hearing.
(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):	
Enter Code ☐	0 Understands: clear comprehension without cues or repetitions. 1 Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand. 2 Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand. 3 Rarely/Never Understands. UK Unable to assess understanding.
(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):	
Enter Code ☐	0 Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. 1 Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance). 2 Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences. 3 Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases. 4 Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible). 5 Patient nonresponsive or unable to speak.
(M1240) Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?	
Enter Code ☐	0 No standardized, validated assessment conducted 1 Yes, and it does not indicate severe pain 2 Yes, and it indicates severe pain
(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

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers**?	
Enter Code ☐	0 No assessment conducted **[*Go to M1306*]** 1 Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool 2 Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)
(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?	
Enter Code ☐	0 No 1 Yes

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)	
Enter Code ☐	0 No **[*Go to M1322*]** 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 at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	☐
A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	☐
B2. Number of <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 at FU/DC Go to M1311D1]	☐
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: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 at FU/DC Go to M1311E1	☐
D2. Number of <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	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 at FU/DC Go to M1311F1]	☐
E2. Number of <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: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)]	☐
F2. Number of <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	☐
[*Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC*]	

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:

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

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

Enter Code ☐

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

(M1322) Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. 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 that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

Enter Code ☐

1 Stage 1
2 Stage 2
3 Stage 3
4 Stage 4
NA Patient has no pressure ulcers or no stageable pressure ulcers

(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 **[*At SOC/ROC, go to M1350 ; At FU//DC, 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 **[*At SOC/ROC, go to M1350 ; At FU/DC, 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
(M1350) Does this patient have a **Skin Lesion** or **Open Wound** (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency?	
Enter Code ☐	0 No 1 Yes

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)

(M1410) Respiratory Treatments utilized at home: **(Mark all that apply.)**

- ☐ 1 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continually or at night)
- ☐ 3 - Continuous / Bi-level positive airway pressure
- ☐ 4 - None of the above

CARDIAC STATUS

(M1501) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the most recent SOC/ROC assessment?	
Enter Code ☐	0 No **[*Go to M2005 at TRN; Go to M1600 at DC*]** 1 Yes 2 Not assessed **[*Go to M2005 at TRN; Go to M1600 at DC*]** NA Patient does not have diagnosis of heart failure **[*Go to M2005 at TRN; Go to M1600 at DC*]**

(M1511) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

- ☐ 0 - No action taken
- ☐ 1 - Patient's physician (or other primary care practitioner) contacted the same day
- ☐ 2 - Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
- ☐ 3 - Implemented physician-ordered patient-specific established parameters for treatment
- ☐ 4 - Patient education or other clinical interventions
- ☐ 5 - Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

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) **[*Go to M1620*]** 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) **[*Go to M1620*]**
(M1615) When does **Urinary Incontinence** occur?	
Enter Code ☐	0 Timed-voiding defers incontinence 1 Occasional stress incontinence 2 During the night only 3 During the day only 4 During the day and night
(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 not have an ostomy for bowel elimination.

1 Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.

2 The ostomy was related to an inpatient stay or did 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.

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week **(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
(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?	
Enter Code ☐	0 No 1 Yes

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.

(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.

Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC

(GG0170C) Mobility

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

Coding: **Safety** and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activity may be completed with or without assistive devices.* 06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper. 05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. 04 **Supervision or touching assistance –** Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01 **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. **If activity was not attempted, code reason:** 07 **Patient refused** 09 **Not applicable** 88 Not attempted due to **medical condition or safety concerns**	**1. SOC/ROC Performance**	**2. Discharge Goal**	
	↓Enter Codes in Boxes↓		
	☐☐	☐☐	**Lying to Sitting on Side of Bed**: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

(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.

(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely:

Enter Code ☐

0 (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
  (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (specifically: prior to this home care admission).
1 Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
2 Unable to prepare any light meals or reheat any delivered meals.

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

Enter Code ☐

0 Able to dial numbers and answer calls appropriately and as desired.
1 Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers.
2 Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
3 Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
4 Unable to answer the telephone at all but can listen if assisted with equipment.
5 Totally unable to use the telephone.
NA Patient does not have a telephone.

(M1900) Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury.

Enter Code ☐

a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene)
  0 Independent
  1 Needed Some Help
  2 Dependent

Enter Code ☐

b. Ambulation
  0 Independent
  1 Needed Some Help
  2 Dependent

Enter Code ☐

c. Transfer
  0 Independent
  1 Needed Some Help
  2 Dependent

Enter Code ☐

d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use)
  0 Independent
  1 Needed Some Help
  2 Dependent

(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 M2040*]**
(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?	
Enter Code ☐	0 No 1 Yes
(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?	
Enter Code ☐	0 No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications
(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: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes 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; OR (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 Unable to take medication unless administered by another person. NA No oral medications prescribed.
M2030) Management of Injectable Medications: Patient's current ability to prepare and take all 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; OR (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 Unable to take injectable medication unless administered by another person. NA No injectable medications prescribed.
(M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation or injury.	
Enter Code ☐	a. Oral medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable
Enter Code ☐	a. Injectable medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable

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 ☐	b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances) 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 ☐	e. **Management of Equipment** (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies) 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
Enter Code ☐	g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments) 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

(M2110) **How Often** does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?	
Enter Code ☐	1 At least daily 2 Three or more times per week 3 One to two times per week 4 Received, but less often than weekly 5 No assistance received UK Unknown

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.

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

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐0	☐1	☐NA	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference.
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
c. Falls prevention interventions	☐0	☐1	☐NA	Falls risk assessment indicates patient has no risk for falls.
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	☐0	☐1	☐NA	Patient has no diagnosis of depression AND depression screening indicates 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.
e. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA	Pain assessment indicates patient has no pain.
f. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA	Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers.
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐0	☐1	☐NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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
- ☐ 2 - Injury caused by fall
- ☐ 3 - Respiratory infection (for example, pneumonia, bronchitis)
- ☐ 4 - Other respiratory problem
- ☐ 5 - Heart failure (for example, fluid overload)
- ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)
- ☐ 7 - Myocardial infarction or chest pain
- ☐ 8 - Other heart disease
- ☐ 9 - Stroke (CVA) or TIA
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 11 - GI bleeding, obstruction, constipation, impaction
- ☐ 12 - Dehydration, malnutrition
- ☐ 13 - Urinary tract infection
- ☐ 14 - IV catheter-related infection or complication
- ☐ 15 - Wound infection or deterioration
- ☐ 16 - Uncontrolled pain
- ☐ 17 - Acute mental/behavioral health problem
- ☐ 18 - Deep vein thrombosis, pulmonary embolus
- ☐ 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 **[*Go to M2430*]**
2 Rehabilitation facility **[*Go to M0903*]**
3 Nursing home **[*Go to M0903*]**
4 Hospice **[*Go to M0903*]**
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 **[*Go to M0903*]**

(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Injury caused by fall
- ☐ 3 - Respiratory infection (for example, pneumonia, bronchitis)
- ☐ 4 - Other respiratory problem
- ☐ 5 - Heart failure (for example, fluid overload)
- ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)
- ☐ 7 - Myocardial infarction or chest pain
- ☐ 8 - Other heart disease
- ☐ 9 - Stroke (CVA) or TIA
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 11 - GI bleeding, obstruction, constipation, impaction
- ☐ 12 - Dehydration, malnutrition
- ☐ 13 - Urinary tract infection
- ☐ 14 - IV catheter-related infection or complication
- ☐ 15 - Wound infection or deterioration
- ☐ 16 - Uncontrolled pain
- ☐ 17 - Acute mental/behavioral health problem
- ☐ 18 - Deep vein thrombosis, pulmonary embolus
- ☐ 19 - Scheduled treatment or procedure
- ☐ 20 - Other than above reasons
- ☐ UK - Reason unknown

(M0903) Date of Last (Most Recent) Home Visit:

☐☐ / ☐☐ / ☐☐☐☐
month day year

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

☐☐ / ☐☐ / ☐☐☐☐
month day year

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-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Resumption of Care ---------- Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Follow-Up ---------- Recertification (follow-up) assessment Other follow-up assessment	M0080-M0100, M0110, M1011, M1021-M1023, M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
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, M1501, M1511, M2005, M2016, M2301-M2410, M2430, M0903, M0906
Discharge from Agency — Not to an Inpatient Facility	
Death at home ----------	M0080-M0100, M2005, M0903, M0906
Discharge from agency ----------	M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1501-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906

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 M1017*]**

(M1005) Inpatient Discharge Date (most recent):

☐☐ / ☐☐ / ☐☐☐☐
month day year

☐ UK - Unknown

(M1011) List each **Inpatient Diagnosis** and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Inpatient Facility Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Changed Medical Regimen Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

☐ 1 - Urinary incontinence
☐ 2 - Indwelling/suprapubic catheter
☐ 3 - Intractable pain
☐ 4 - Impaired decision-making
☐ 5 - Disruptive or socially inappropriate behavior
☐ 6 - Memory loss to the extent that supervision required
☐ 7 - None of the above
☐ NA No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
☐ UK Unknown

(M1021/1023/1025) **Diagnoses, Symptom Control, and Optional Diagnoses**: 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. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses - Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment.

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.

Column 3: (OPTIONAL) There is no requirement that HHAs enter a diagnosis code in M1025 (Columns 3 and 4). Diagnoses reported in M1025 will not impact payment.

Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition . An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1021) Primary Diagnosis & (M1023) Other Diagnoses		(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)	
Column 1	**Column 2**	**Column 3**	**Column 4**
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	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM
(M1021) Primary Diagnosis a. _____	**V, W, X, Y codes NOT allowed** a. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** a. _____ (☐☐☐ ☐☐☐☐)	**V, W, X, Y, Z codes NOT allowed** a. _____ (☐☐☐.☐☐☐☐)
(M1023) Other Diagnoses b. _____	**All ICD-10–C M codes allowed** b. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** b. _____ (☐☐☐.☐☐☐☐)	**V, W, X, Y, Z codes NOT allowed** b. _____ (☐☐☐.☐☐☐☐)
c. _____	c. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	c. _____ (☐☐☐.☐☐☐☐)	c. _____ (☐☐☐.☐☐☐☐)
d. _____	d. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	d. _____ (☐☐☐.☐☐☐☐)	d. _____ (☐☐☐.☐☐☐☐)
e. _____	e. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	e. _____ (☐☐☐.☐☐☐☐)	e. _____ (☐☐☐.☐☐☐☐)
f. _____	f. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	f. _____ (☐☐☐.☐☐☐☐)	f. _____ (☐☐☐.☐☐☐☐)

(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)

(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

(M1034) Overall Status: Which description best fits the patient's overall status?	
Enter Code ☐	0 The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 1 The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 2 The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death. 3 The patient has serious progressive conditions that could lead to death within a year. UK The patient's situation is unknown or unclear.

(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome: **(Mark all that apply.)**

- ☐ 1 - Smoking
- ☐ 2 - Obesity
- ☐ 3 - Alcohol dependency
- ☐ 4 - Drug dependency
- ☐ 5 - None of the above
- ☐ UK - Unknown

(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 weigh 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.)**

	Availability of Assistance				
Living Arrangement	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 can 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.

(M1210) Ability to Hear (with hearing aid or hearing appliance if normally used):

Enter Code ☐

0 Adequate: hears normal conversation without difficulty.

1 Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.

2 Severely Impaired: absence of useful hearing.

UK Unable to assess hearing.

(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):

Enter Code ☐

0 Understands: clear comprehension without cues or repetitions.

1 Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.

2 Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.

3 Rarely/Never Understands.

UK Unable to assess understanding.

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language)**:**	
Enter Code ☐	0 Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. 1 Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance). 2 Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences. 3 Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases. 4 Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible). 5 Patient nonresponsive or unable to speak.
(M1240) Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?	
Enter Code ☐	0 No standardized, validated assessment conducted 1 Yes, and it does not indicate severe pain 2 Yes, and it indicates severe pain
(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

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers**?	
Enter Code ☐	0 No assessment conducted **[*Go to M1306*]** 1 Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool 2 Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)
(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?	
Enter Code ☐	0 No 1 Yes
(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)	
Enter Code ☐	0 No **[*Go to M1322*]** 1 Yes

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers**	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers**	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers**	☐
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device**	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**	☐

(M1320) **Status of Most Problematic Pressure Ulcer that is Observable:** (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)	
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing NA No observable pressure ulcer
(M1322) **Current Number of Stage 1 Pressure Ulcers:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. 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 that is Stageable:** (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)	
Enter Code ☐	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers or no stageable pressure ulcers
(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 M1350*]** 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 M1350*]**
(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
(M1350) Does this patient have a **Skin Lesion** or **Open Wound** (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency?	
Enter Code ☐	0 No 1 Yes

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)

(M1410) Respiratory Treatments utilized at home: **(Mark all that apply.)**

- ☐ 1 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continually or at night)
- ☐ 3 - Continuous / Bi-level positive airway pressure
- ☐ 4 - None of the above

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

(M1610) Urinary Incontinence or Urinary Catheter Presence:

Enter Code ☐

0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[*Go to M1620*]**
1 Patient is incontinent
2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) **[*Go to M1620*]**

(M1615) When does **Urinary Incontinence** occur?

Enter Code ☐

0 Timed-voiding defers incontinence
1 Occasional stress incontinence
2 During the night only
3 During the day only
4 During the day and night

(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

(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 not have an ostomy for bowel elimination.
1 Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
2 The ostomy was related to an inpatient stay or did 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.

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week **(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
(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?	
Enter Code ☐	0 No 1 Yes

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.

(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.

Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC

(GG0170C) Mobility

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

Coding: **Safety** and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activity may be completed with or without assistive devices.* 06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper. 05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. 04 **Supervision or touching assistance –** Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01 **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. If activity was not attempted, code reason: 07 Patient refused 09 Not applicable 88 Not attempted due to medical condition or safety concerns	**1. SOC/ROC Performance** ↓Enter Codes in Boxes↓ ☐☐	**2. Discharge Goal** ☐☐	**Lying to Sitting on Side of Bed**: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

(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.
(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely:	
Enter Code ☐	0 (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (specifically: prior to this home care admission). 1 Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. 2 Unable to prepare any light meals or reheat any delivered meals.
(M1890) **Ability to Use Telephone:** Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.	
Enter Code ☐	0 Able to dial numbers and answer calls appropriately and as desired. 1 Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers. 2 Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. 3 Able to answer the telephone only some of the time or is able to carry on only a limited conversation. 4 Unable to answer the telephone at all but can listen if assisted with equipment. 5 Totally unable to use the telephone. NA Patient does not have a telephone.

(M1900) **Prior Functioning ADL/IADL:** Indicate the patient's usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury.	
Enter Code ☐	a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene) 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	b. Ambulation 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	c. Transfer 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use) 0 Independent 1 Needed Some Help 2 Dependent
(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 M2040*]**
(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?	
Enter Code ☐	0 No 1 Yes
(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:** Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes 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; OR (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 Unable to take medication unless administered by another person. NA No oral medications prescribed.
(M2030)	**Management of Injectable Medications:** Patient's current ability to prepare and take all 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; OR (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 Unable to take injectable medication unless administered by another person. NA No injectable medications prescribed.
(M2040)	**Prior Medication Management:** Indicate the patient's usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation or injury.
Enter Code ☐	a. Oral medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable
Enter Code ☐	b. Injectable medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable

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 ☐	b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances) 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 ☐	e. **Management of Equipment** (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies) 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
Enter Code ☐	g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments) 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

(M2110) **How Often** does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?	
Enter Code ☐	1 At least daily 2 Three or more times per week 3 One to two times per week 4 Received, but less often than weekly 5 No assistance received UK Unknown

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.

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

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐0	☐1	☐NA	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference.
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
c. Falls prevention interventions	☐0	☐1	☐NA	Falls risk assessment indicates patient has no risk for falls.
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	☐0	☐1	☐NA	Patient has no diagnosis of depression AND depression screening indicates 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.
e. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA	Pain assessment indicates patient has no pain.
f. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA	Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers.
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐0	☐1	☐NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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

Time Point	Items Used
Start of Care ----------	M0010-M0030, M0040-M0150, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Start of care—further visits planned	
Resumption of Care ----------	M0032, M0080-M0110, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Resumption of care (after inpatient stay)	
Follow-Up ----------	M0080-M0100, M0110, M1011, M1021-M1023, M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
Recertification (follow-up) assessment Other follow-up assessment	
Transfer to an Inpatient Facility ----------	M0080-M0100, M1041-M1056, M1501, M1511, M2005, M2016, M2301-M2410, M2430, M0903, M0906
Transferred to an inpatient facility—patient not discharged from an agency Transferred to an inpatient facility—patient discharged from agency	
Discharge from Agency — Not to an Inpatient Facility	
Death at home ----------	M0080-M0100, M2005, M0903, M0906
Discharge from agency ----------	M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1501-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906

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 M1017*]**

(M1005) Inpatient Discharge Date (most recent):

☐☐ / ☐☐ / ☐☐☐☐
month day year

☐ UK - Unknown

(M1011) List each **Inpatient Diagnosis** and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Inpatient Facility Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Changed Medical Regimen Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

☐ 1 - Urinary incontinence
☐ 2 - Indwelling/suprapubic catheter
☐ 3 - Intractable pain
☐ 4 - Impaired decision-making
☐ 5 - Disruptive or socially inappropriate behavior
☐ 6 - Memory loss to the extent that supervision required
☐ 7 - None of the above
☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
☐ UK - Unknown

(M1021/1023/1025) **Diagnoses, Symptom Control, and Optional Diagnoses**: 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. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses - Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment.

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.

Column 3: (OPTIONAL) There is no requirement that HHAs enter a diagnosis code in M1025 (Columns 3 and 4). Diagnoses reported in M1025 will not impact payment.

Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition . An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1021) Primary Diagnosis & (M1023) Other Diagnoses		(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)	
Column 1	**Column 2**	**Column 3**	**Column 4**
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	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM
(M1021) Primary Diagnosis a. _____	**V, W, X, Y codes NOT allowed** a. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** a. _____ (☐☐☐ ☐☐☐☐)	**V, W, X, Y, Z codes NOT allowed** a. _____ (☐☐☐.☐☐☐☐)
(M1023) Other Diagnoses b. _____	**All ICD-10–C M codes allowed** b. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** b. _____ (☐☐☐.☐☐☐☐)	**V, W, X, Y, Z codes NOT allowed** b. _____ (☐☐☐.☐☐☐☐)
c. _____	c. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	c. _____ (☐☐☐.☐☐☐☐)	c. _____ (☐☐☐.☐☐☐☐)
d. _____	d. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	d. _____ (☐☐☐.☐☐☐☐)	d. _____ (☐☐☐.☐☐☐☐)
e. _____	e. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	e. _____ (☐☐☐.☐☐☐☐)	e. _____ (☐☐☐.☐☐☐☐)
f. _____	f. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	f. _____ (☐☐☐.☐☐☐☐)	f. _____ (☐☐☐.☐☐☐☐)

(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)

(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

(M1034) Overall Status: Which description best fits the patient's overall status?	
Enter Code ☐	0 The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 1 The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 2 The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death. 3 The patient has serious progressive conditions that could lead to death within a year. UK The patient's situation is unknown or unclear.

(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome: **(Mark all that apply.)**

- ☐ 1 - Smoking
- ☐ 2 - Obesity
- ☐ 3 - Alcohol dependency
- ☐ 4 - Drug dependency
- ☐ 5 - None of the above
- ☐ UK - Unknown

(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 weigh 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.)**

	Availability of Assistance				
Living Arrangement	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 can 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.

(M1210) Ability to Hear (with hearing aid or hearing appliance if normally used):

Enter Code ☐

0 Adequate: hears normal conversation without difficulty.

1 Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.

2 Severely Impaired: absence of useful hearing.

UK Unable to assess hearing.

(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):

Enter Code ☐

0 Understands: clear comprehension without cues or repetitions.

1 Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.

2 Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.

3 Rarely/Never Understands.

UK Unable to assess understanding.

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language)**:**

Enter Code ☐

0 Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.

1 Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).

2 Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.

3 Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.

4 Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible).

5 Patient nonresponsive or unable to speak.

(M1240) Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?	
Enter Code ☐	0 No standardized, validated assessment conducted 1 Yes, and it does not indicate severe pain 2 Yes, and it indicates severe pain
(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

(M1300) **Pressure Ulcer Assessment:** Was this patient assessed for **Risk of Developing Pressure Ulcers**?	
Enter Code ☐	0 No assessment conducted **[*Go to M1306*]** 1 Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool 2 Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)
(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?	
Enter Code ☐	0 No 1 Yes
(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)	
Enter Code ☐	0 No **[*Go to M1322*]** 1 Yes

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers**	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers**	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers**	☐
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device**	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution**	☐

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

Enter Code ☐

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

(M1322) Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. 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 that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

Enter Code ☐

1 Stage 1
2 Stage 2
3 Stage 3
4 Stage 4
NA Patient has no pressure ulcers or no stageable pressure ulcers

(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 M1350*]**
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 M1350*]**

(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
(M1350) Does this patient have a **Skin Lesion** or **Open Wound** (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency?	
Enter Code ☐	0 No 1 Yes

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)

(M1410) Respiratory Treatments utilized at home: **(Mark all that apply.)**

- ☐ 1 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continually or at night)
- ☐ 3 - Continuous / Bi-level positive airway pressure
- ☐ 4 - None of the above

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
(M1610) Urinary Incontinence or Urinary Catheter Presence:	
Enter Code ☐	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[*Go to M1620*]** 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) **[*Go to M1620*]**
(M1615) When does **Urinary Incontinence** occur?	
Enter Code ☐	0 Timed-voiding defers incontinence 1 Occasional stress incontinence 2 During the night only 3 During the day only 4 During the day and night

(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
(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 not have an ostomy for bowel elimination. 1 Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen. 2 The ostomy was related to an inpatient stay or did 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.

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week **(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

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

Enter Code ☐

0 No
1 Yes

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 <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.

(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.

Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC

(GG0170C) Mobility

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

Coding:	**1. SOC/ROC Performance**	**2. Discharge Goal**	
Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.			
Activity may be completed with or without assistive devices.	↓Enter Codes in Boxes↓		
06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper.	☐☐	☐☐	**Lying to Sitting on Side of Bed**: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.			
04 **Supervision or touching assistance –** Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.			
03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.			
02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.			
01 **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.			
If activity was not attempted, code reason:			
07 Patient refused			
09 Not applicable			
88 Not attempted due to medical condition or safety concerns			

(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.
(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely:	
Enter Code ☐	0 (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (specifically: prior to this home care admission). 1 Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. 2 Unable to prepare any light meals or reheat any delivered meals.
(M1890) **Ability to Use Telephone:** Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.	
Enter Code ☐	0 Able to dial numbers and answer calls appropriately and as desired. 1 Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers. 2 Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. 3 Able to answer the telephone only some of the time or is able to carry on only a limited conversation. 4 Unable to answer the telephone at all but can listen if assisted with equipment. 5 Totally unable to use the telephone. NA Patient does not have a telephone.

(M1900) **Prior Functioning ADL/IADL:** Indicate the patient's usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury.	
Enter Code ☐	a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene) 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	b. Ambulation 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	c. Transfer 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use) 0 Independent 1 Needed Some Help 2 Dependent
(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 M2040*]**
(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?	
Enter Code ☐	0 No 1 Yes
(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: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes 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; OR (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 Unable to take medication unless administered by another person. NA No oral medications prescribed.
(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all 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; OR (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 Unable to take injectable medication unless administered by another person. NA No injectable medications prescribed.
(M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation or injury.	
Enter Code ☐	a. Oral medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable
Enter Code ☐	b. Injectable medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable

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 ☐	b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances) 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 ☐	e. **Management of Equipment** (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies) 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

(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 ☐	g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments) 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
(M2110) **How Often** does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?	
Enter Code ☐	1 At least daily 2 Three or more times per week 3 One to two times per week 4 Received, but less often than weekly 5 No assistance received UK Unknown

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.

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

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐0	☐1	☐NA	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference.
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
c. Falls prevention interventions	☐0	☐1	☐NA	Falls risk assessment indicates patient has no risk for falls.
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	☐0	☐1	☐NA	Patient has no diagnosis of depression AND depression screening indicates 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.
e. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA	Pain assessment indicates patient has no pain.
f. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA	Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers.
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐0	☐1	☐NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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

Time Point	Items Used
Start of Care ----------	M0010-M0030, M0040-M0150, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Start of care—further visits planned	
Resumption of Care ----------	M0032, M0080-M0110, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Resumption of care (after inpatient stay)	
Follow-Up ----------	M0080-M0100, M0110, M1011, M1021-M1023, M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
Recertification (follow-up) assessment Other follow-up assessment	
Transfer to an Inpatient Facility ----------	M0080-M0100, M1041-M1056, M1501, M1511, M2005, M2016, M2301-M2410, M2430, M0903, M0906
Transferred to an inpatient facility—patient not discharged from an agency Transferred to an inpatient facility—patient discharged from agency	
Discharge from Agency — Not to an Inpatient Facility	
Death at home ----------	M0080-M0100, M2005, M0903, M0906
Discharge from agency ----------	M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1501-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906

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 M0903*]**
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

(M1011) List each **Inpatient Diagnosis** and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Inpatient Facility Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (patient was not discharged from an inpatient facility)

(M1021/1023/1025) **Diagnoses, Symptom Control, and Optional Diagnoses**: 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. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses - Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment.

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.

Column 3: (OPTIONAL) There is no requirement that HHAs enter a diagnosis code in M1025 (Columns 3 and 4). Diagnoses reported in M1025 will not impact payment.

Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition . An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1021) Primary Diagnosis & (M1023) Other Diagnoses		(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)	
Column 1	**Column 2**	**Column 3**	**Column 4**
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	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM
(M1021) Primary Diagnosis a. _____	**V, W, X, Y codes NOT allowed** a. [ ][ ][ ].[ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** a. _____ ([ ][ ][ ].[ ][ ][ ][ ])	**V, W, X, Y, Z codes NOT allowed** a. _____ ([ ][ ][ ].[ ][ ][ ][ ])
(M1023) Other Diagnoses b. _____	**All ICD-10–C M codes allowed** b. [ ][ ][ ].[ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** b. _____ ([ ][ ][ ].[ ][ ][ ][ ])	**V, W, X, Y, Z codes NOT allowed** b. _____ ([ ][ ][ ].[ ][ ][ ][ ])
c. _____	c. [ ][ ][ ].[ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4	c. _____ ([ ][ ][ ].[ ][ ][ ][ ])	c. _____ ([ ][ ][ ].[ ][ ][ ][ ])
d. _____	d. [ ][ ][ ].[ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4	d. _____ ([ ][ ][ ].[ ][ ][ ][ ])	d. _____ ([ ][ ][ ].[ ][ ][ ][ ])
e. _____	e. [ ][ ][ ].[ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4	e. _____ ([ ][ ][ ].[ ][ ][ ][ ])	e. _____ ([ ][ ][ ].[ ][ ][ ][ ])
f. _____	f. [ ][ ][ ].[ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4	f. _____ ([ ][ ][ ].[ ][ ][ ][ ])	f. _____ ([ ][ ][ ].[ ][ ][ ][ ])

(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

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 can 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 at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)	
Enter Code ☐	0 No **[*Go to M1322*]** 1 Yes

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 - Go to M1311 B1]	☐
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 M1311 C1]	☐
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 M1311 D1]	☐
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: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 - Go to M1311 E1]	☐
D2. 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	☐
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 M1311 F1]	☐
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: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 - Go to M1322]	☐
F2. 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	☐

(M1322) Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. 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 that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

Enter Code ☐

1 Stage 1
2 Stage 2
3 Stage 3
4 Stage 4
NA Patient has no pressure ulcers or no stageable pressure ulcers

(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

(M1610) Urinary Incontinence or Urinary Catheter Presence:	
Enter Code ☐	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620] 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) *[Go to M1620]*
(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
(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 not have an ostomy for bowel elimination. 1 Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen. 2 The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

ADL/IADLs

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.

(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.

(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.

(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.
(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all 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; OR (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 Unable 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 year.

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-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Resumption of Care ---------- Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Follow-Up ---------- Recertification (follow-up) assessment Other follow-up assessment	M0080-M0100, M0110, M1011, M1021-M1023, M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
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, M1501, M1511, M2005, M2016, M2301-M2410, M2430, M0903, M0906
Discharge from Agency — Not to an Inpatient Facility	
Death at home ----------	M0080-M0100, M2005, M0903, M0906
Discharge from agency ----------	M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1501-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906

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.
(M01051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?	
Enter Code ☐	0 No 1 Yes **[***Go to M1501* **]**
(M01056) 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

CARDIAC STATUS

(M1501) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the most recent SOC/ROC assessment?	
Enter Code ☐	0 No **[***Go to M2005* **]** 1 Yes 2 Not assessed **[***Go to M2005***]** NA Patient does not have diagnosis of heart failure **[***Go to M2005* **]**

(M1511) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

- ☐ 0 - No action taken
- ☐ 1 - Patient's physician (or other primary care practitioner) contacted the same day
- ☐ 2 - Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
- ☐ 3 - Implemented physician-ordered patient-specific established parameters for treatment
- ☐ 4 - Patient education or other clinical interventions
- ☐ 5 - Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

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
- ☐ 2 - Injury caused by fall
- ☐ 3 - Respiratory infection (for example, pneumonia, bronchitis)
- ☐ 4 - Other respiratory problem
- ☐ 5 - Heart failure (for example, fluid overload)
- ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)
- ☐ 7 - Myocardial infarction or chest pain
- ☐ 8 - Other heart disease
- ☐ 9 - Stroke (CVA) or TIA
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 11 - GI bleeding, obstruction, constipation, impaction
- ☐ 12 - Dehydration, malnutrition
- ☐ 13 - Urinary tract infection
- ☐ 14 - IV catheter-related infection or complication
- ☐ 15 - Wound infection or deterioration
- ☐ 16 - Uncontrolled pain
- ☐ 17 - Acute mental/behavioral health problem
- ☐ 18 - Deep vein thrombosis, pulmonary embolus
- ☐ 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 **[*Go to M2430*]**

2 Rehabilitation facility **[*Go to M0903*]**

3 Nursing home **[*Go to M0903*]**

4 Hospice **[*Go to M0903*]**

(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Injury caused by fall
- ☐ 3 - Respiratory infection (for example, pneumonia, bronchitis)
- ☐ 4 - Other respiratory problem
- ☐ 5 - Heart failure (for example, fluid overload)
- ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)
- ☐ 7 - Myocardial infarction or chest pain
- ☐ 8 - Other heart disease
- ☐ 9 - Stroke (CVA) or TIA
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 11 - GI bleeding, obstruction, constipation, impaction
- ☐ 12 - Dehydration, malnutrition
- ☐ 13 - Urinary tract infection
- ☐ 14 - IV catheter-related infection or complication
- ☐ 15 - Wound infection or deterioration
- ☐ 16 - Uncontrolled pain
- ☐ 17 - Acute mental/behavioral health problem
- ☐ 18 - Deep vein thrombosis, pulmonary embolus
- ☐ 19 - Scheduled treatment or procedure
- ☐ 20 - Other than above reasons
- ☐ UK - Reason unknown

(M0903) Date of Last (Most Recent) Home Visit:

☐☐ / ☐☐ / ☐☐☐☐
month day year

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

☐☐ / ☐☐ / ☐☐☐☐
month day year

Outcome and Assessment Information Set
Discharge from Agency
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-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Resumption of Care ---------- Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Follow-Up ---------- Recertification (follow-up) assessment Other follow-up assessment	M0080-M0100, M0110, M1011, M1021-M1023, M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
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, M1501, M1511, M2005, M2016, M2301-M2410, M2430, M0903, M0906
Discharge from Agency — Not to an Inpatient Facility	
Death at home ----------	M0080-M0100, M2005, M0903, M0906
Discharge from agency ----------	M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1501-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906

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*]**

(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 M1230]
(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

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):	
Enter Code ☐	0 Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. 1 Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance). 2 Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences. 3 Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases. 4 Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible). 5 Patient nonresponsive or unable to speak.
(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 at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)	
Enter Code ☐	0 No **[*Go to M1322*]** 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 at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** If 0 - Go to M1311B1] **A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐ ☐
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] **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] **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: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 - Go to M1311E1] **D2. 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	☐ ☐
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] **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: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 - Go to M1313] **F2. 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	☐ ☐

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:

Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.	
	Enter Number
a. Stage 2	☐
b. Stage 3	☐
c. Stage 4	☐

Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.	
	Enter Number
d. Unstageable—Known or likely but Unstageable due to non-removable dressing.	☐
e. Unstageable—Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	☐
f. Unstageable—Suspected deep tissue injury in evolution.	☐

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

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

(M1322) Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. 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 that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

Enter Code ☐	1	Stage 1
	2	Stage 2
	3	Stage 3
	4	Stage 4
	NA	Patient has no pressure ulcers or no stageable pressure ulcers

(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)

CARDIAC STATUS

(M1501) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the most recent SOC/ROC assessment?

Enter Code ☐

0 No **[*Go to M1600*]**
1 Yes
2 Not assessed **[*Go to M1600*]**
NA Patient does not have diagnosis of heart failure **[*Go to M1600*]**

(M1511) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

☐ 0 - No action taken
☐ 1 - Patient's physician (or other primary care practitioner) contacted the same day
☐ 2 - Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
☐ 3 - Implemented physician-ordered patient-specific established parameters for treatment
☐ 4 - Patient education or other clinical interventions
☐ 5 - Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

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

(M1610) Urinary Incontinence or Urinary Catheter Presence:

Enter Code ☐

0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[*Go to M1620*]**
1 Patient is incontinent
2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) **[*Go to M1620*]**

(M1615) When does **Urinary Incontinence** occur?

Enter Code ☐

0 Timed-voiding defers incontinence
1 Occasional stress incontinence
2 During the night only
3 During the day only
4 During the day and night

(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

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.
(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.

(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.

(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely:	
Enter Code ☐	0 (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (specifically: prior to this home care admission). 1 Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. 2 Unable to prepare any light meals or reheat any delivered meals.
(M1890) **Ability to Use Telephone:** Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.	
Enter Code ☐	0 Able to dial numbers and answer calls appropriately and as desired. 1 Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers. 2 Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. 3 Able to answer the telephone only some of the time or is able to carry on only a limited conversation. 4 Unable to answer the telephone at all but can listen if assisted with equipment. 5 Totally unable to use the telephone. NA Patient does not have a telephone.

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:** Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes 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; OR (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 Unable to take medication unless administered by another person. NA No oral medications prescribed.
(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all 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; OR (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 Unable 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 ☐	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 ☐	b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances) 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

(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 ☐	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 ☐	e. **Management of Equipment** (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies) 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
Enter Code ☐	g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments) 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
- ☐ 2 - Injury caused by fall
- ☐ 3 - Respiratory infection (for example, pneumonia, bronchitis)
- ☐ 4 - Other respiratory problem
- ☐ 5 - Heart failure (for example, fluid overload)
- ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)
- ☐ 7 - Myocardial infarction or chest pain
- ☐ 8 - Other heart disease
- ☐ 9 - Stroke (CVA) or TIA
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 11 - GI bleeding, obstruction, constipation, impaction
- ☐ 12 - Dehydration, malnutrition
- ☐ 13 - Urinary tract infection
- ☐ 14 - IV catheter-related infection or complication
- ☐ 15 - Wound infection or deterioration
- ☐ 16 - Uncontrolled pain
- ☐ 17 - Acute mental/behavioral health problem
- ☐ 18 - Deep vein thrombosis, pulmonary embolus
- ☐ 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 **[*Go to M2430*]**
2 Rehabilitation facility **[*Go to M0903*]**
3 Nursing home **[*Go to M0903*]**
4 Hospice **[*Go to M0903*]**
NA No inpatient facility admission

(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 **[*Go to M0903*]**

(M0903) Date of Last (Most Recent) Home Visit:

☐☐ / ☐☐ / ☐☐☐☐
month day year

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

☐☐ / ☐☐ / ☐☐☐☐
month day year

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-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Resumption of Care ---------- Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Follow-Up ---------- Recertification (follow-up) assessment Other follow-up assessment	M0080-M0100, M0110, M1011, M1021-M1023, M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
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, M1501, M1511, M2005, M2016, M2301-M2410, M2430, M0903, M0906
Discharge from Agency — Not to an Inpatient Facility	
Death at home ----------	M0080-M0100, M2005, M0903, M0906
Discharge from agency ----------	M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1501-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906

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

(M0903) Date of Last (Most Recent) Home Visit:

☐☐ / ☐☐ / ☐☐☐☐
month day year

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

☐☐ / ☐☐ / ☐☐☐☐
month day year

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** text.
- **ITEM INTENT:** Describes the rationale for collecting the information, in the context of outcome and process quality measurement, care planning, outcome risk adjustment, or prospective payment rate adjustment.
- **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 should 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 to determine the most accurate response to this specific item. This may include other clinicians, administrative records, online guidance regarding coding or other assessment guidelines, or standards promulgated by professional or accrediting organizations.

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:

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, regulatory requirements, coverage criteria (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, 2017 = 05/04/2017). 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:

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

- ROC.
- 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, 2017 = 05/04/2017). 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); 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:

(including suffix)

☐ **NA – No Medicare**

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); updated if change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS

- Enter the number identified as "Claim No." on the patient's Medicare card. (NOTE: This may or may not be the patient's Social Security number.)
- 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); 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, 2017 = 05/04/2017). 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); 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); 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

- Enter the response associated with the discipline of the individual completing the assessment.
- Only one individual completes the comprehensive assessment. Even if two disciplines are seeing the patient at the time a comprehensive assessment is due, while care coordination and consultation are needed, only one individual actually completes and records the assessment.
- 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.
- Conditions of Participation.

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, 2017 = 05/04/2017). 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.
- If the clinician needs to follow-up, off site, with the patient's family or physician in order to complete an OASIS or non-OASIS portion of the comprehensive assessment, M0090 should reflect the date that last needed information is collected.
- If the original assessing clinician gathers additional information during the SOC 5-day assessment time frame that would change a data item response, the M0090 date would be changed to reflect the date the information was gathered and the response change was made.
- 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 M0903]*** 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 does not 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 not required 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 and 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, if the date was specified by the physician. The item refers to the order to start home care services (that is, provide the first covered service), 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) 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 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, 2017 = 05/04/2017). Enter all four digits of the year.
- Mark "N/A" if the initial orders did not specify a SOC date.
- Because the State Operations Manual (SOM) requires a visit within 48 hours of ROC following hospitalization, mark "N/A" if the physician orders a ROC date that extends beyond 2 calendar days of the inpatient facility discharge.
- In order to be considered a physician-ordered SOC date, the physician must give a specific date to initiate care, not a range of dates. If a single date to initiate services is not provided, the initial contact (via the initial assessment 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 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 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, 2017 = 05/04/2017). 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

☐ 4 Long-term care hospital (LTCH)

☐ 5 Inpatient rehabilitation hospital or unit (IRF)

☐ 6 Psychiatric hospital or unit

☐ 7 Other (specify) _____

☐ 8 Patient was not discharged from an inpatient facility **[*Go to M1017*]**

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.

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

- 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
  - 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 or Not Available**

ITEM INTENT

- Identifies the date of the most recent discharge from an inpatient facility (within last 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, 2014 = 05/04/2017). 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

(M1011) List each Inpatient Diagnosis and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Inpatient Facility Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (patient was not discharged from an inpatient facility) **[Omit "NA" option on SOC, ROC]**

ITEM INTENT

- Identifies diagnosis(es) for which patient was actively receiving treatment in an inpatient facility within the past 14 days. This list of diagnoses is intended to include only those diagnoses that required active treatment during the inpatient stay and may or may not correspond with the hospital admitting diagnosis.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE—SPECIFIC INSTRUCTIONS

- "Actively treated" should be defined as receiving something more than the regularly scheduled medications and treatments necessary to maintain or treat an existing condition.
- The term "past 14 days" is the two-week period immediately preceding the Start/Resumption of Care date (or for Follow-Up, the M0090 Date Assessment Completed). This means that for purposes of counting the 14-day period, the date of 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 diagnoses related to inpatient stays with discharges falling on or after August 6 and prior to the HHA admission would be reported.
- If a diagnosis was not treated during an inpatient admission, it should not be listed. (Example: The patient has a long-standing diagnosis of "osteoarthritis," but was treated during hospitalization only for "peptic ulcer disease." Do not list "osteoarthritis" as an inpatient diagnosis.)
- No surgical codes. List the underlying diagnosis that was surgically treated. If a joint replacement was done for osteoarthritis, list the disease, not the procedure.
- No V, W, X, Y, or Z codes. List the underlying diagnosis.
- It is not necessary to fill in every line (a-f) if the patient had fewer than six inpatient diagnoses.
- Select "NA" at follow-up if the patient was not discharged from an inpatient facility within the past 14 days.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Referral information (may include inpatient facility discharge summary, physician history and physical, progress notes, etc.).
- Physician.
- 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).

OASIS ITEM

(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Changed Medical Regimen Diagnosis	ICD-10-CM Code
a.	_____	
b.	_____	
c.	_____	
d.	_____	
e.	_____	
f.	_____	

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

ITEM INTENT

- Identifies if any change has occurred to the patient's treatment regimen, health care services, or medications within the past 14 days. The purpose of this question is to help identify the patient's recent history by identifying new diagnoses or diagnoses that have exacerbated over the past 2 weeks.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

RESPONSE—SPECIFIC INSTRUCTIONS

- No surgical codes - list the underlying diagnosis.
- No V, W, X, Y, or Z codes - list the appropriate diagnosis.
- A diagnosis reported in M1011 – Inpatient Diagnosis may also be reported in M1017 if within the 14 days prior to the SOC/ROC date the condition was new or exacerbated, required changes in the treatment regimen, AND the patient was discharged from an inpatient facility where the condition was actively treated.
- Mark "NA" if no medical or treatment regimen changes were made within the past 14 days OR all changes in the medical or treatment regimen were made because a diagnosis improved.
- 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 SOC/ROC date is day 0 and the day immediately prior to the SOC/ROC date is day 1. For example, if the patient's SOC date is August 20, any diagnoses requiring medical or treatment regimen change on or after August 6 and prior to the HHA admission would be reported.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Physician.
- Physician orders.
- Referral information.
- 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).

OASIS ITEM

(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

☐ 1 Urinary incontinence

☐ 2 Indwelling/suprapubic catheter

☐ 3 Intractable pain

☐ 4 Impaired decision-making

☐ 5 Disruptive or socially inappropriate behavior

☐ 6 Memory loss to the extent that supervision required

☐ 7 None of the above

☐ NA No inpatient facility discharge and no change in medical or treatment regimen in past 14 days

☐ UK Unknown

ITEM INTENT

- Identifies existence of condition(s) prior to medical regimen change or inpatient stay within past 14 days.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

RESPONSE—SPECIFIC INSTRUCTIONS

- Select Response 7 – None of the above – if the patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, and none of the indicated conditions existed prior to the inpatient stay or change in medical or treatment regimen.
- Select Response "NA" if no inpatient facility discharge and no change in medical or treatment regimen in past 14 days. Note that both situations must be true for this response to be marked "NA."
- Select Response "Unknown" if the patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, and it is unknown whether the indicated conditions existed prior to the inpatient stay or change in medical or treatment regimen.
- 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 SOC/ROC date is day 0 and the day immediately prior to the SOC/ROC date is day 1.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Physician.
- Referral information (for example, history and physical).

(M1021/1023/1025) Diagnoses, Symptom Control, and Optional Diagnoses: 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. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses – Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment.

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.

Column 3: (OPTIONAL) There is no requirement that HHAs enter a diagnosis code in M1025 (Columns 3 and 4). Diagnoses reported in M1025 will not impact payment. Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition. An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row. (Form on next page)

OASIS ITEM (M1021/1023/1025) Diagnoses, Symptom Control, and Optional Diagnoses

(M1021) Primary Diagnosis & (M1023) Other Diagnoses		**(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)**	
Column 1	Column 2	Column 3	Column 4
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.	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved.	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code).
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM
(M1021) Primary Diagnosis a. _____	**V, W, X, Y codes NOT allowed** a. [ ][ ][ ].[ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** a. _____ ([ ][ ][ ].[ ][ ][ ][ ])	**V, W, X, Y, Z codes NOT allowed** a. _____ ([ ][ ][ ].[ ][ ][ ][ ])
(M1023) Other Diagnoses b. _____	**All ICD-10–C M codes allowed** b. [ ][ ][ ].[ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** b. _____ ([ ][ ][ ].[ ][ ][ ][ ])	**V, W, X, Y, Z codes NOT allowed** b. _____ ([ ][ ][ ].[ ][ ][ ][ ])
c. _____	c. [ ][ ][ ].[ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4	c. _____ ([ ][ ][ ].[ ][ ][ ][ ])	c. _____ ([ ][ ][ ].[ ][ ][ ][ ])
d. _____	d. [ ][ ][ ].[ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4	d. _____ ([ ][ ][ ].[ ][ ][ ][ ])	d. _____ ([ ][ ][ ].[ ][ ][ ][ ])
e. _____	e. [ ][ ][ ].[ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4	e. _____ ([ ][ ][ ].[ ][ ][ ][ ])	e. _____ ([ ][ ][ ].[ ][ ][ ][ ])
f. _____	f. [ ][ ][ ].[ ][ ][ ][ ] ☐0 ☐1 ☐2 ☐3 ☐4	f. _____ ([ ][ ][ ].[ ][ ][ ][ ])	f. _____ ([ ][ ][ ].[ ][ ][ ][ ])

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.
- M1025 (OPTIONAL): the intent of this item is to provide the agency with the option of documenting a resolved underlying condition in Columns 3 and 4, if a Z-code is reported as a primary or secondary diagnosis in Columns 1 and 2, and the underlying condition is no longer active.

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.
    - 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.
    - 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

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEMS M1021/1023/1025)

- 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."
- 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).

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEMS M1021/1023/1025)

- 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.
- M1025 (OPTIONAL)
  - If a Z-code is reported in Column 2 and the underlying condition for the Z-code is resolved, then the resolved condition may be reported in Columns 3 and 4 at the agency's discretion.
  - If an agency chooses to report a diagnosis in Columns 3 and 4, then the instructions that accompany items M1021/M1023/M1025 in the OASIS-C1 data set should be followed to code each row in Column 3 and/or 4. If a diagnosis and ICD-10-CM code is entered in Columns 3 and/or 4, it must be placed in the same row as the corresponding Z-code. Note that external cause codes (ICD-10-CM codes beginning with V, W, X, or Y) may not be reported in M1025.
- 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)

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).

Item Rationale

- Disease processes can have a significant adverse effect on an individual's health status and quality of life.
- This section identifies active diagnoses that are associated with a patient's home health episode of care.

TIME POINTS ITEM(S) COMPLETED

- Start of Care.
- Resumption of Care.

Steps for Assessment

- **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.
  - Medical 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, medication sheets, physician orders, consults and official diagnostic reports, diagnosis./problem list(s), and other resources as available.
  - 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 medical 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 medical record by the 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.
- **Determine whether diagnoses are active:** Once a diagnosis has been identified, determine if the diagnosis is active.

- 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, mood or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.

- Medical record sources to identify active diagnoses at the time of assessment include, but are not limited to, transfer documents, physician progress notes, recent history and physical, discharge summary, medication sheets, physician orders, consults and other official diagnostic reports, diagnosis/problem list(s), and other resources as available.
  - Only diagnoses confirmed by the physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized licensed staff if allowable under state licensure laws) that are active should be coded on the OASIS Data Set.
  - If information regarding active diagnoses is learned after the Assessment Completed Date, 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 that a **documented** active diagnosis was 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 (available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-15-18.html?DLPage=1&DLFilter=15-18&DLSort=3&DLSortDir=descending) and the OASIS Submission User's guide (available at https://www.qtso.com/hhatrain.html)

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

Definitions

- **Nurse monitoring** Nurse monitoring includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management).

RESPONSE SPECIFIC INSTRUCTIONS

- Complete only if M0100 = 01 Start of care or 03 Resumption of care.
- Select Response 1 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 bypass graft(s) of the extremities
    - I70.4 – Atherosclerosis of autologous vein bypass graft(s) of the extremities
    - I70.5 – Atherosclerosis of nonautologous biological bypass graft(s) of the extremities
    - I70.6 – Atherosclerosis of nonbiological bypass graft(s) of the extremities
    - I70.7 – Atherosclerosis of other type of bypass graft(s) of the extremities
    - I70.91 – Generalized atherosclerosis
    - I70.92 – Chronic total occlusion of artery of the extremities
  - Codes that start with the first 3 characters of
    - I73. – Other peripheral vascular diseases

RESPONSE SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM 1028)

- **Select Response 2** 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 specific diabetes mellitus

Tips

- The following tips may assist staff in determining whether a disease or condition may be identified as an active diagnosis on the OASIS.
  - There must be specific documentation in the medical record by a physician (or nurse practitioner, physician assistant, clinical nurse specialist, or other authorized staff if allowable under state licensure laws) of the disease or condition being an active diagnosis.
  - The physician (nurse practitioner, physician assistant, clinical nurse specialist, authorized licensed staff if allowable under state licensure laws) may specifically indicate that a diagnosis is active. Specific documentation areas in the medical record may include, but are not limited to, progress notes, admission history and physical, transfer notes, and the hospital discharge summary.
  - 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 mediation regimen needed to be modified.
  - For the purposes of the OASIS Data Set, Home Health Agencies should consider only the documented active diagnoses. A diagnosis should not be inferred by association with other conditions (e.g., "weight loss" should not be inferred to mean "malnutrition").

Examples of Active Diagnoses

- **Example 1:** 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.
- **Response 2:** Diabetes Mellitus would be checked.
- **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.
- **Example 2:** Mrs. I underwent a below the knee amputation due to gangrene associated with peripheral vascular disease. She requires dressing changes to the stump and monitoring for wound healing. In addition, peripheral pulse monitoring is ordered. The nurse practitioner's progress note documents peripheral vascular disease and left below the knee amputation.
- **Response 1:** Peripheral Vascular Disease (PVD) would be checked.
- **Rationale:** This would be considered an active diagnosis because the nurse practitioner's note documents the peripheral vascular disease diagnosis, with peripheral pulse monitoring and recent below the knee amputation, with dressing changes and wound status monitoring.

OASIS ITEM

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

☐ 1 Intravenous or infusion therapy (excludes TPN)

☐ 2 Parenteral nutrition (TPN or lipids)

☐ 3 Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)

☐ 4 None of the above

ITEM INTENT

- Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy at home, whether or not the home health agency is administering the therapy. This item is not intended to identify therapies administered in outpatient facilities or by any provider outside the home setting.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE—SPECIFIC INSTRUCTIONS

- This item addresses only therapies administered at home, defined as the patient's place of residence. Exclude therapies administered in outpatient facilities or by any provider outside the home setting.
- If the patient will receive such therapy as a result of this SOC/ROC or follow-up assessment (for example, the IV will be started at this visit or a specified subsequent visit; the physician will be contacted for an enteral nutrition order; etc.), mark the applicable therapy.
- Select Response 1 if a patient receives intermittent medications or fluids via an IV line (including heparin or saline flushes). If IV catheter is present but not active (for example, site is observed only or dressing changes are provided), do not mark Response 1.
- Select Response 1 if ongoing infusion therapy is being administered at home via central line, subcutaneous infusion, epidural infusion, intrathecal infusion, or insulin pump.
- Select Response 1 if the patient receives hemodialysis or peritoneal dialysis in the home.
- Do not select Response 1 if there are orders for an IV infusion to be given when specific parameters are present (for example, weight gain), but those parameters are not met on the day of the assessment.
- An irrigation or infusion of the bladder is not included when completing M1030, Therapies at Home.
- Select Response 3 if any enteral nutrition is provided. If a feeding tube is in place, but not currently used for nutrition, Response 3 does not apply. A flush of a feeding tube does not provide nutrition.

DATA SOURCES / RESOURCES

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

OASIS ITEM

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

- ☐ 1 History of falls (2 or more falls—or any fall with an injury—in the past 12 months)
- ☐ 2 Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- ☐ 3 Multiple hospitalizations (2 or more) in the past 6 months
- ☐ 4 Multiple emergency department visits (2 or more) in the past 6 months
- ☐ 5 Decline in mental, emotional, or behavioral status in the past 3 months
- ☐ 6 Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- ☐ 7 Currently taking 5 or more medications
- ☐ 8 Currently reports exhaustion
- ☐ 9 Other risk(s) not listed in 1–8
- ☐ 10 None of the above

ITEM INTENT

- Identifies patient characteristics that may indicate the patient is at risk for hospitalization.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

RESPONSE—SPECIFIC INSTRUCTIONS

- Select all Responses 1-9 that apply.
- If Response 10 is selected, none of the other responses should be selected.
- Response 1 includes witnessed and reported (unwitnessed) falls.
- In Response 5, decline in mental, emotional, or behavioral status refers to significant changes occurring within the past 3 months that may impact the patient's ability to remain safely in the home and increase the likelihood of hospitalization. In Response 7, medications includes 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

(M1034) Overall Status: Which description best fits the patient's overall status?	
Enter Code ☐	0 The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 1 The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 2 The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death. 3 The patient has serious progressive conditions that could lead to death within a year. UK The patient's situation is unknown or unclear.

ITEM INTENT

- Identifies the general potential for health status stabilization, decline, or death in the care provider's professional judgment.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

RESPONSE—SPECIFIC INSTRUCTIONS

- Use information from other providers and clinical judgment to enter the response that best identifies the patient's status.
- Consider current health status, medical diagnoses, and information from the physician and patient/family on expectations for recovery or life expectancy.
- A "Do Not Resuscitate" order does not need to be in place for Response 2 or 3.

DATA SOURCES / RESOURCES

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

OASIS ITEM

(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome:
(Mark all that apply.)

- ☐ 1 Smoking
- ☐ 2 Obesity
- ☐ 3 Alcohol dependency
- ☐ 4 Drug dependency
- ☐ 5 None of the above
- ☐ UK Unknown

ITEM INTENT

- Identifies specific factors that may exert a substantial impact on the patient's health status, response to medical treatment, and ability to recover from current illnesses, in the care provider's professional judgment.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

RESPONSE—SPECIFIC INSTRUCTIONS

- Select all Responses 1-4, that apply.
- If Response 5 is selected, none of the other responses should be selected.
- CMS does not provide a specific definition for each of these factors.
- Amount and length of exposure should be considered when responding (for example, smoking one cigarette a month may not be considered a risk factor).
- Care providers should use judgment in evaluating risks to current health conditions from behaviors that were stopped in the past.
- For determination of obesity, consider using Body Mass Index guidelines.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Physician.
- Review of past health history.
- Physical assessment.
- Links to Body Mass Index guidelines for obesity can be found in Chapter 5 of this manual.

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 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 indicate—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. Medical contraindications include anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, or bone marrow transplant within 6 months.
- 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 (see link in Chapter 5). 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 M1501 at TRN; Go to M1230 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. Medical contraindications include anaphylactic hypersensitivity to component(s) of the vaccine, acute febrile illness, bone marrow transplant within past 12 months, or receiving course of chemotherapy or radiation therapy within past 2 weeks.
- 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

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

inches

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.

Item Rationale

- Diminished nutritional and hydration status can lead to debility that can adversely affect wound healing and increase risk for the development of pressure ulcers.
- Height and weight measurements (and BMI calculation) assist staff in assessing the patient's nutrition and hydration status by providing a mechanism for monitoring stability of weight and BMI over a period of time. The measurement of height and weight for the calculation of BMI is one guide for determining nutritional status.
- Weight measurement is also used in assessment of heart failure.

TIME POINTS ITEMS COMPLETED

Start of care.

Resumption of care.

Steps for Assessment for M1060 – a, Height

1. Measure height in accordance with the agency's policies and procedures, which should reflect current standards of practice (shoes off, etc.).
2. Measure and record height in inches.
3. 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).

Instructions for M1060 – a, Height

- Complete only if M0100 = 1 Start of Care or 3 Resumption of Care.
- 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.
- A dash (–) value is a valid response for this item. A dash (–) value indicates that no information is available and /or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before the assessment of the item could be completed. CMS expects dash use to be a rare occurrence.

Steps for Assessment for M1060 – b, Weight

1. Weight should be measured in accordance with the agency's policies and procedures, which should reflect current standards of practice (shoes off, etc.).
2. Measure and record the patient's weight in pounds.
3. If a patient cannot be weighed, for example, because of extreme pain, immobility, or risk of pathological fractures, enter the dash value ("-") and document the rationale on the patient's medical record.

Instructions for M1060 – b, Weight

Complete only if M0100 = 1 Start of Care, or 3 Resumption of Care

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

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.)

	Availability of Assistance				
Living Arrangement	**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.
  - 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.

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

- 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 M2100.
  - 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.)
- 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.)*

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

- 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 can 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

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

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

(M1210) Ability to Hear (with hearing aid or hearing appliance if normally used):	
Enter Code ☐	0 Adequate: hears normal conversation without difficulty. 1 Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly. 2 Severely Impaired: absence of useful hearing. UK Unable to assess hearing.

ITEM INTENT

- Identifies the patient's ability to hear spoken language and other sounds (for example, alarms).

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

RESPONSE—SPECIFIC INSTRUCTIONS

- Hearing is evaluated with the patient wearing hearing aids or devices if he/she usually uses them.
- If the patient is not able to respond or if the patient's condition makes it impossible to assess hearing (for example, severe dementia, schizophrenia, unconscious).
- If evaluating ability to hear with hearing aids, be sure that the devices are in place, turned on, and that the hearing aids are working (for example, batteries are functional).

DATA SOURCES / RESOURCES

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

OASIS ITEM

(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):	
Enter Code ☐	0 Understands: clear comprehension without cues or repetitions. 1 Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand. 2 Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand. 3 Rarely/Never Understands. UK Unable to assess understanding.

ITEM INTENT

- Identifies the patient's functional ability to comprehend spoken words and instructions in the patient's primary language. Both hearing and cognitive abilities may impact a patient's ability to understand verbal content.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

RESPONSE—SPECIFIC INSTRUCTIONS

- Enter "UK" if the patient is not able to respond or if it is otherwise impossible to assess understanding of spoken words.
- For patients whose primary language differs from the clinician's, an interpreter may be necessary.
- If a patient can comprehend lip reading, they have the ability to understand verbal content, even if they are deaf.

DATA SOURCES / RESOURCES

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

OASIS ITEM

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):	
Enter Code ☐	0 Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. 1 Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance). 2 Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences. 3 Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases. 4 Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible). 5 Patient nonresponsive or unable to speak.

ITEM INTENT

- Identifies the patient's physical and cognitive ability to communicate with words in the patient's primary language. The item does not address communicating in sign language, in writing, or by any nonverbal means.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE—SPECIFIC INSTRUCTIONS

- Augmented speech (for example, a trained esophageal speaker, use of an electrolarynx) is considered verbal expression of language.
- Presence of a tracheostomy requires further evaluation of the patient's ability to speak. Can the trach be covered to allow speech? If so, to what extent can the patient express him/herself?
- Enter Response 5 for a patient who communicates entirely nonverbally (for example, by sign language or writing) or is unable to speak.
- "Nonresponsive" means that the patient is not able to respond.

DATA SOURCES / RESOURCES

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

OASIS ITEM

(M1240) Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?	
Enter Code ☐	0 No standardized, validated assessment conducted 1 Yes, and it does not indicate severe pain 2 Yes, and it indicates severe pain

ITEM INTENT

- Identifies if a standardized, validated pain assessment is conducted and whether a clinically significant level of pain is present, as determined by the assessment tool used. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. 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

- A standardized, validated tool is one that 1) 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. Severe pain is defined according to the scoring parameters specified for the tool being used. CMS does not endorse a specific tool.
- If the standardized, validated tool does not define levels of "severe" pain, then the agency or care provider should use the level(s) of pain identified in the tool that best reflect the concept of "severe."
- Enter Response 0 if such a tool was not used to assess pain.
- When a standardized, validated assessment has been conducted, enter Response 1 or Response 2 based on the severity level that corresponds to the patient's pain level, per the tool's scoring instructions. Enter Response 2 when the patient's reported level of pain equates to a severe pain rating on the tool used.
- In order to enter Response 1 or 2, the pain assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the allowed time frame (that is, within five days of SOC and within two days of discharge from the inpatient facility at ROC).

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Physical assessment.
- Clinical record.
- A variety of standardized pain assessment approaches have been tested and are available for provider use in patient assessment. These approaches include visual analog scales, the Wong-Baker FACES Pain Rating Scale, numerical scales, and the Memorial Pain Assessment Card. Links to these and other assessment tools can be found in Chapter 5 of this manual.

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

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers**?	
Enter Code ☐	0 No assessment conducted **[*Go to M1306*]** 1 Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool 2 Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)

ITEM INTENT

- Identifies whether the home health agency care providers assessed the patient's risk of developing pressure ulcers. CMS does not require the use of standardized, validated tools, nor does it endorse one particular tool.
- This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. 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, if the patient was not assessed for pressure ulcer risk.
- In order to enter Response 1 or 2, the pressure ulcer risk assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment.
- Enter Response 1, if the patient's risk for pressure ulcer development was clinically assessed, but no formal pressure ulcer screening tool was used.
- Enter Response 2, only if the patient was screened using a standardized, validated screening tool. This is defined as a tool that 1) 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); and 2) includes a standard response scale. The tool must be appropriately administered per the tool's instructions.
- If both a standardized, validated screening tool and an evaluation of clinical factors are utilized, enter Response 2.

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

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?	
Enter Code ☐	0 No 1 Yes

ITEM INTENT

- Identifies if the patient is at risk for developing pressure ulcers. This item should be skipped if Response 0 was entered for M1300 (no pressure ulcer risk assessment).

TIME POINTS ITEM(S) COMPLETED

- Start of Care.
- Resumption of Care.

RESPONSE—SPECIFIC INSTRUCTIONS

- If pressure ulcer risk was assessed using a standardized, validated screening tool, use the scoring parameters specified for the tool to identify if a patient is at risk for developing pressure ulcers. If the evaluation was based on clinical factors (without a validated standardized screening tool), then the agency or care provider may define what constitutes risk.
- A validated standardized screening tool is a tool that 1) has been scientifically tested and evaluated with a population with characteristics similar to the patient who is being evaluated and shown to be effective in identifying people at risk for developing pressure ulcers; and 2) includes a standard response scale. The standardized, validated tool must be appropriately administered per the tool's instructions.
- If both a standardized, validated screening tool and an evaluation of clinical factors are utilized, enter Response 1 (Yes), if either assessment is positive for risk.

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

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)	
Enter Code ☐	0 No **[*Go to M1322*]** 1 Yes

ITEM INTENT

- Identifies the presence or absence of Unhealed Stage 2 or higher or Unstageable pressure ulcers 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&As, providers should rely on the CMS OASIS instructions.
- Pressure ulcers 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.
- Terminology referring to “healed” vs. “unhealed” ulcers can refer to whether the ulcer is “closed” vs. “open”. Recognize, however, that Stage 1 pressure ulcers and Suspected Deep Tissue Injury (sDTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers, 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(s) is/are Stage 1 OR healed pressure ulcers (of any previous stage) AND the patient has no other pressure ulcers.
- 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, defined as:
  - Pressure ulcers 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 exists under the non-removable dressing/device.
  - Pressure ulcers that are present on clinical assessment, but that cannot be staged because no bone, muscle, tendon, or joint capsule (Stage 4 structures) are visible, and some degree of necrotic tissue (eschar or slough) is present that the clinician believes may be obscuring the visualization of Stage 4 structures.

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

- Suspected deep tissue injury in evolution, 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. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

- 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.
- Agencies should be aware that the patient is at higher risk of having the site of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue. Tensile strength of the skin overlying a closed full thickness pressure ulcer is only 80% of normal skin tensile strength. Agencies should pay careful attention that preventative measures are put into place that will mitigate the re-opening of a closed 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 when first assessed 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 most recent 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, 2017 would be 05/04/2017).
- If no pressure ulcer existed at the SOC, then a Stage 1 pressure ulcer 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 not 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

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

ITEM INTENT

- Identifies the number of Stage 2 or higher pressure ulcers at each stage present at the time of assessment. Stage 1 pressure ulcers and ulcers that have healed 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 refers to whether the ulcer is “closed” vs. “open”. Recognize, however, that Stage 1 pressure ulcers and Suspected Deep Tissue Injury (sDTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.

Determining “Present on Admission”

- For the OASIS, “Present on Admission” and “Present at SOC/ROC” have equivalent meanings.
- For each pressure ulcer, determine whether the pressure ulcer was present at the time of the most recent SOC/ROC, and did not form during this home health quality episode.
- If the pressure ulcer was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge assessment, its “Present on Admission” stage should be considered the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, do not report the higher stage ulcer as being “present at SOC/ROC” when completing the Discharge assessment.
- The general standard of practice for patients starting or resuming care is that patient assessments are completed beginning as close to the actual time of the SOC/ROC as possible. If a pressure ulcer that is identified on the SOC date increases in numerical stage (worsens) within the assessment time frame, the initial stage of the pressure ulcer would be reported in M1311 at the SOC.
- At SOC/ROC, 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 currently present. Enter 0 if no Stage 3 pressure ulcers are present at the time of the assessment.
- At Follow-Up and Discharge, enter a response for each row of this item: A1, A2, B1, B2, C1, C2, D1, D2, E1, E2, F1, F2.
  - Example: At Discharge, in A1 enter the number of Stage 2 pressure ulcers that are currently present. If no Stage 2 pressure ulcers are currently present, enter 0 in A1 and skip A2. If at least one Stage 2 pressure ulcer is reported in A1, enter in A2 the number of these Stage 2 pressure ulcers that were present at the most recent SOC/ROC.

Stage 2 ulcers

- Report the number of Stage 2 or higher pressure ulcers that are present 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.

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 or Stage 4 pressure ulcer that is currently open again should be reported at its worst stage.
- 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 stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst. An ulcer's stage can worsen, and this item should be answered using the worst stage if this occurs.
- A muscle flap, skin advancement flap, or rotational flap (defined as full thickness skin and subcutaneous tissue partially attached to the body by a narrow strip of tissue so that it retains its blood supply) performed to surgically replace a pressure ulcer is a surgical wound. It should not be reported as a pressure ulcer on M1311.
- A pressure ulcer treated with a skin graft (defined as transplantation of skin to another site) should not be reported as a pressure ulcer and until the graft edges completely heal, 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

- Definition: Pressure ulcers covered with slough and/or eschar are unstageable. Rationale: The true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. The pressure ulcer stage can be determined only when enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage.
- Pressure ulcers that are known to be present but that are Unstageable due to a dressing/device, such as a cast that cannot be removed to assess the skin underneath, should be reported as D1 (Unstageable). "Known" refers to when documentation is available that states a pressure ulcer 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.
- Response F1 refers to a suspected deep tissue injury in evolution, 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 ulcers 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. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

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

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

ITEM INTENT

- This item documents the number of pressure ulcers present at Discharge that were not present (are new) or have "worsened" (increased in numerical stage) since the most recent Start or Resumption of Care assessment.

TIME POINTS ITEM(S) COMPLETED

- Discharge.

RESPONSE—SPECIFIC INSTRUCTIONS

- Review the history of each current pressure ulcer. Specifically, compare the current stage at Discharge to past stages to determine whether any pressure ulcer currently present is new or at an increased numerical stage (worsened) when compared to the most recent SOC/ROC. Then, for each current stage, count the number of current pressure ulcers that are new or have increased in numerical stage since the last SOC/ROC was completed. This allows a more accurate assessment than simply comparing total counts at Discharge and most recent SOC/ROC.
- If a pressure ulcer increased in numerical stage from SOC (or ROC) to Discharge, it is considered worsened and would be included in counts of worsened pressure ulcers on M1313 at Discharge.
- For definitions of pressure ulcer stages, see M1311.
- For pressure ulcers that are currently Stage 2, 3 or 4 (rows a, b and c):
  - Mark a response for each row of this item: a, b, and c. If at Discharge there are currently NO ulcers at a given stage, enter "0" for that stage/row.
  - Report the number of current pressure ulcers at each stage that are new or have worsened since the most recent SOC/ROC assessment.
- For pressure ulcers that are currently Stage 2, 3 or 4, "worsening" refers to a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 at the time of discharge in comparison to the most recent SOC/ROC assessment.
- For row a: Stage 2. Enter the number of current pressure ulcers at Discharge, whose deepest anatomical stage is Stage 2, that were not present or were a Stage 1 at most recent SOC/ROC. Enter "0" if there are no current Stage 2 pressure ulcers or no Stage 2 pressure ulcers that are new or worsened since most recent SOC/ROC.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1313)

- For row b: Stage 3. Enter the number of current pressure ulcers at Discharge whose deepest anatomical stage is Stage 3, that were not present or were a Stage 1 or 2 at the most recent SOC/ROC. Enter "0" if there are no current Stage 3 pressure ulcers or no Stage 3 pressure ulcers that are new or worsened since most recent SOC/ROC.
- For row c: Stage 4. Enter the number of current pressure ulcers at Discharge whose deepest anatomical stage is Stage 4, that were not present or were at Stage 1, 2, or 3 at the most recent SOC/ROC. Enter "0" if there are no current Stage 4 pressure ulcers or no Stage 4 pressure ulcers that are new or worsened since most recent SOC/ROC.
- For row d: Unstageable due to non-removable dressing. Enter the number of current pressure ulcers at Discharge that are unstageable due to a non-removable dressing, that were not present at the most recent SOC/ROC.
- For row e: Unstageable due to slough and/or eschar. Enter the number of current pressure ulcers at Discharge that are unstageable due to slough and/or eschar, that were not present or were a Stage 1 or 2 at the most recent SOC/ROC. Pressure ulcers that are currently Unstageable due to presence of slough or eschar and were Stage 3 or 4 at the most recent SOC/ROC are not considered worsened.
- For row f: Unstageable–Suspected Deep Tissue Injury (sDTI). Enter the number of sDTIs present at Discharge that were not present or were a Stage 1 or 2 pressure ulcer at the most recent SOC/ROC.
- See the following page for a reporting algorithm.
- 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.
- Once the pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered healed, and should no longer be reported as an unhealed pressure ulcer.
- A previously closed Stage 3 or Stage 4 pressure ulcer that breaks down again should be staged at its worst stage.
- If the pressure ulcer was unstageable for any reason at the most recent SOC/ROC, do not consider it new or worsened if at some point between SOC/ROC and Discharge it became stageable and remained at that same stage at Discharge.
- If the pressure ulcer was unstageable at SOC/ROC, then was stageable on a routine visit and/or Follow-Up assessment, and by Discharge the pressure ulcer had increased in numerical stage since the routine visit and/or Follow-Up assessment, is should be considered worsened at Discharge.
- If a previously stageable pressure ulcer becomes unstageable, then was debrided sufficiently to be restaged by Discharge, compare its stage before and after it was deemed unstageable. If the pressure ulcer's stage has increased in numerical staging, report this as worsened.
- Pressure ulcers that are Unstageable at Discharge due to a dressing/device, such as a cast that cannot be removed to assess the skin underneath cannot be reported as new or worsened unless no pressure ulcer existed at that site at the most recent SOC/ROC.
- A dash (–) value is a valid response for this item. A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. CMS expects dash use to be a rare occurrence.

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
Reporting algorithm for M1313

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

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

OASIS ITEM

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)		
Enter Code ☐	0	Newly epithelialized
	1	Fully granulating
	2	Early/partial granulation
	3	Not healing
	NA	No observable pressure ulcer

ITEM INTENT

- Identifies the degree of closure visible in the most problematic observable pressure ulcer, Stage 2 or higher. Please note, Stage 1 pressure ulcers and ulcers that have healed are not considered for this item.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.
- Discharge from agency—not to inpatient facility.

RESPONSE—SPECIFIC INSTRUCTIONS

- Terminology referring to "healed" vs. "unhealed" ulcers refers to whether the ulcer is "closed" vs. "open". Recognize, however, that Stage 1 pressure ulcers and Suspected Deep Tissue Injury (sDTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.
- Determine which pressure ulcer(s) are observable:
  - Includes all Stage 2 or higher pressure ulcers that are not covered with a non-removable dressing or device, even if Unstageable
  - When determining the healing status of a pressure ulcer for answering M1320, the presence of necrotic tissue does NOT make the pressure ulcer "NA – No observable pressure ulcer."
- Determine which observable pressure ulcer is 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 observable pressure ulcer, that ulcer is the most problematic.
- Utilize the Wound Ostomy and Continence Nurses (WOCN) Society's Guidance on OASIS to determine status of the most problematic observable pressure ulcer:
  - Response 0 – Newly Epithelialized: wound bed completely covered with new epithelium, no exudate, no avascular tissue (eschar and/or slough); no signs or symptoms of infection.
  - Response 1 – Fully Granulating: wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium; no dead space, no avascular tissue (eschar and/or slough); no signs or symptoms of infection; wound edges are open
  - Response 2 – Early/Partial Granulation: wound with ≥25% of the wound bed covered with granulation tissue; <25% of the wound bed covered with avascular tissue (eschar and/or slough); may have dead space; no signs or symptoms of infection; wound edges open.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1320)

- Response 3 – Not Healing: wound with ≥25% avascular tissue (eschar and/or slough) 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.

- Because Stage 2 ulcers do not granulate and newly epithelialized Stage 2 ulcers are not counted, the only appropriate response for a Stage 2 ulcer is 3 – Not Healing.
- Since a suspected Deep Tissue Injury in evolution does not granulate and would not be covered with new epithelial tissue, the only appropriate response for a suspected Deep Tissue Injury is 3 – Not Healing.
- A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base cannot be staged, but its healing status is either Response 2 – Early/Partial Granulation if necrotic or avascular tissue covers <25% of the wound bed, or Response 3 - Not Healing, if the wound has ≥25% necrotic or avascular tissue.

DATA SOURCES / RESOURCES

- Observation.
- Physical Assessment.
- Referral documentation.
- Review of health history.
- Physician.
- See references/resources (including a link to the Wound Ostomy and Continence Nurses (WOCN) Society's Guidance on OASIS) in Chapter 5 of the OASIS Guidance Manual.

OASIS ITEM

(M1322) **Current Number of Stage 1 Pressure Ulcers:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. 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 ulcers.

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE—SPECIFIC INSTRUCTIONS

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

ITEM INTENT

- Identifies the stage of the most problematic stageable pressure ulcer.
- Please note; ulcers 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 ulcers and Suspected Deep Tissue Injury (sDTI), although closed (intact skin), would not be considered healed. Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough, would not be considered healed,
- Determine which pressure ulcer(s) are stageable or Unstageable. A pressure ulcer is considered Unstageable if:
  - it is covered with a non-removable dressing/device, such as a cast, that cannot be removed.
  - it is a suspected deep tissue injury in evolution, 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.
- Enter the response that most accurately describes the stage of the most problematic stageable pressure ulcer using the definitions of Stage in M1311 that were derived from the National Pressure Ulcer Advisory Panel (NPUAP) staging system.
  - Enter “NA” if the patient has NO pressure ulcers or only has pressure ulcers that are Unstageable as defined above.

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

- 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.
- 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.

DATA SOURCES / RESOURCES (cont'd for OASIS ITEM M1324)

- 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.
- Discharge from agency—not to inpatient facility.

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.
- Utilize the Wound Ostomy and Continence Nurses (WOCN) Society's Guidance on OASIS to determine status of the most problematic observable stasis ulcer:
  - 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 (including a link to the Wound Ostomy and Continence Nurses (WOCN) Society's Guidance on OASIS) in Chapter 5 of the OASIS Guidance Manual.

OASIS ITEM

(M1340) Does this patient have a **Surgical Wound?**	
Enter Code ☐	0 No [*At SOC/ROC, go to M1350 ; At FU//DC, 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 [*At SOC/ROC, go to M1350 ; At FU/DC, 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, thoracotomy, tracheostomy, gastrostomy, etc. These may be reported in M1350 if the home health agency is providing intervention specific to the ostomy.
- 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.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1340)

- 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 Wound Ostomy and Continence Nurses (WOCN) Society’s Guidance on OASIS guidance:
  - 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 M1340)

- 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 (including a link to the Wound Ostomy and Continence Nurses (WOCN) Society's Guidance on OASIS) in Chapter 5 of the OASIS Guidance Manual.

OASIS ITEM

(M1350) Does this patient have a **Skin Lesion** or **Open Wound** (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency?	
Enter Code ☐	0 No 1 Yes

ITEM INTENT

- Identifies the presence of a skin lesion or open wound NOT ALREADY ADDRESSED IN PREVIOUS ITEMS that is receiving clinical assessment or intervention from the home health agency.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

RESPONSE—SPECIFIC INSTRUCTIONS

- A lesion is a broad term used to describe an area of pathologically altered tissue. All alterations in skin integrity are considered to be lesions. Examples of lesions include but are not limited to sores, skin tears, burns, ulcers, rashes, edema, and persistent redness without a break in the skin.
- Certain open wounds/lesions are not included in this item. These include:
    - bowel ostomies (which are reported in OASIS item M1630);
    - wounds resulting from cataract surgery, surgery to mucosal membranes, or gynecological surgical procedures by a vaginal approach;
    - tattoos, piercings, and other skin alterations unless ongoing assessment and/or clinical intervention by the home health agency is a part of the planned/provided care;
    - any other skin lesions or open wounds that are not receiving clinical intervention from the home health agency.
- "Receiving clinical assessment or intervention from the home health agency" means the lesion is being clinically assessed on an ongoing basis as indicated on the home health agency's Plan of Care (for example, wound measurements for a traumatic laceration).
- Response 0 – "No" should be entered if:
    - the patient does not have any open wounds/skin lesions (as defined above), or;
    - all of the patient's open wounds/skin lesions are pressure ulcers, stasis ulcers, and/or surgical wounds, which are addressed in other OASIS integumentary items;
    - the patient's open wounds/skin lesions are not receiving clinical intervention from the home health agency (as defined above).
- Response 1 – "Yes" should be entered for all types of other open wounds/skin lesions that are part of the agency's planned/provided care but are NOT addressed in other OASIS Integumentary Items. Examples include but are not limited to:
    - burns, diabetic ulcers, cellulitis, abscesses, edema, wounds caused by trauma of various kinds;
    - PICC line and peripheral IV sites;

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1350)

- non-bowel ostomies (for example, tracheostomies, thoracotomies, urostomies, jejunostomies, gastrostomies) if clinical interventions (for example, cleansing, dressing changes, assessment) are being provided by the home health agency during the care episode.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Observation.
- Physical Assessment.
- Referral documentation.
- Review of health history.
- Physician.

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 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.

OASIS ITEM

(M1410) **Respiratory Treatments** utilized at home: **(Mark all that apply.)**	
☐ 1	Oxygen (intermittent or continuous)
☐ 2	Ventilator (continually or at night)
☐ 3	Continuous / Bi-level positive airway pressure
☐ 4	None of the above

ITEM INTENT

- Identifies any of the listed respiratory treatments being used by this patient in the home.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

RESPONSE—SPECIFIC INSTRUCTIONS

- Excludes any respiratory treatments that are not listed in the item (for example, does not include nebulizers, inhalers).
- Response 3 reflects both CPAP and BiPAP.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Observation.
- Physician's orders.
- Referral information.
- Review of health history.

OASIS ITEM

(M1501) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the most recent SOC/ROC assessment?	
Enter Code ☐	0 No **[*Go to M2005 at TRN; Go to M1600 at DC*]** 1 Yes 2 Not assessed **[*Go to M2005 at TRN; Go to M1600 at DC*]** NA Patient does not have diagnosis of heart failure **[*Go to M2005 at TRN; Go to M1600 at DC*]**

ITEM INTENT

- Identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of heart failure at the time of or at any time since the most recent SOC/ROC assessment.
- This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices/assessments stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

- Transfer to inpatient facility.
- Discharge from agency—not to inpatient facility.

RESPONSE—SPECIFIC INSTRUCTIONS

- Enter Response 0, 1 or 2 if the patient has a diagnosis of heart failure, regardless of whether the diagnosis is documented elsewhere in the OASIS assessment.
- Enter "NA" if the patient does not have a diagnosis of heart failure.
- If the patient has a diagnosis of heart failure, enter Response 1 – Yes, to report symptoms associated with heart failure even if there are other co-morbidities that also could produce the symptom (for example, dyspnea in a patient with pneumonia and heart failure).
- Consider any new or ongoing heart failure symptoms (reported or observed) that occurred at the time of or at any time since the most recent SOC/ROC.

DATA SOURCES / RESOURCES

- Review of clinical record including physical assessment data, weight trends, and clinical notes using HHA systems put into place to accomplish such a review (for example, flow sheets, reports from electronic health record data) at the time of, or at any time since, the most recent SOC/ROC assessment.
- A complete list of symptoms of heart failure can be found in clinical heart failure guidelines in Chapter 5 of this manual.

OASIS ITEM

(M1511) **Heart Failure Follow-up:** If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**	
☐ 0	No action taken
☐ 1	Patient's physician (or other primary care practitioner) contacted the same day
☐ 2	Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
☐ 3	Implemented physician-ordered patient-specific established parameters for treatment
☐ 4	Patient education or other clinical interventions
☐ 5	Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

ITEM INTENT

- Identifies actions the home health care providers took in response to symptoms of heart failure that occurred at the time of or at any time since the most recent SOC/ROC assessment. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. 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

- Include any actions that were taken **in response to HF symptoms** at least one time at the time of or at any time since the most recent SOC/ROC assessment. If the interventions are not completed as outlined in this item, select Response 0 – No action taken. However, in this case, the care provider should document rationale in the clinical record.
- If Response 0 is selected, none of the other responses should be selected.
- Response 1 includes communication to the physician or primary care practitioner made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status. Response 1 is appropriate only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions on the same day. Same day means by the end of this calendar day. In many situations, other responses also will be marked that indicate the action taken as a result of the contact (that is, any of Responses 2-5).
- Response 2 should be selected when the patient exhibits symptoms of heart failure that require immediate attention in an emergency room and is advised to do so by agency staff. It is not selected when a patient is educated to go to the ER or call 911 based on pre-established parameters.
- Response 3 would be best for a situation in which either the home care clinician reminds the patient to implement or is aware that the patient is following physician-established parameters for treatment.
- Response 4 includes "Patient education," referring to the effective sharing of pertinent heart failure-related information to increase patient knowledge, skill, and responsibility. Simply providing a patient with printed materials regarding heart failure without assessment of their understanding of the content should not be considered patient education.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1511)

- Interventions provided via the telephone or other telehealth methods utilized to address heart failure symptoms can be reported.

DATA SOURCES / RESOURCES

- Review of clinical record at the time of or at any time since the previous OASIS assessment.
- Physician-ordered home health Plan of Care.
- Examples of standard clinical guidelines can be found in Chapter 5 of this manual.

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 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) *[Go to M1620]* 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) *[Go to M1620]*

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.
- Discharge from agency - not to inpatient facility.

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.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1610)

- 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

(M1615) When does **Urinary Incontinence** occur?	
Enter Code ☐	0 Timed-voiding defers incontinence 1 Occasional stress incontinence 2 During the night only 3 During the day only 4 During the day and night

ITEM INTENT

- Identifies when the urinary incontinence occurs.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.
- Discharge from agency—not to inpatient facility.

RESPONSE—SPECIFIC INSTRUCTIONS

- Enter Response 0 if timed-voiding defers incontinence. Timed voiding determines the patient's pattern for voiding and schedules toileting to prevent episodes of leaking. The patient can self-schedule toileting or the caregiver can prompt or bring the patient to the toilet. Timed voiding is a compensatory strategy; it does not cure incontinence. If timed voiding does not defer incontinence, do not enter Response 0.
- Enter Response 1 – Occasional stress incontinence—when the patient is unable to prevent escape of relatively small amounts of urine when coughing, sneezing, laughing, lifting, moving from sitting to standing position, or other activities (stress), which increase abdominal pressure.
- If urinary incontinence happens with regularity or in other circumstances than those described in the definition of stress incontinence, determine when the incontinence usually occurs and enter Response 2, 3, or 4 as appropriate.
- Enter Response 2 – During the night only – when the patient's incontinence occurs while the patient is sleeping at night.
- Enter Response 3 – During the day only—when the patient's incontinence occurs while the patient is up/awake during the day. Includes incontinence during daytime naps.
- Enter Response 4 – During the day and night—when the patient is incontinent when sleeping at night and up/awake during the day.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Observation.
- Physical assessment.
- 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 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; or b) necessitated a change in medical or treatment regimen?	
Enter Code ☐	0 Patient does not have an ostomy for bowel elimination. 1 Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen. 2 The ostomy was related to an inpatient stay or did 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 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 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 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.

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. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. 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.

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

- 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.
- In order to enter Response 1, 2 or 3, the standardized, validated depression screening must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment (specifically, within five days of SOC or within two days of discharge from the inpatient facility at ROC).

- 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 at least once a week **(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

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?	
Enter Code ☐	0 No 1 Yes

ITEM INTENT

- Identifies whether the patient is receiving psychiatric nursing services at home as provided by a qualified psychiatric nurse. “Psychiatric nursing services” address mental/emotional needs; a “qualified psychiatric nurse” is so qualified through educational preparation, certification, or experience.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

RESPONSE—SPECIFIC INSTRUCTIONS

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Observation.
- Referral information.
- Physician orders/Plan of Care.
- Clinical record.
- HHAs may elect to reference Section 40.1.2.15 of Chapter 7 in the Medicare Benefit Policy Manual for additional information.

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

- 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.
    - 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

- 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.
- 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

- 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 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.

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

- 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 <u>independently</u> 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 <u>safely</u> 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 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.

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

- 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

- 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 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

- 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.

Section GG: FUNCTIONAL ABILITIES and GOALS

(GG0170C) Mobility

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

Coding: **Safety** and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.	**1. SOC/ROC Performance**	**2. Discharge Goal**	
Activity may be completed with or without assistive devices.	↓Enter Response in Boxes↓		**Lying to Sitting on Side of Bed**: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper.	☐☐	☐☐	
05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.			
04 **Supervision or touching assistance –** Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.			
03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.			
02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.			
01 **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.			
If activity was not attempted, code reason: 07 **Patient refused** 09 **Not applicable** 88 Not attempted due to **medical condition or safety concerns**			

ITEM INTENT

- Identifies the patient's need for assistance with the mobility task of moving from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

ITEM RATIONALE

- Mobility limitations can adversely affect wound healing and increase risk for the development of pressure ulcers.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

STEPS FOR ASSESSMENT

1. Assess the patient's functional status based on direct observation and/or on report by the patient, caregiver/family.
2. Patients should be allowed to perform activities as independently as possible, as long as they are safe.
3. If caregiver assistance is required because patient's performance is unsafe or of poor quality, enter the response according to amount of assistance required to be safe.
4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect the scoring of the activity.
5. If the patient's self-care performance varies during the assessment time frame, report the patient's usual status, not the patient's most independent status and not the patient's most dependent status.

INSTRUCTIONS

- **For GG0170C1 – SOC/ROC Performance,** report the patient's usual status at SOC/ROC using the 6-point scale or, using one of the three "activity was not attempted" codes, report the reason the activity was not attempted.
    - **Enter 06 – Independent,** if the patient completes the activity by him/herself with no human assistance
    - **Enter 05 – Setup or clean-up assistance,** if the caregiver SETS UP or CLEANS UP; patient completes activity. Caregiver assists only prior to or following the activity, but not during the activity. For example, the patient requires assistance putting on a shoulder sling prior to the transfer, or requires assistance removing the bedding from off his/her lower body to get out of bed.
    - **Enter 04 – Supervision or touching assistance,** if the caregiver must provide VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be required throughout the activity or intermittently. For example, the patient requires verbal cueing, coaxing, or general supervision for safety to complete activity; or patient may require only incidental help such as contact guard or steadying assist during the activity.
    - **Enter 03 – Partial/moderate assistance,** if the caregiver must provide LESS THAN HALF the effort. Caregiver lifts, holds, or supports trunk or limbs, but provides less than half the effort.
    - **Enter 02 – Substantial/maximal assistance,** if the caregiver must provide MORE THAN HALF the effort. Caregiver lifts or holds trunk or limbs and provides more than half the effort.
    - **Enter 01 – Dependent,** if the caregiver must provide ALL of the effort. Patient is unable to contribute any of the effort to complete the activity; or the assistance of two or more caregivers is required for the patient to complete the activity.

- **If the patient does not attempt the activity and a caregiver does not complete the activity for the patient, report the reason the activity was not attempted.**
- **Enter 07 – Patient refused,** if the patient refused to complete the activity.
- **Enter 09 – Not Applicable,** if the patient did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 88 – Not attempted due to medical condition or safety concerns,** if the activity was not attempted due to medical condition or safety concerns.
- **If no information is available or assessment is not possible for reason other than above, enter a dash ("–") for 1-SOC/ROC Performance.**
- A dash (–) value is a valid response for this item. A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. CMS expects dash use to be a rare occurrence.

- **For GG0170C2 – Discharge Goal,** report the discharge goal using the 6-point scale. Do not enter 07, 09, or 88 to report the discharge goal. The assessing clinician, in conjunction with patient and family input, can establish the discharge goal.
  - If the clinician, in collaboration with the patient and caregiver(s), determines that the patient is expected to make functional progress by discharge, the response reported for Discharge Goal will be higher (more independent) than the SOC/ROC Performance response.
  - If the clinician, patient, and family determine that the medically complex patient is not expected to make progress during the home health episode, but it is expected that the patient would be able to maintain his/her SOC functional level, the Discharge Goal response will be the same as the patient's SOC Performance response.
  - If the clinician, in collaboration with the patient and/or caregiver(s) determine that a patient with a progressive neurological condition is expected to rapidly decline, and that skilled therapy services may slow the decline of function, the Discharge Goal would be lower (more dependent) than the SOC/ROC Performance response.
  - If the assessing clinician does not establish a Discharge Goal for the patient's bed mobility task, enter a dash ("–") for 2-Discharge Goal.
  - A dash (–) value is a valid response for this item. A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. CMS expects dash use to be a rare occurrence.

Scoring Examples

1) The patient pushes up from the bed to get himself from a lying to a seated position. The caregiver must provide steadying (touching) as the patient scoots himself to the edge of the bed and lowers his feet onto the floor.

   - **GG0170C1 – SOC/ROC Performance:** ENTER 04 – Supervision or touching assistance
   - **Rationale:** The patient required steadying/touching assistance in order to safely complete the task of lying on his back to sitting on the side of the bed.

2) The patient pushes up on the bed to attempt to get himself from a lying to a seated position as the OT provides much of the lifting assistance necessary for him to sit upright. The OT provides assistance as the patient scoots himself to the edge of the bed and lowers his feet to the floor. Overall, the OT must provide more than half of the effort to complete the task.

- **GG0170C1 - SOC/ROC Performance:** ENTER 02 – Substantial/maximal assistance
- **Rationale:** The patient required the caregiver to provide lifting and assistance that represents more than half of the effort required to complete the task of lying on his back to sitting on the side of the bed.

3) The patient is obese and recovering from surgery for spinal stenosis with lower extremity weakness. The caregiver partially lifts the patient's trunk to a fully upright sitting position on the bed and minimally lifts each leg toward the edge of the bed. The patient then scoots toward the edge of the bed, placing both feet flat onto the floor. The patient completes most of the activity himself.

- **GG0170C1 - SOC/ROC Performance:** ENTER 03 – Partial/moderate assistance
- **Rationale:** The patient required the caregiver to provide limited assistance that represents more than just verbal cues/touching/steadying, but less than half of the effort required to complete the task of lying on his back to sitting on the side of the bed.

4) The patient states he wishes he could get out of bed himself rather than depending on his wife to help. At the SOC the patient requires his wife to do most of the effort. Based on the patient's prior functional status, his current diagnoses, the expected length of stay, and his motivation to improve, the clinician expects that by discharge, the patient would likely only require assistance helping his legs off the bed to complete the supine to sitting task.

- **GG0170C1 - SOC/ROC Performance:** ENTER 02 – Substantial/maximal assistance
- **GG0170C2 - Discharge Goal:** Enter 03 – Partial/moderate assistance
- **Rationale:** At the SOC, the patient required the caregiver to provide more than half of the effort required to complete the task. The assessing clinician and patient expect functional improvement so that by discharge the patient needs a caregiver to assistant, providing less than half of the effort.

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, 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.

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

- 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 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.

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

- 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

(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely:	
Enter Code ☐	0 (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (specifically: prior to this home care admission). 1 Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. 2 Unable to prepare any light meals or reheat any delivered meals.

ITEM INTENT

- Identifies the patient's physical, cognitive, and mental ability to plan and prepare meals, even if the patient does not routinely perform this task.
- 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 light meal planning and preparation, 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 IADLs. 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, pain)
    - environmental barriers (for example, location of cooking appliances, food and meal prep supplies).

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE—SPECIFIC INSTRUCTIONS

- 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.
- In cases where a patient's ability is different for various light meal preparation tasks, enter the response that best describes the patient's level of ability to perform the majority of light meal preparation tasks.
- Response 0 indicates that during the day of assessment, the patient has the consistent physical and cognitive ability to plan and prepare meals.
- Response 1 indicates that during the day of assessment, the patient has inconsistent ability to prepare light meals (for example, can't prepare breakfast due to morning arthritic stiffness, but can prepare other meals throughout day).
- Response 2 indicates patient does not have the ability to prepare light meals at any point during the day of assessment.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1880)

- While nutritional appropriateness of the patient's food selections is not the focus of this item, any prescribed diet requirements (and related planning/preparation) should be considered when entering a response.
- When a patient's prescribed diet consists either partially or completely of enteral nutrition, the clinician must assess the patient's ability to plan and prepare their prescribed diet, including their knowledge of the feeding amount and ability to prepare the enteral feeding, based on product used. Note that the ability to set up, monitor and change the feeding equipment is excluded from M1880, as it is addressed on row "e" of M2102.

DATA SOURCES / RESOURCES

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

OASIS ITEM

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.	
Enter Code ☐	0 Able to dial numbers and answer calls appropriately and as desired. 1 Able to use a specially adapted telephone (for example, large numbers on the dial, teletype phone for the deaf) and call essential numbers. 2 Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. 3 Able to answer the telephone only some of the time or is able to carry on only a limited conversation. 4 Unable to answer the telephone at all but can listen if assisted with equipment. 5 Totally unable to use the telephone. NA Patient does not have a telephone.

ITEM INTENT

- Identifies the ability of the patient to answer the phone, dial number, and effectively use the telephone to communicate.
- 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 use the telephone, 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 IADLs. 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)
    - environmental barriers (for example, phone type/features, size of numbers).

TIME POINTS ITEM(S) COMPLETED

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

RESPONSE—SPECIFIC INSTRUCTIONS

- 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 telephone use 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 M1890)

- Ability to use telephone identifies the patient's ability to safely answer the phone, dial a number, and effectively use the telephone to communicate. If a speech impaired patient can only communicate using a phone equipped with texting functionality, enter Response 1 - Able to use a specially adapted telephone.

DATA SOURCES / RESOURCES

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

OASIS ITEM

(M1900) Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury.	
Enter Code ☐	a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene) 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	b. Ambulation 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	c. Transfer 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use) 0 Independent 1 Needed Some Help 2 Dependent

ITEM INTENT

- Identifies the patient's functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. The intent of the item is to identify the patient's prior ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

RESPONSE—SPECIFIC INSTRUCTIONS

- For each functional area, enter a response.
- "Independent" means that the patient had the ability to complete the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper.
- "Needed some help" means that the patient contributed effort but required help from another person to accomplish the task/activity safely.
- "Dependent" means that the patient was physically and/or cognitively unable to contribute effort toward completion of the task, and the helper must contribute all the effort.
- "Self-care" refers specifically to grooming, dressing, bathing, and toileting hygiene. Medication management is not included in the definition of self-care for M1900 as it is addressed in a separate question (M2040).
- "Ambulation" refers to walking (with or without assistive device). Wheelchair mobility is not directly addressed in this item. A patient who is unable to ambulate safely (even with devices and/or assistance), but

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M1900)

is able to use a wheelchair (with or without assistance) would be reported as "Dependent" in Ambulation for M1900.

- "Transfer" refers specifically to tub, shower, commode, and bed to chair transfers.
- "Household tasks" refers specifically to light meal preparation, laundry, shopping, and phone use.
- If the patient was previously independent in some self-care tasks (or some transfers, or some household tasks), but needed help or was completely dependent in others, pick the response that best describes the patient's level of ability to perform the majority of included tasks.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Referral information.
- Review of past health history.
- Physician.

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.
- This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. 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.
- 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".
- In order to enter Response 1 or 2, the falls risk assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment.

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,
    - a standardized, validated multi-factor falls risk screening was conducted during the assessment time frame, but NOT by the assessing clinician.
    - 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 M2040]*

ITEM INTENT

- Identifies if review of the patient's medications indicated any potential clinically significant medication issues.

TIME POINTS ITEM(S) COMPLETED

- Start of Care.
- Resumption of Care.

RESPONSE—SPECIFIC INSTRUCTIONS

- 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.
- The drug regimen review includes all medications, prescribed and over the counter (including TPN and herbals), administered by any route (for example, oral, topical, inhalant, pump, injection, intravenous and via enteral tube).
- A potential clinically significant medication issue is an issue that in the care provider's clinical judgment, requires physician/physician-designee notification by midnight of the next calendar day (at the latest).
- In addition to "potential" issues, the item also includes the identification of an existing clinically significant medication issue that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day.
- Potential or actual clinically significant medication issues may include but are not limited to: adverse reactions to medications (such as a rash), ineffective drug therapy (analgesic that does not reduce pain), side effects (potential bleeding from an anticoagulant), drug interactions (serious drug-drug, drug-food and drug-disease interactions), duplicate therapy (generic name and brand name equivalent drugs are both prescribed), omissions (missing drugs from an ordered regimen), dosage errors (either too high or too low), and nonadherence (regardless of whether the nonadherence is purposeful or accidental).

Definition: Medication interaction is the impact of another substance (such as another medication, nutritional supplement including herbal products, food, or substances used in diagnostic studies) upon a medication. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.

Definition: Adverse drug reaction (ADR) is a form of adverse consequences. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term "side effect" is often used interchangeably with ADR, however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2001)

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 clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2001 may be entered. 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) does not violate the requirement that the comprehensive patient assessment is the responsibility of and must be ultimately completed by one clinician. Agency policy and practice will determine this process and how it is documented. The M0090 date—the date the assessment is completed—would be the date the two clinicians collaborated and the assessment was completed.

- A dash (–) value is a valid response for this item. A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. However, providers should complete transfer and discharge assessments to the best of their ability when a care episode ends unexpectedly. CMS expects dash use to be a rare occurrence.

These are situations where based on clinical judgment during the drug regimen, the clinician may determine that Response 0 – no issues found during review should be entered:

- Patient's list of medications from the inpatient facility discharge instructions matches 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 adequately controlled (as able to be assessed within the clinician's scope of practice).
- Patient possesses all medications prescribed.
- 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.

These are situations where based on clinical judgment during the drug regimen review, the clinician may determine that a potential clinically significant issues exists, and determine that Response 1 – issues found during review should be entered:

- 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 (as able to be assessed within the clinician's scope of practice).
- Patient seems confused about when/how to take medications indicating a high risk for medication errors.
- Patient has not obtained medications or indicates that he/she will probably 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.

Any of these 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.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2001)

Scoring Example

- During the comprehensive assessment visit, 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 states they were only going to pick it up from the pharmacy if "the pain got bad enough". The PT emphasizes the need to comply with the physician's instructions for the new medication and prior to the PT leaving the home, the daughter has gone to the drugstore and returned with the medication.
- M2001: ENTER Response 0 – No – No issues found during review
- **Rationale:** Because the issue did not require physician/physician-designee contact by midnight of the next calendar day to resolve, it does not meet the criteria for a potential clinically significant medication issue.

DATA SOURCES / RESOURCES

- Patient assessment, specifically the drug regimen review as required by Conditions of Participation (§484.55).
- Clinical record.
- Communication notes.
- Medication list.
- Discussions with other agency staff responsible for completing drug regimen review.
- Since medication issues continue to evolve and new medications are being approved regularly, it is important to refer to a current authoritative source for detailed medication information such as indications and precautions, dosage, monitoring or adverse consequences.
- Physician's Drug Reference (PDR) or other clinical medication handbook or software intended to provide warning of severity levels of risk for medication review.
- CMS OASIS Q&As can be accessed through the CMS OASIS web page.
- Several online resources for evaluating drug reactions, side effects, interactions, etc., can be found in Chapter 5 of this manual.

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 clinically significant medication issues identified through a medication review were addressed with the physician (or physician-designee) by midnight of the next calendar day following their identification.
- A complete drug regimen review and identification of actual or potential clinically significant medication issues are medication management best practices in health care settings. These best practices are not necessarily required in the Conditions of Participation.

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

TIME POINTS ITEM(S) COMPLETED

- Start of Care.
- Resumption of Care.

RESPONSE—SPECIFIC INSTRUCTIONS

- Complete if Response 1 (Yes) is entered for M2001.
- A potential clinically significant medication issue is an issue that in the care provider's clinical judgment, requires physician/physician-designee notification by midnight of the next calendar day (at the latest). The term "potential" means that the clinician may identify a patient is at risk for occurrence of a clinically significant medication issue before the issue occurs, and contacts the physician/physician-designee to prevent the issue from occurring.
- In addition to "potential" issues, the item also includes identification of existing clinically significant medication issues that in the care provider's clinical judgment require physician/physician-designee notification by midnight of the next calendar day.
- To enter Response 1 – Yes, the two-way communication AND completion of the prescribed/recommended actions must have occurred by midnight of the next calendar day after the potential clinically significant medication issue was identified.
- 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. Examples of recommended actions 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, 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.
- If the physician/physician-designee provides no new orders or instruction in response to timely reported potential clinically significant medication issue(s), enter Response 1 – Yes, indicating that the physician/physician-designee was contacted and prescribed/recommended actions were completed.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2003)

- When multiple potential clinically significant medication issues are identified at the SOC/ROC, all must be communicated to the physician/physician-designee, with completion of all prescribed/recommended actions occurring by midnight of the next calendar day in order to enter Response 1 –Yes.
- If two potential clinically significant medication issues are identified at the SOC/ROC, both are communicated to the physician/physician-designee timely, and the physician/physician-designee provides a recommended action for each issue (for example, patient education for one medication, and a new dosage for another); enter Response 1 – Yes if both recommended actions are completed by midnight of the next calendar day. If both recommended actions could have been addressed by midnight of the next calendar day, but only one was addressed, enter Response 0 – No.
- If a potential clinically significant medication issue was identified, and the clinician attempted to communicate with the physician, but did not receive communication back from the physician/physician designee until after midnight of the next calendar day, enter Response 0 – No.
- If agency staff other than the clinician responsible for completing the SOC/ROC OASIS contacted the physician/physician-designee to follow up on clinically significant medication issues, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2003 may be entered. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and must ultimately be completed by one clinician.
- A dash (–) value is a valid response for this item. A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment could be completed. However, providers should complete transfer and discharge assessments to the best of their ability when a care episode ends unexpectedly. CMS expects dash use to be a rare occurrence.

Scoring Example

- During the SOC comprehensive assessment visit, the RN completes a drug 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.
- M2001: ENTER Response 1 – Yes - Issues found during review.
- M2003: ENTER Response 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 resolved by physician contact and completion of prescribed/recommended actions by midnight of the next calendar day, the criteria for M2003 were met.

DATA SOURCES / RESOURCES

- Clinical record.
- Communication notes.
- Plan of Care.
- Medication list.
- Discussions with other agency staff responsible for completing drug regimen review.

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 clinically significant medication issues such as adverse effects or drug reactions identified at the time of or at any time since the SOC/ROC were addressed with the physician or physician-designee.
- The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

- Transfer to inpatient facility.
- Death at home.
- Discharge from agency— not to an inpatient facility.

RESPONSE—SPECIFIC INSTRUCTIONS

- A potential clinically significant medication issue is an issue that in the care provider's clinical judgment, requires physician/physician-designee notification by midnight of the next calendar day (at the latest).
- In addition to "potential" issues, the item also includes physician/physician-designee follow-up when an existing clinically significant medication issue is identified, that in the care provider's clinical judgment requires physician/physician-designee notification by midnight of the next calendar day.
- Potential or actual clinically significant medication issues may include but are not limited to adverse reactions to medications (such as a rash), ineffective drug therapy (analgesic that does not reduce pain), side effects (potential bleeding from an anticoagulant), drug interactions (serious drug-drug, drug-food and drug-disease interactions), duplicate therapy (generic name and brand name equivalent drugs are both prescribed), omissions (missing drugs from an ordered regimen), dosage errors (either too high or too low), nonadherence (regardless of whether the nonadherence is purposeful or accidental).
- Contact with physician is defined as communication to the physician or physician-designee made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status. Communication can be directly to/from the physician or physician-designee, or indirectly through physician's office staff on behalf of the physician or physician-designee, in accordance with the legal scope of practice.
- To enter Response 1 – Yes, the two-way communication AND completion of the prescribed/recommended actions must have occurred by midnight of the next calendar day each time a potential clinically significant issue was identified.

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. Examples of recommended actions 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, 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.
- If, when a potential clinically significant issue was identified, the physician/physician-designee provided no new orders or instruction in response to the timely reported concern, Response 1 – Yes should be reported, indicating that the physician/physician-designee was contacted and prescribed/recommended actions were completed.
- When multiple potential clinically significant medication issues were identified since the SOC/ROC, all must have been communicated to the physician/physician-designee, with completion of all prescribed/recommended actions occurring by midnight of the next calendar day in order to enter Response 1 –Yes.
- If any potential clinically significant medication issue was identified at the time of or anytime since the SOC/ ROC, and was not both communicated to the physician/physician-designee AND addressed through completion of any physician/physician-designee recommended action, enter Response 0 – No.
- If the last OASIS assessment completed was the SOC or ROC, and a clinically significant medication issue was identified at that SOC or ROC visit, the issue (and/or related physician/physician-designee communication) would be reported at both the SOC/ROC (on M2003) and again at Transfer, Death or Discharge (on M2005), since the time frame under consideration for M2005 is at the time of or at any time since SOC/ROC.
- A dash (–) value is a valid response for this item. A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment could be completed. However, providers should complete transfer and discharge assessments to the best of their ability when a care episode ends unexpectedly. CMS expects dash use to be a rare occurrence.

Scoring Examples:

1) 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.

   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, requiring physician contact by midnight of the next calendar day, it meets the criteria for a potential 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.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2005)

2) 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 earlier in the episode, and no potential clinically significant medication issues were identified. There is no other documentation to indicate that potential clinically significant medication issues occurred during the episode of care.
    - 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 the agency looked for potential clinically significant medication issues via completion of a drug regimen review conducted since the SOC/ROC was completed, and no issues were found. Had there been documentation that a potential clinically significant medication issue occurred during the episode, and there was no documentation indicating follow-up with the physician/physician-designee by midnight of the next calendar day to complete recommended actions, Response 0 (No) would be entered.

DATA SOURCES / RESOURCES

- Clinical record.
- Communication notes.
- Medication list.
- Plan of Care.
- Discussions with other agency staff responsible for completing drug regimen review.

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 9 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 quality organizations 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.
- This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. 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 high-risk medications.
- 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.

DATA SOURCES / RESOURCES (cont'd for OASIS Item M2010)

- Discussions with other agency staff responsible for educating patient/caregivers on medications.
- Sources to identify high-risk medications for the purposes of responding to this item can include the Institute for Safe Medication Practices High Alert Medication List, Beer's Criteria, Joint Commission's High Alert Medication lists, or other authoritative resources.
- 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 9 NA – Patient not taking any drugs

ITEM INTENT

- Identifies if clinicians instructed the patient/caregiver about how to manage all medications effectively and safely within the time period under consideration.
- This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. 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.
- 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.
- The timeframe should be considered at the time of or at any time since the most recent SOC/ROC assessment.

DATA SOURCES / RESOURCES

- Review of clinical record including teaching guidelines, flow sheets, clinical notes, etc.
- Medication list.
- Plan of Care.
- Discussions with 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:** Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes 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; OR (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 Unable 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 at **all** times. 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) 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 this, 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 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 interventions, such as reminders or a med planner, were adequate assistance 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.
- 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:** Patient's current ability to prepare and take all 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; OR (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 Unable 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 all times. 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.
- Discharge from agency – not to an inpatient facility.

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 all 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.
- 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

(M2040)	**Prior Medication Management:** Indicate the patient's usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation or injury.
Enter Code ☐	a. Oral medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable
Enter Code ☐	b. Injectable medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable

ITEM INTENT

- Identifies the patient's ability to manage all prescribed oral and injectable medications prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. The intent of the item is to identify the patient's prior ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. This item is used for risk adjustment and can be helpful for setting realistic goals for the patient.

TIME POINTS ITEM(S) COMPLETED

- Start of Care.
- Resumption of Care.

RESPONSE—SPECIFIC INSTRUCTIONS

- A care episode is not the same as a payment episode. The care episode begins with the most recent SOC or ROC and ends with a Transfer or Discharge. For example, if a patient is resuming home care services after a recent inpatient admission, report the patient's ability to manage medications prior to the most recent illness, exacerbation or injury that is the cause of this resumption of home care services.
- Includes all prescribed and OTC (over-the-counter) oral medications and all prescribed injectable medications that the patient was taking prior to most recent illness, and are included on the Plan of Care.
- For each functional area (oral medications and injectable medications), enter a response.
- If the patient's prior ability to manage oral or injectable medications varied from medication to medication, consider the medication for which the most assistance was needed when selecting a response.
- "Independent" means that the patient completed the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper or reminders from another person. (Reminders provided by a device that the patient can independently manage are not considered "assistance" or "reminders.")
- "Needed some help" means that the patient required some help from another person to accomplish the task/activity.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2040)

- "Dependent" means that the patient was incapable of performing any of the task/activity. For oral medications, this means that the patient was capable only of swallowing medications that were given to her/him. For injectable medications, this means that someone else must have prepared and administered the medication.
- Enter "NA" if there were no oral medications (row a) or no injectable medications (row b) used.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Referral information.
- Review of past health history.
- Physician.

OASIS ITEM

(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 ☐	b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances) 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 ☐	e. **Management of Equipment** (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies) 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

(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 ☐	g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments) 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.
- For each row a-g, 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 b – IADLs include activities associated with independent living necessary to support the ADLs 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.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2102)

- 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 e – Management of equipment refers to the ability to safely use medical equipment as ordered. Examples of medical equipment include oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies, continuous passive motion machine, wheelchair, hoyer lift, etc.
- 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 includes a wide range of activities that may be necessary due to cognitive, functional, or other health deficits. Such assistance may range from calls to remind the patient to take medications, to in-person visits to ensure that the home environment is safely maintained, to the need for the physical presence of another person in the home to ensure that the patient doesn't wander, fall, or for other safety reasons (for example, leaving the stove burner on).
- Row g – Advocacy or facilitation of patient's participation in appropriate medical care includes taking patient to medical appointments, following up with filling prescriptions, or making subsequent appointments, etc.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.
- Review of previous health history.

OASIS ITEM

(M2110) **How Often** does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?	
Enter Code ☐	1 At least daily 2 Three or more times per week 3 One to two times per week 4 Received, but less often than weekly 5 No assistance received UK Unknown

ITEM INTENT

- Identifies the frequency of the assistance with ADLs (for example, bathing, dressing, toileting, transferring, ambulating, feeding) or IADLs (for example, medication management, meal preparation, housekeeping, laundry, shopping, financial management) provided by any non-agency caregivers.

TIME POINTS ITEM(S) COMPLETED

- Start of care.
- Resumption of care.

RESPONSE—SPECIFIC INSTRUCTIONS

- Responses are arranged in order of most to least assistance received from caregivers.
- Note that this question is concerned broadly with ADLs and IADLs, not just the ones specified in other OASIS items. ADLs are defined as **t**he tasks of everyday life. Basic ADLs include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet. Instrumental activities of daily living (IADL) are activities related to independent living and include preparing meals, managing money, shopping, doing housework, and using a telephone.
- Enter the response that reports how often the patient receives assistance with any ADL or IADL.

DATA SOURCES / RESOURCES

- Patient/caregiver interview.

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 timepoints. 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

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

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐ 0	☐ 1	☐ NA	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference.
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐ 0	☐ 1	☐ NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
c. Falls prevention interventions	☐ 0	☐ 1	☐ NA	Falls risk assessment indicates patient has no risk for falls.
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	☐ 0	☐ 1	☐ NA	Patient has no diagnosis of depression AND depression screening indicates 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.
e. Intervention(s) to monitor and mitigate pain	☐ 0	☐ 1	☐ NA	Pain assessment indicates patient has no pain.
f. Intervention(s) to prevent pressure ulcers	☐ 0	☐ 1	☐ NA	Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers.
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐ 0	☐ 1	☐ NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

ITEM INTENT

- Identifies if the physician-ordered home health Plan of Care incorporates specific best practices. Included in the physician-ordered Plan of Care means that the patient condition has been discussed and there is agreement as to the Plan of Care between the home health agency staff and the physician.
- This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. 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

- Select “Yes” if the Plan of Care contains orders for best practice interventions as specified in each row, based on the patient’s needs.
  - The physician Plan of Care includes all additional orders as an extension of the original Plan of Care.
- “Yes” is an appropriate response if the intervention is in the Plan of Care even if the assessment indicated the intervention was not applicable.
- This question can be answered “Yes” prior to the receipt of signed orders if the clinical record reflects evidence of communication with the physician to include specified best practice interventions in the Plan of Care. Assuming all other OASIS information is completed, the Date Assessment Completed (M0090) then becomes the date of the communication with the physician to establish the Plan of Care that includes interventions listed in M2250.
- If “NA” criteria does not apply, select “No" if orders for interventions have been requested but not authorized by the end of the comprehensive assessment time period, unless otherwise indicated in rows d & g. This means Plan of Care orders must be in place within five days for SOC in order to respond “Yes.” For ROC, the Plan of Care orders must be in place within two days of inpatient discharge, or within two days of becoming aware of an inpatient discharge, in order to respond “Yes” to M2250.
- After reviewing physician orders for home health care and conducting a comprehensive assessment of the patient, the Plan of Care should be developed as required by Conditions of Participation: 484.14 Standard: Plan of Care. If the physician refers the patient under a Plan of Care that cannot be completed until after an initial visit and eligibility has been determined, the physician is consulted to approve additions or modification to the original plan.
- If the assessing clinician chooses to wait to complete M2250 until after discussion with another discipline that has completed their assessment and care plan development, this does not violate the requirement that the comprehensive assessment be completed by one clinician within the required time frame (within five days of SOC, within two days of discharge from the inpatient facility at ROC). For example, if the RN identifies falls risk during the SOC comprehensive assessment, the RN can wait until the PT conducts his/her evaluation and develops the PT care plan to determine if the patient’s Plan of Care includes interventions to prevent falls risk. The M0090 date should reflect the last date that information was gathered that was necessary for completion of the assessment.
- For each row a-g, select one response.
- Row a: If the physician-ordered Plan of Care contains specific clinical parameters relevant to the patient's condition that, when out of specified range, would indicate that the physician should be contacted, select “Yes.” The parameters may be ranges and may include temperature, pulse, respirations, blood pressure, weight, wound measurements, pain intensity ratings, intake and output measurements, blood sugar levels, or other relevant clinical assessment findings. Select “NA” if the physician chooses not to identify patient-specific parameters and the agency will use standardized guidelines that are made accessible to all care team members.
- If the Plan of Care includes specific parameters ordered by the physician for this specific patient or after reviewing the agency's standardized parameters with the physician, s/he agrees they would meet the needs of this specific patient, select “Yes.” If there are no patient-specific parameters on the Plan of Care and the agency will not use standardized physician notification parameters for this patient, select “No.” If the agency uses their own agency standardized guidelines, which the physician has NOT agreed to include in the Plan of Care for this particular patient, select “NA.”

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS ITEM M2250)

- Row b: 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, select "Yes." If the physician-ordered Plan of Care contains orders for only one (or none) of the interventions, select "No" unless "NA" applies. Select "NA" if the patient does not have a diagnosis of diabetes mellitus or is a bilateral amputee or is missing lower legs due to a congenital or acquired condition.

- Row c: If the physician-ordered Plan of Care contains specific interventions to reduce the risk of falls, select "Yes." Environmental changes and strengthening exercises are examples of possible fall prevention interventions. If the Plan of Care does not include interventions for fall prevention, mark "No" unless "NA" applies. Select "NA" if an informal or formal falls risk assessment indicates no risk for falls, or if the response scale of a standardized, validated falls risk assessment tool rates the patient as no risk or 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 patient scoring "not at risk" should be scored as "NA," (unless fall prevention orders are present). If more than one falls risk assessment was completed by the assessing clinician, all must be negative in order to select "NA."

- Row d: If the physician-ordered Plan of Care contains orders for further evaluation or treatment of depression, AND/OR if the physician has been notified about a positive depression screen, select "Yes." Examples of interventions for depression may include new or existing 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 patient has no diagnosis of depression AND does not meet criteria for further evaluation based on a formal or informal depression assessment, select "NA" (unless the physician has been notified about a positive depression screen, or orders for further evaluation or treatment of depression are present). If more than one depression screen was completed by the assessing clinician, all must be negative in order to select "NA."

- Row e: If the physician-ordered Plan of Care contains interventions to monitor AND mitigate pain, select "Yes." Examples of interventions to mitigate pain include medication, massage, visualization, and biofeedback. If the physician-ordered Plan of Care contains orders for only one (or none) of the interventions (for example, pain medications but no monitoring plan), select "No," unless "NA" applies. If the clinician completed a formal or informal assessment that indicated the patient has no pain, select "NA" (unless orders for further monitoring and mitigating pain are present). If more than one pain assessment was completed by the assessing clinician, all must be negative in order to select "NA."

- Row f: 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, 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 clinician completed a formal or informal assessment that indicated the patient is not at risk for pressure ulcers, select "NA" (unless orders for interventions to reduce pressure on areas of skin at risk for breakdown are present). If more than one pressure ulcer risk assessment was completed by the assessing clinician, all must be negative in order to select "NA."

- Row g: 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) OR if such orders have been requested from the physician, select "Yes." If the patient has no pressure ulcers OR no pressure ulcers needing moist wound healing treatments per physician, select "NA" (unless orders for pressure ulcer treatments based on principles of moist wound healing are present).
  - Moist wound healing treatment is any primary dressing that hydrates or delivers moisture to a wound thus promoting an optimal wound environment and includes films, alginates, hydrocolloids, hydrogels, collagen, negative pressure wound therapy, Unna boots, medicated creams/ointments.

DATA SOURCES / RESOURCES

- Plan of Care.
- Physician's orders.
- Clinical record.
- Communication notes.
- See Chapter 5 of this manual for links to additional resources.

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 at the time of or at any time since the most recent SOC/ROC assessment. 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—with or without agency discharge.
- Discharge from agency.

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 patient stay was for 24 hours or more 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 marked 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 for a patient who, at the time of or at any time since the most recent SOC/ROC was collected, 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 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 stay is for 24 hours or longer, 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
☐ 2	Injury caused by fall
☐ 3	Respiratory infection (for example, pneumonia, bronchitis)
☐ 4	Other respiratory problem
☐ 5	Heart failure (for example, fluid overload)
☐ 6	Cardiac dysrhythmia (irregular heartbeat)
☐ 7	Myocardial infarction or chest pain
☐ 8	Other heart disease
☐ 9	Stroke (CVA) or TIA
☐ 10	Hypo/Hyperglycemia, diabetes out of control
☐ 11	GI bleeding, obstruction, constipation, impaction
☐ 12	Dehydration, malnutrition
☐ 13	Urinary tract infection
☐ 14	IV catheter-related infection or complication
☐ 15	Wound infection or deterioration
☐ 16	Uncontrolled pain
☐ 17	Acute mental/behavioral health problem
☐ 18	Deep vein thrombosis, pulmonary embolus
☐ 19	Scheduled treatment or procedure
☐ 20	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 - with or without agency discharge.
- Discharge from agency.

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 responses.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2310)

- Response 2 should be selected when the patient sought care in the hospital emergency department for an injury caused by a fall, regardless of where the fall occurred.
- Select Response 19 if a patient seeks emergent care in the hospital emergency department for a new wound that was not the result of a fall.
- 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).
- 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 during the home health care episode (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.
- This item is used to calculate process measures to capture the use of best practices. The problem-specific interventions referenced in the item may or may not directly correlate to stated requirements in the Conditions of Participation.
- The formal assessment that is referred to in the last column for rows b–e refers to the assessment defined in OASIS items for M1240, M1300, M1730, and M1910.

TIME POINTS ITEM(S) COMPLETED

- Transfer to inpatient facility—with or without agency discharge.
- 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 allowed assessment time frame, 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-e, a formal assessment (as defined in the relevant OASIS item M1240, M1300, M1730, and M1910) must have been performed to select “NA.”
- An evaluation of clinical factors is not considered a formal assessment for M1300 pressure ulcer risk.

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 changes, 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.
- Home Health Conditions of Participation.
- Guidance on each particular item for the Plan of Care and intervention can be found in other item-by-item tips within this document.

OASIS ITEM

(M2410) To which **Inpatient Facility** has the patient been admitted?		
Enter Code ☐	1	Hospital **[*Go to M2430*]**
	2	Rehabilitation facility **[*Go to M0903*]**
	3	Nursing home **[*Go to M0903*]**
	4	Hospice **[*Go to M0903*]**
	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 inpatient facility—with or without agency discharge.
- 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.
- 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
- 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 **[*Go to M0903*]**

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

(M2430) Reason for Hospitalization: For what reason(s) did the patient require hospitalization? **(Mark all that apply.)**

- ☐ 1 Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ☐ 2 Injury caused by fall
- ☐ 3 Respiratory infection (for example, pneumonia, bronchitis)
- ☐ 4 Other respiratory problem
- ☐ 5 Heart failure (for example, fluid overload)
- ☐ 6 Cardiac dysrhythmia (irregular heartbeat)
- ☐ 7 Myocardial infarction or chest pain
- ☐ 8 Other heart disease
- ☐ 9 Stroke (CVA) or TIA
- ☐ 10 Hypo/Hyperglycemia, diabetes out of control
- ☐ 11 GI bleeding, obstruction, constipation, impaction
- ☐ 12 Dehydration, malnutrition
- ☐ 13 Urinary tract infection
- ☐ 14 IV catheter-related infection or complication
- ☐ 15 Wound infection or deterioration
- ☐ 16 Uncontrolled pain
- ☐ 17 Acute mental/behavioral health problem
- ☐ 18 Deep vein thrombosis, pulmonary embolus
- ☐ 19 Scheduled treatment or procedure
- ☐ 20 Other than above reasons
- ☐ UK Reason unknown

ITEM INTENT

- Identifies the specific condition(s) necessitating hospitalization.

TIME POINTS ITEM(S) COMPLETED

- Transfer to inpatient facility—with or without agency discharge.

RESPONSE—SPECIFIC INSTRUCTIONS

- Select all that apply. For example, if a psychotic episode results from an untoward medication side effect, both Response 1 and Response 17 would be marked. As another example, if a patient requires hospitalization for both heart failure and pneumonia, both Response 3 and Response 5 would be selected.
- Response 2 should be selected if patient is hospitalized for an injury caused by a fall, regardless of where the fall occurred.
- Response 20 should be selected if the patient is hospitalized for a new wound that is not the result of a fall.
- If the reason is not included in the choices, select Response 20 “Other than above reasons.”

DATA SOURCES / RESOURCES

- Telephone contact with patient/caregiver/family.
- Facility discharge planner or case manager.
- Physician.
- Insurance case manager.

OASIS ITEM

(M0903) Date of Last (Most Recent) Home Visit:

month day year

ITEM INTENT

- Identifies the last or most recent home visit by any agency provider.

TIME POINTS ITEM(S) COMPLETED

- Transfer to an inpatient facility—with or without agency discharge.
- Death at home.
- Discharge from agency.

RESPONSE—SPECIFIC INSTRUCTIONS

- If the date or month is only one digit, that digit is preceded by a “0” (for example, May 4, 2017 = 05/04/2017). Enter all four digits of the year.
- If the agency policy is to have an RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge assessment after the last visit by the therapist.
- Report the date of the last visit made to the home by agency staff, whether or not it was included on the Plan of Care.

DATA SOURCES / RESOURCES

- Clinical record.

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—with or without agency discharge.
- Death at home.
- Discharge from agency.

RESPONSE—SPECIFIC INSTRUCTIONS

- If the date or month is only one digit, that digit is preceded by a "0" (for example, May 4, 2017 = 05/04/2017). 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.

CHAPTER 4 ILLUSTRATIVE CLINICAL RECORD FORM PAGES WITH OASIS ITEMS INTEGRATED

Chapter 4 of this manual contains sample pages from illustrative clinical record forms showing the integration of OASIS C2 items. These illustrative forms pages are included for the following time points.

- Illustration 1 – Start of Care Assessment.
- Illustration 2 – Start of Care Assessment.
- Illustration 3 – Discharge Assessment.
- Illustration 4 – Transfer to Inpatient Facility.

ILLUSTRATION 1
Sample Page from Clinical Record Form with Integrated OASIS Items.

START OF CARE ASSESSMENT	Client's Name:
(Also used for Resumption of Care Following Inpatient Stay) (Page 1 of __)	Client Record No. _____

A. DEMOGRAPHIC INFORMATION – Complete Patient Tracking Sheet at SOC and Update at ROC

(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)

(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.

Economic/Financial Problems or Needs (describe):

(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 M1017]

(M1005) Inpatient Discharge Date (most recent):
☐☐ / ☐☐ / ☐☐☐☐
month day year
☐ UK - Unknown

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

(M1011) List each Inpatient Diagnosis and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

Inpatient Facility Diagnosis	ICD-10-CM code
a.	☐☐☐ ☐☐☐☐
b.	☐☐☐ ☐☐☐☐
c.	☐☐☐ ☐☐☐☐
d.	☐☐☐ ☐☐☐☐
e.	☐☐☐ ☐☐☐☐
f.	☐☐☐ ☐☐☐☐

(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-C M codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):

Changed Medical Regimen Diagnosis	ICD-10-CM code
a.	☐☐☐ ☐☐☐☐
b.	☐☐☐ ☐☐☐☐
c.	☐☐☐ ☐☐☐☐
d.	☐☐☐ ☐☐☐☐
e.	☐☐☐ ☐☐☐☐
f.	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

ILLUSTRATION 2
Sample Page from Clinical Record Form with Integrated OASIS Items.

START OF CARE ASSESSMENT	Client's Name:
(Also used for Resumption of Care Following Inpatient Stay) (Page 1 of __)	Client Record No. _____

L. Review of Systems/Physical Assessment (cont'd).
14. NEURO/EMOTIONAL/BEHAVIORAL STATUS
History of previous psychiatric illness _____
Other (specify) _____

(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 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

(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.

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (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

ILLUSTRATION 3
Sample Page from Clinical Record Form with Integrated OASIS Items.

DISCHARGE ASSESSMENT	Client's Name:
(Page ___ of __)	Client Record No. _____

C. IMMUNIZATIONS

(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.

(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

D. SENSORY/PAIN ASSESSMENT

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language)**:**

Enter Code ☐

0 Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
1 Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
2 Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
3 Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
4 Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible).
5 Patient nonresponsive or unable to speak.

(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

10. Pain notes (location, time of day, activities that exacerbate pain, avoidance of activities, etc.)

E. INTEGUMENTARY STATUS

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)

Enter Code ☐

0 No **[*Go to M1322*]**
1 Yes

(M1307) The Oldest Stage 2 Pressure Ulcer that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers)

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

ILLUSTRATION 4
Sample Page from Clinical Record Form with Integrated OASIS Items.

TRANSFER TO INPATIENT FACILITY	Client's Name:
(Page 1 of __)	Client Record No. _____

B. 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	☐ 11-GI bleeding, obstruction, constipation, impaction
☐ 2-Injury caused by fall	☐ 12-Dehydration, malnutrition
☐ 3-Respiratory infection (for example, pneumonia, bronchitis)	☐ 13-Urinary tract infection
☐ 4-Other respiratory problem	☐ 14-IV catheter-related infection or complication
☐ 5-Heart failure (for example, fluid overload)	☐ 15-Wound infection or deterioration
☐ 6-Cardiac dysrhythmia (irregular heartbeat)	☐ 16-Uncontrolled pain
☐ 7-Myocardial infarction or chest pain	☐ 17-Acute mental/behavioral health problem
☐ 8-Other heart disease	☐ 18-Deep vein thrombosis, pulmonary embolus
☐ 9-Stroke (CVA) or TIA	☐ 19-Other than above reasons
☐ 10-Hypo/Hyperglycemia, diabetes out of control	☐ UK – Reason Unknown

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

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education	☐ 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 last OASIS 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 last OASIS assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for
d. Intervention(s) to monitor and mitigate pain	☐ 0	☐ 1	☐ NA	Every standardized, validated pain assessment conducted at or since the last OASIS assessment
e. Intervention(s) to prevent pressure ulcers	☐ 0	☐ 1	☐ NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the last OASIS assessment indicates the patient is not at risk of developing
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 [*Go to M2430*]
2 Rehabilitation facility **[*Go to M0903*]**
3 Nursing home [*Go to M0903*]
4 Hospice [*Go to M0903*]
NA No inpatient facility admission **[*Omit "NA" option on TRN*]**

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 practice.

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. Users are urged to work with their OASIS Education Coordinators for questions regarding official CMS policy.

OASIS Q&A Help Desk: cmsoasisquestions@oasisanswers.com
Questions related to OASIS data collection (scoring convention, time points, patient populations, item-specific guidance)

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

Outcome and Assessment Information Set (OASIS)
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/index.html

Background & Regulations	User Manual	Home Health Agency Q&A
iHAVEN	Education Coordinators	Reports
Data Set	Automation Coordinators	Training
Data Specifications	OASIS PPS	Archives

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

Medicare Learning Network
http://www.cms.hhs.gov/MLNGenInfo/

National Provider Identifier (NPI) Registry
https://npiregistry.cms.hhs.gov/

Quality Measures Management System (MMS)
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/index.html

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

Guidelines and Best Practices

Evidence-Based Practice Guidelines, University of Iowa, College of Nursing
http://www.nursing.uiowa.edu/excellence/evidence-based-practice-guidelines

National Guideline Clearinghouse (NGC): http://www.guideline.gov

American Heart Association Statements and Practice Guidelines
http://professional.heart.org/professional/GuidelinesStatements/UCM_316885_Guidelines-Statements.jsp

Home Health Best Practice Intervention Packages (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

Collaboration for Home Care Advances in Management and Practice (VNSNY) – Tools and Toolkits
http://www.champ-program.org/page/40/resources

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	http://www.healthit.gov/newsroom/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	http://www.cdc.gov/nchs/icd/icd10cm.htm#icd

Influenza Control and Immunizations

Centers for Disease Control and Prevention Vaccines

Vaccines Home Page	http://www.cdc.gov/vaccines/default.htm
Guidelines	http://www.cdc.gov/vaccines/recs/vac-admin/default.htm#guide
Influenza Home Page	http://www.cdc.gov/flu

Clinical Resources

Activities of Daily Living Definitions: Definition and History http://aspe.hhs.gov/daltcp/reports/guide.htm

Heart Failure

http://www.heart.org/HEARTORG/Conditions/HeartFailure/Heart-Failure_UCM_002019_SubHomePage.jsp
http://www.nlm.nih.gov/medlineplus/ency/article/000158.htm

Diabetes

http://www.diabetes.org
http://www.niddk.nih.gov/health-information/health-topics/diabetes/Pages/default.aspx

Diabetic Foot Care

http://www.niddk.nih.gov/health-information/health-topics/Diabetes/prevent-diabetes-problems/Pages/index.aspx

Medications (MEDLINE)

http://www.nlm.nih.gov/medlineplus/druginformation.html

Diversity: The Provider's Guide to Quality and Culture

http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English

Caregivers

http://www.aarp.org/home-family/caregiving/caregiving-tools/

http://www.nextstepincare.org/

Mental Health Resources

Alzheimer's

http://www.alz.org/care/overview.asp

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

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.* http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2009.02626.x/abstract

Cognitive Assessment

Clock Drawing Test	http://alzheimers.about.com/od/testsandprocedures/a/The-Clock-Drawing-Test.htm
Tools	http://www.alz.org/health-care-professionals/cognitive-tests-patient-assessment.asp
MMSE	https://www.mountsinai.on.ca/care/psych/on-call-resources/on-call-resources/mmse.pdf

Risk Assessment Tools

Depression: Patient Health Questionnaire Resources

AHRQ (PHQ2) https://innovations.ahrq.gov/qualitytools/patient-health-questionnaire-phq-2

U of Washington (PHQ9) http://impact-uw.org/tools/phq9.html

Fall Risk

Missouri Alliance for Home Care
http://www.homecaremissouri.org/projects/falls/index.php
Multi-Factorial Fall Risk Assessment Tool (MAHC-10) designed for home care patients

Iowa Geriatric Education Center, University of Iowa
http://www.healthcare.uiowa.edu/igec/tools/categoryMenu.asp?categoryID=3

Screen for Obesity – BMI

National Heart, Lung, and Blood Institute
http://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

Pain

City of Hope Pain & Palliative Care Resource Center, Pain Assessment Tools
http://prc.coh.org/pain_assessment.asp

Iowa Geriatric Education Center, University of Iowa
http://www.healthcare.uiowa.edu/igec/tools/categoryMenu.asp?categoryID=7

Pressure Ulcer Risk

Braden Scale for Predicting Pressure Sore Risk
http://www.healthcare.uiowa.edu/igec/tools/pressureulcers/bradenscale.pdf

Norton Pressure Sore Risk Assessment
http://www.nutrition411.com/sites/default/files/w0513_norton_presure_sore_risk_assessment_scale_scoring_system.pdf

NQF Framework
http://www.qualityforum.org/Publications/2011/12/National_Voluntary_Consensus_Standards_for_Developing_a_Framework_for_Measuring_Quality_for_Prevention_and_Management_of_Pressure_Ulcers.aspx

National Pressure Ulcer Advisory Panel (NPUAP) www.npuap.org

Guidance on OASIS Integumentary items, Wound Ostomy and Continence Nurses Society (WOCN)
http://www.wocn.org/?page=oasis

Wound Ostomy and Continence Nurses Society (WOCN) http://www.wocn.org/

Leg ulcers http://c.ymcdn.com/sites/www.wocn.org/resource/collection/E3050C1A-FBF0-44ED-B28B-C41E24551CCC/A_Quick_Reference_Guide_for_LE_Wounds_%282013%29.pdf

Professional Organizations

ANA http://www.nursingworld.org/
AOTA http://www.aota.org/
APTA http://www.apta.org/
ASHA http://www.asha.org/

Quality Resources

Agency for Healthcare Research and Quality http://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/

Institute for Healthcare Improvement
http://www.ihi.org/Pages/default.aspx

Institute of Medicine http://www.nationalacademies.org/hmd/
Crossing the Quality Chasm http://books.nap.edu/openbook.php?isbn=0309072808&page=1

Care Transitions
Transitional Care Model http://www.transitionalcare.info
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/

Safety Resources

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/

Joint Commission http://www.jointcommission.org/accreditation/home_care_accreditation_requirements.aspx

Medication Safety – Institute for Safe Medication Practices (ISMP)
http://www.ismp.org/Tools/anticoagulantTherapy.asp
http://www.ismp.org/Tools/highalertmedications.pdf

1. WHAT IS A COMPREHENSIVE ASSESSMENT?

Patient assessment is an essential component of health care delivery. Assessment requires the collection of pertinent data regarding the patient, supportive assistance, and the patient's environment. Clinicians of all types systematically collect and categorize such data, analyze and evaluate these data, and draw conclusions from the data that guide their subsequent interventions. It is the interventions that then are directed toward improving or maintaining health status (or supporting the patient in a dignified dying process). Assessment involves the active gathering of accurate and well-defined patient status information.

A comprehensive assessment involves collecting data on multiple aspects of the patient and the environment. The patient receiving home care particularly benefits from a comprehensive assessment because the interrelated aspects of patient and environment all influence current and future health status. An assessment with too narrow a focus omits many components relevant to care delivery. Consider the example of a patient with an open surgical wound requiring dressing changes. A narrowly focused assessment would evaluate only the wound status. Such an assessment fails to take into account other factors relevant for wound healing, such as nutrition. The comprehensive assessment will consider the patient's nutritional status, which must address the actual food intake, the ability to prepare food, the ability to shop for food, and the presence of financial factors that may limit the ability to purchase food. The presence (or absence) of sanitation hazards, also important for wound healing, can be identified by the comprehensive assessment. In addition, the patient's ability to perform his/her own dressing change or the availability, willingness, and ability of a family member (or other caregiver) to change the dressing will also be evaluated in the comprehensive assessment. By collecting data on the variety of interrelated aspects of patient and environment that affect health status, such an assessment clearly provides a better base for care planning and delivery.

It should be noted that the data items in OASIS are not, in and of themselves, a complete or comprehensive assessment. Home health agencies will need to supplement the OASIS data items with others necessary for a full 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 assessment. Each agency will be expected to incorporate the OASIS items into its own comprehensive assessment documentation and related policies and procedures.

2. HOW ARE THE COMPREHENSIVE ASSESSMENT DATA COLLECTED AND DOCUMENTED?

Patient assessment data are collected through a combination of methods -- including interaction with patient/family, observation, and measurement. When used in combination, these methods provide a full picture of the patient's health status. Interaction and interview (specifically, a patient and/or caregiver report) data can be verified through observation and measurement; observation data can identify factors that require additional interview questions.

Interaction and interview involve purposeful communication with the patient or family. Some interview questions are short and direct (for example, what is your birth date? are you taking/receiving any injectable medications?), while others begin with an open-ended question that leads to further inquiries with a more specific focus (for example, what kind of assistance do you receive from family or friends?) can be followed by more specific questions about types and frequency of assistance if an affirmative response is obtained). In all cases, the patient is the preferred source for interview/interaction data, though the family/caregiver (or other health care provider) can provide information if the patient is unable to do so. Information such as biographical data, pertinent health and social history, and the review of body systems can only be obtained through interview/interaction. Observation often supplements and enriches the interview data. For example, the clinician observing a healed surgical wound scar may supplement the health history when additional questions identify disease conditions not previously mentioned.

Observation techniques obtain data through the senses. Using sight, sound, smell, and touch, the clinician collects and records patient status information. Measurement is a form of observation that uses a calibrated "instrument" to obtain data. For example, blood pressure, joint range of motion, height, and weight are all obtained by measurement. In all observational approaches, consistency and objectivity are particularly important. Professional standards for clinical observation are important to apply in conducting patient assessment.

All these methods and techniques should be used in conducting the comprehensive assessment and collecting OASIS data. Using only one approach limits both the amount and quality of the information obtained. Direct observation is the preferred method for data collection, but some historical data may only be obtained by interview. The interview should supplement, not replace, observational techniques.

The patient receiving care at home presents both unique opportunities and challenges for clinicians in assessing patients. One opportunity is that the clinician is able to collect data on environmental characteristics (such as safety features) through first-hand observation rather than needing to rely exclusively on report. Thus, the accuracy of the patient status information is increased, which also increases the likelihood of appropriate pertinent interventions. Within this setting, however, the patient and family exercise control, in contrast to other health care delivery settings where the provider controls the environment. The clinician does not have the immediate and constant support of rules, policies, and colleagues to aid in data verification or compliance. The home care clinician often is required to exercise creativity and flexibility in collecting patient assessment data for care planning. For example, assessment of the home care patient begins even before the clinician enters the home. The initial referral provides an introduction to the client situation. A telephone contact with the patient/family to arrange the visit furnishes additional data. Environmental characteristics of the neighborhood and the patient residence are apparent as the clinician approaches the home. When the comprehensive assessment is documented, the clinician's actual observations that describe the patient's current status should be recorded. The conclusions derived from these assessment data will direct the subsequent care planning activities.

3. COMPREHENSIVE ASSESSMENT AND OASIS REGULATION

In 1999, the Centers for Medicare & Medicaid Services (CMS) revised the Conditions of Participation (CoP) that home health agencies (HHAs) must meet to participate in the Medicare program. Specifically, this added rule states that each patient receive from the HHA a patient-specific, comprehensive assessment that identifies the patient's need for home care and that meets the patient's medical, nursing, rehabilitative, social, and discharge planning needs. The rule requires that as part of the comprehensive assessment, HHAs use OASIS when evaluating adult, non-maternity patients. Additionally, the OASIS meets the condition specified in §1891(d) of the Social Security Act, which requires the Secretary of the Department of Health and Human Services to designate an assessment instrument for use by an agency in order to evaluate the extent to which the quality and scope of services furnished by the HHA attain and maintain the highest practicable functional capacity of the patient as reflected in the plan of care.

These components were identified as an integral part of CMS' efforts to achieve broad-based improvements in the quality of care furnished through Federal programs and in the measurement of that care. The following briefly describes the CoP relevant to OASIS data collection. Specific regulatory language can be found within the CoP (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).

Condition of Participation: Comprehensive Assessment of Patients

HHAs are required to provide patients with a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must (1) identify the patient's continuing need for home care; (2) meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs; and (3) for Medicare patients, identify eligibility for the home health benefit, including the patient's homebound status. The comprehensive assessment must also incorporate the exact use of the current version of the OASIS data set, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-Data-Sets.html. A comprehensive assessment identifies patient progress toward desired outcomes or goals of the care plan.

> CMS expects that HHAs will collect OASIS data in the context of a comprehensive assessment on adult Medicare or Medicaid patients (age 18 or over) receiving skilled health services from the HHA, except for patients receiving care for pre- and post-partum conditions. Patients receiving skilled health services, whose care is reimbursed by other than Medicare or Medicaid, must receive comprehensive assessments, but the collection of OASIS data is not required. For patients receiving only personal care services, regardless of payer source, a comprehensive assessment is also required, but not the collection of OASIS data. Patients who

receive only services such as homemaker, chore, or companion services do not require the comprehensive assessment.

Standards in the CoP include:

- **Initial Assessment Visit**

  The initial visit is performed to determine the immediate care and support needs of the patient. This visit is conducted within 48 hours of referral or within 48 hours of a patient's return home from an inpatient stay, or on the physician-ordered start of care date. The initial assessment visit is intended to ensure that the patient's most critical needs for home care services are identified and met in a timely fashion. For Medicare patients, this initial assessment determines eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be conducted by a registered nurse unless rehabilitation therapy services are the only services ordered by the physician. Under the Medicare home health benefit, any one of three services (skilled nursing, physical therapy, or speech-language pathology) can establish program eligibility. If rehabilitation therapy services are the only services ordered by the physician, the initial assessment may be made by the appropriate rehabilitation skilled professional if the need for that service establishes eligibility for the home health benefit.

  The law governing home health eligibility prevents occupational therapy from establishing eligibility for the Medicare home health benefit at the initial assessment, though once eligibility is established, then continuing occupational therapy could establish eligibility for a subsequent episode (meaning that the occupational therapist could complete the Recertification assessment). If no skilled service is delivered at this initial assessment, this visit will not be considered the SOC nor is it considered a reimbursable visit for the Medicare home health benefit.

  Note that for payers other than Medicare, the occupational therapist may complete the initial assessment if the need for occupational therapy establishes program eligibility. The comprehensive assessment is not required to be completed at the initial assessment visit, although the HHA may choose to do so. If a skilled service is delivered at the initial assessment visit, thus establishing the SOC, the comprehensive assessment may be initiated at this visit and completed by the same clinician within the time frames discussed below. Agency policy may make the time frames for completion more restrictive than the CoP.

- **Completion of the Comprehensive Assessment**

  The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than five calendar days after the start of care.

  This requirement does not preclude an HHA from completing the comprehensive assessment during the SOC visit, and many HHAs currently operate in such a manner. This time frame provides operational flexibility to the HHA while maintaining patient safety in ensuring that all patient needs will be identified within a standard time period. Some HHAs have policies requiring that a nurse conduct the comprehensive assessment. Home care staff should follow agency policies governing which disciplines can complete the comprehensive assessment.

- **Drug Regimen Review**

  Under this requirement, the comprehensive assessment must include a review of all medications the patient is currently using to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects and drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

  While patients receive their drug regimen from the physician, review of this regimen is an integral part of the comprehensive assessment. In addition, this review is an important safeguard for patients who may receive medications from a variety of physicians and pharmacies. Some agencies have policies requiring nurses to do the drug regimen review. In addition, some state practice acts may preclude therapists from completing the drug regimen review. Home care staff should follow state regulations and agency polices governing which disciplines can complete the drug regimen review.

- **Update of the Comprehensive Assessment**

  The comprehensive assessment, which includes OASIS items for Medicare and Medicaid patients, must be updated and revised as frequently as the patient's condition requires, but not less frequently than every 60 days beginning with the start of care date; within 48 hours of the patient's return home from an inpatient facility stay of 24 hours or more for any reason except diagnostic testing; and at discharge. The update of the comprehensive assessment must include completion of all required OASIS items for that time point, plus any others determined necessary by the HHA for a comprehensive assessment. This assessment provides information for determination of changes in treatment or plan of care. Therefore, a comprehensive assessment also is required when there is a major decline or improvement in a patient's health status as defined by the HHA.

  An inpatient facility admission as an event is generally a predictor of a change in the patient's health status and therefore should be captured in the OASIS data. In addition, because patients frequently improve rapidly upon returning home from an inpatient facility, it is important for the HHA to assess the patient's true needs as quickly as possible after discharge from the inpatient facility. Therefore, the comprehensive assessment is required within 48 hours of the patient's return to the home from an inpatient facility admission of 24 hours or more for any reason other than diagnostic tests.

  Follow-up assessments must be completed every 60 days that a patient is under care. For Medicare and Medicaid patients, when a follow-up assessment is due, it must be completed no earlier than four calendar days before, and no later than the day marking the end of the 60-day period (that is, day 56 through day 60 of the period).

- **Incorporation of the OASIS Data Set**

  OASIS must be incorporated into the HHA's own assessment, exactly as written. Both the language and the groupings of the OASIS items must be maintained. Integrating the OASIS items into the agency's own assessment system in the sequence presented in the OASIS form would facilitate data entry of the items into data collection and reporting software. However, HHAs may integrate the items in such a way that best suits the agency's own assessment.

  The OASIS data set is not intended to constitute a complete comprehensive assessment instrument. Rather, the data set comprises items that are a necessary part of a complete comprehensive assessment and that are essential to uniformly and consistently measure patient outcomes. An HHA can use the data set as the foundation for valid and reliable information for patient assessment, care planning, service delivery, and improvement efforts.

  The OASIS items are already used in one form or another by virtually all HHAs that conduct thorough assessments, and simply adding the OASIS data set to the rest of the HHA's paperwork would be burdensome and duplicative. Therefore, we expect HHAs to replace similar assessment items with OASIS items in their assessment forms to avoid lengthening the assessment unnecessarily. This may be accomplished by modification of existing forms or using commercially available comprehensive assessment forms that include OASIS items. The Mxxxx numbers for each OASIS data item should be retained to allow for easy recognition of the required OASIS item in the HHA comprehensive assessments.

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 ÷ 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 m^{th} patient, and select every n^{th} patient after that. Using the above example, you would select the 4^{th} person and then every 8^{th} 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 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[2] and the OASIS Submission User's Guide[3].

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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.

2 http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/Survey-and-Cert-Letter-15-18.html?DLPage=1&DLFilter=15-18&DLSort=3&DLSortDir=descending

3 https://www.qtso.com/hhatrain.html

APPENDIX C OASIS-C2 ITEMS, TIME POINTS, AND USES

This table can be used in identifying the time points and potential uses for each OASIS-C2 data item.

The following key should be used for the Item Uses column:

A = Administrative
C = Consistency Check
Q = Quality Measure
PQ = Potential Quality Measure
PRA = Potential Quality Measure Risk Adjustment
$ = Payment

The following key should be used for the Time Points columns:

S = Start of Care
R = Resumption of Care
FU = Follow-Up
TRF = Transfer
DC = Discharge
H = Death at Home

Items		Time Points						Item
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	–	–	–	–	–	C,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	C,Q
M0100	**This Assessment is Currently Being Completed for the Following Reason**	S	R	F	T	D	H	C,Q
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	–	–	–	C, $, PRA
M0140	**Race/Ethnicity**	S	–	–	–	–	–	A
M0150	**Current Payment Sources for Home Care**	S	–	–	–	–	–	A, PRA

Items		Time Points						Item
Item #	**Item Description**	**SOC**	**ROC**	**FU**	**TRF**	**DC**	**DAH**	
M0903	**Date of Last (Most Recent) Home Visit**	–	–	–	**T**	**D**	**H**	**A**
M0906	**Discharge/Transfer/ Death Date**	–	–	–	**T**	**D**	**H**	**Q**
M1000	**Inpatient Facilities**	**S**	**R**	–	–	–	–	**PRA**
M1005	**Inpatient Discharge Date**	**S**	**R**	–	–	–	–	**A**
M1011	List each **Inpatient Diagnosis** and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days	**S**	**R**	**F**	–	–	–	**PRA**
M1017	**Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days**	**S**	**R**	–	–	–	–	**PRA**
M1018	**Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days**	**S**	**R**	–	–	–	–	**PRA**
M1021	**Primary Diagnosis,** ICD-10-CM and Symptom Control Rating	**S**	**R**	**F**	–	–	–	**$, PRA**
M1023	**Other Diagnoses**, ICD-10-CM and Symptom Control Rating	**S**	**R**	**F**	–	–	–	**PRA**
M1025	**Optional Diagnoses** and ICD-10-CM codes	**S**	**R**	**F**	–	–	–	**$, PRA**
M1028	**Active Diagnoses – Comorbidities and Co-existing Conditions**	**S**	**R**	–	–	–	–	**PRA**
M1030	**Therapies** patient receives at home	**S**	**R**	**F**	–	–	–	**$, PRA**
M1033	**Risk for Hospitalization**	**S**	**R**	–	–	–	–	**PRA**
M1034	**Overall Status**	**S**	**R**	–	–	–	–	**PRA**
M1036	**Risk Factors**	**S**	**R**	–	–	–	–	**PRA**
M1041	**Influenza Vaccine Data Collection Period**	–	–	–	**T**	**D**	–	**Q**
M1046	**Influenza Vaccine Received**	–	–	–	**T**	**D**	–	**Q**
M1051	**Pneumococcal Vaccine**	–	–	–	**T**	**D**	–	**Q**
M1056	**Reason Pneumococcal Vaccine not received**	–	–	–	**T**	**D**	–	**Q**
M1060	**Height and Weight**	**S**	**R**	–	–	–	–	**PRA**
M1100	**Patient Living Situation**	**S**	**R**	–	–	–	–	**Q, PRA**
M1200	**Vision**	**S**	**R**	**F**				**$, PRA**
M1210	**Ability to Hear**	**S**	**R**	–	–	–	–	**PRA**
M1220	**Understanding of Verbal Content**	**S**	**R**	–	–	–	–	**PRA**
M1230	**Speech and Oral (Verbal) Expression of Language** (in patient's own language)	**S**	**R**	–	–	**D**	–	**Q, PRA**
M1240	Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?	**S**	**R**	–	–	–	–	**Q**
M1242	**Frequency of Pain Interfering** with patient's activity or movement:	**S**	**R**	**F**	–	**D**	–	**Q, $, PRA**

Items		Time Points						Item
Item #	Item Description	SOC	ROC	FU	TRF	DC	DAH	
M1300	**Pressure Ulcer Assessment:** Was this patient assessed for **Risk of Developing Pressure Ulcers?**	S	R	–	–	–	–	Q
M1302	**Risk of Developing Pressure Ulcers**	S	R	–	–	–	–	Q, PRA
M1306	Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher or designated as Unstageable**	S	R	F	–	D	–	C,Q, PRA
M1307	The **Oldest Stage 2 Pressure Ulcer** that is present at discharge	–	–	–	–	D	–	Q, PRA
M1311	**Current Number of Unhealed Pressure Ulcers at Each Stage**	S	R	F	–	D	–	Q, $, PRA
M1313	**Worsening in Pressure Ulcer Status since SOC/ROC**	–	–	–	–	D	–	Q
M1320	**Status of Most Problematic Pressure Ulcer that is Observable**	S	R	–	–	D	–	C, PRA
M1322	**Current Number of Stage 1 Pressure Ulcers**	S	R	F	–	D	–	$, PRA
M1324	**Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable**	S	R	F	–	D	–	Q, $, PRA
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	–	D	–	$, PRA
M1334	**Status of Most Problematic Stasis Ulcer that is Observable**	S	R	F	–	D	–	$, PRA
M1340	Does this patient have a **Surgical Wound?**	S	R	F	–	D	–	C,Q, PRA
M1342	**Status of Most Problematic Surgical Wound that is Observable**	S	R	F	–	D	–	Q, $ PRA
M1350	Does this patient have a **Skin Lesion or Open Wound,** excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency?	S	R	–	–	–	–	C, PRA
M1400	When is the patient dyspneic or noticeably **Short of Breath**?	S	R	F	–	D	–	Q, $, PRA
M1410	**Respiratory Treatments** utilized at home	S	R	–	–	–	–	PRA
M1501	**Symptoms in Heart Failure Patients**	–	–	–	T	D	–	Q
M1511	**Heart Failure Follow-up**	–	–	–	T	D	–	Q
M1600	Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?	S	R	–	–	D	–	Q, PRA
M1610	**Urinary Incontinence or Urinary Catheter Presence**	S	R	F	–	D	–	Q, $, PRA
M1615	**When** does **Urinary Incontinenc**e occur?	S	R		–	D	–	Q, PRA
M1620	**Bowel Incontinence Frequency**	S	R	F	–	D	–	Q, $, PRA
M1630	**Ostomy for Bowel Elimination**	S	R	F	–		–	$, PRA
M1700	**Cognitive Functioning**	S	R	–	–	D	–	Q, PRA
M1710	**When Confused (Reported or Observed Within the Last 14 Days)**	S	R	–	–	D	–	Q, PRA

Items		Time Points						Item
Item #	Item Description	SOC	ROC	FU	TRF	DC	DAH	
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	–	Q, PRA
M1750	**Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?	S	R	–	–	–	–	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
GG0170C	**Mobility – Lying to sitting on side of bed**	S	R		–	–	–	PRA
M1860	**Ambulation/Locomotion**	S	R	F	–	D	–	Q, $, PRA
M1870	**Feeding or Eating**	S	R	–	–	D	–	Q, PRA
M1880	**Ability to Plan and Prepare Light Meals**	S	R	–	–	D	–	Q, PRA
M1890	**Ability to Use Telephone**	S	R	–	–	D	–	Q, PRA
M1900	**Prior Functioning ADL/IADL**.	S	R	–	–	–	–	PRA
M1910	**Falls Risk Assessment**	S	R	–	–	–		Q
M2001	**Drug Regimen Review**	S	R	–	–	–	–	C, Q
M2003	**Medication Follow-up**	S	R	–	–	–	–	Q
M2005	**Medication Intervention**	–	–	–	T	D	H	Q
M2010	**Patient/Caregiver High-Risk Drug Education**	S	R	–	–	–	–	Q, PRA
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	–	D	–	$, PRA
M2040	**Prior Medication Management**	S	R	–	–		–	PRA
M2102	**Types and Sources of Assistance**	S	R	–	–	D	–	PRA
M2110	**How Often** does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?	S	R	–	–	–	–	PRA
M2200	**Therapy Need**	S	R	F	–	–	–	$, PRA
M2250	**Plan of Care Synopsis**	S	R	–	–	–	–	Q, PRA
M2301	**Emergent Care**	–	–	–	T	D	–	Q

Items		Time Points						Item
Item #	**Item Description**	**SOC**	**ROC**	**FU**	**TRF**	**DC**	**DAH**	
M2310	**Reason for Emergent Care**	–	–	–	**T**	**D**	–	**Q**
M2401	**Intervention Synopsis**	–	–	–	**T**	**D**	–	**Q**
M2410	To which **Inpatient Facility** has the patient been admitted?	–	–	–	**T**	**D**	–	**Q**
M2420	**Discharge Disposition**	–	–	–	–	**D**	–	**Q**
M2430	**Reason for Hospitalization**	–	–	–	**T**	–	–	**Q**
TOTAL	**Total items per timepoint**	**94**	**79**	**32**	**18**	**56**	**6**	**113**

APPENDIX D (RESERVED FOR FUTURE USE)

DATA REPORTING REGULATION

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). Staff entering data or preparing for submission may need to contact the qualified clinician who assessed the patient for assistance in making necessary corrections. The clinician's recall of the patient assessment and clinical notes that document the assessment are more accurate if the review occurs soon after the assessment than if edits and corrections are delayed.

  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 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 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 and includes information from the original OASIS Implementation Manual (Chapter 12) (archived but available at the following link:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIArchives.html).

In addition, the State survey process for HHAs may include review of OASIS data collected versus data encoded and transmitted to the State.

- **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. Once transmitted, the data submission is validated and feedback is provided to the HHA 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 877-339-9323 or you can use "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, 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 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 Data Sets", and then on "OASIS-C2." 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 Education Coordinator and OASIS Automation Coordinator, and a link to OASIS Questions and Answers are located at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/OASIS/HHAQA.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. In the future, as OASIS is revised, HHAs will be directed to the CMS OASIS website for the current version of the OASIS data set.

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 http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/index.html?redirect=/hipaageninfo/.)

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 training and 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 System of Records (SOR) Notice was first published in the *Federal Register*, Vol. 64, No. 117, June 18, 1999, and was updated in the Vol. 66, No. 248 *Federal Register*, published on December 27, 2001 and Vol. 72, No. 218 *Federal Register,* published November 13, 2007. The original notice describes the purpose of the new SOR (a national database) and identifies the statutory authority for creation and maintenance of the system and appropriate routine uses of the data. Clinical assessment information for all Medicare or Medicaid patients receiving the services of a Medicare- or Medicaid-approved HHA except for those receiving HHA services for pre- and post-partum conditions, patients less than 18 years of age, and patients receiving exclusively personal care or non-health care services (i.e., chore or homemaker services) is included in the System of Records (SOR). The assessment information contained in the SOR is the OASIS data set. These data are obtained through a patient assessment that is conducted by a registered nurse or qualified therapist. To determine the type of care needed by a patient, HHAs perform an assessment of each patient's physical and emotional status. HHAs will continue to do these assessments, but now they will report a portion of that assessment to CMS to perform several critical functions, such as calculating the appropriate amount to pay for home health services, and to ensure that HHAs are providing the highest quality of care for the entire agency and for each individual patient. Home health patients are one of the most vulnerable populations because services are provided in the home where it is difficult to oversee the quality of services provided. OASIS data allow CMS to measure how well HHAs care for their patients through the development of performance profiles for each agency.

Consistent with the HIPAA Privacy and Security Rules, the Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the stated purpose(s) for which the information was collected. This disclosure is known as "routine use." Several routine use disclosures have been identified for OASIS data. These data may be disclosed only to:

- The Department of Justice, court, or adjudicatory body when CMS is involved in litigation or when CMS' policies or operations could be affected by the outcome of the litigation.
- A third party with whom CMS has contracted to assist in accomplishing CMS functions relating to purposes of the System of Records.
- Another Federal or State Agency, agency of a State Government, or established by State law, for purposes of evaluating and monitoring the quality of home health care and contributing to the accuracy of CMS' health insurance operations.
- A Quality Improvement Organization (QIO), to assist in performing specific functions relating to assessing and improving HHA quality of care.
- An individual or organization for research, evaluation, or epidemiological activities related to health.

- A member of Congress or a Congressional staff member in response to an inquiry of the Congressional Office made at the written request of the constituent about whom the record is maintained.

The December 27, 2001, *Federal Register* notice added a seventh use disclosure:

- National accrediting organizations with approval for deeming authority for Medicare requirements for home health services, allowing these organizations to target potential or identified problems during the accreditation review process.

The June 18, 1999, *Federal Register* notice also identified the specific safeguards in place to ensure confidentiality of patient-level data. Please refer to this announcement for details.

Deficit Reduction Act of 2005 Requirement for Reporting Quality Data and Public Reporting for Quality Measures

In 2005, the Deficit Reduction Act (DRA) Section 5201(c) (2) was passed by Congress and added section 1895(b) (3) (ii) (V) to the Social Security Act requiring each HHA to submit to the Secretary such data that the Secretary determines are appropriate for the measurement of health care quality for 2007 and each subsequent year. Section 5201 (c)(v) requires a payment adjustment if an HHA does not submit data for the reporting year, "the home health market basket percentage increase applicable for such year shall be reduced by 2 percentage points." The two percent reduction would begin to apply to annual payment updates beginning on January 2007 and each year thereafter.

The law also requires the Secretary to establish procedures for making data submitted available to the public and ensures the HHA has the opportunity to review the data prior to the data being made public. HHAs currently have pre-publication access to their own agency's quality data (which the contractor updates periodically). CMS proposes to continue this process, to enable each agency to know how it is performing before public posting of data on the Home Health Compare website. CMS also publishes quarterly Preview Reports (available to home health agencies on the Casper Reporting system and posted the QTSO memorandum in the OASIS State Welcome Page in their folders to advise agencies of the preview reports and how to access them).

The Secretary of the Department of HHS has determined that the OASIS information collection best meets the requirements of this statutory mandate. Continuing to use the OASIS instrument ensures that providers will not have an additional burden of reporting through a separate mechanism and that the costs associated with the development and testing of a new reporting mechanism can be avoided. Therefore, OASIS assessment submissions are monitored by CMS to evaluate compliance with the quality reporting requirements. HHAs that meet the reporting requirements are eligible for the full home health market basket percentage increase. The specific manner in which CMS determines whether an HHA is in compliance with this requirement is laid out in the yearly Prospective Payment Rule. HH PPS regulations, including the Final Rules, are available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html.

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 IMPACT Act (Improving Medicare Post-Acute Care Transformation Act of 2014).

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. This website encouraged consumers to use publicly available home health quality measures when selecting a home health agency. The launch of the Home Health Compare website 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), instrumental activities of daily living (IADLs), 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 as the measures of “Timely Initiation of Care” and “Depression Assessment Conducted.”

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 risk adjusted national reference rate. A subset of all quality measures is available to the public on the Home Health Compare website.

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 are 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. An overview of the utilization measures that are derived from OASIS data and the measures that are derived from claims data can be found in the Home Health Quality Measures Tables found on the CMS Home Health Quality Initiative website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html

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, so 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
Re-hospitalization During the First 30 Days of Home Health (Claims based)	How often home health patients, who have had a recent hospital stay, had to be readmitted to the hospital.	Percentage of home health stays in which patients who had an acute inpatient hospitalization discharge within 5 days before the start of their home health stay and were admitted to an acute care hospital during the 30 days following the start of the home health stay.	Number of home health stays for patients who have a Medicare claim for an admission to an acute care hospital in the 30 days following the start of the home health stay A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.	None – based on Medicare FFS claims.

The complete list of home health quality measures can be in the Home Health Quality Measures Tables found on the CMS Home Health Quality Initiative website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html.

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, immunizations, and use of risk assessment tools (e.g. for falls, depression). As well, there are measures for specific diagnoses (e.g. diabetes).

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 patients for whom drug education on all medications was provided during the episode. 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 time.

The process items in OASIS have been carefully chosen to represent "evidence-based" practice. However, not every process item will apply to every patient.

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. The process measure of "Depression Assessment Conducted" excludes quality episodes for which the patient is nonresponsive. However, the process measure of "Timely Initiation of Care" has no exclusions. Quality episodes that are excluded are not counted favorably or unfavorably toward the measure calculation.

Examples – Process Measures

Measure Name	Consumer Language (on Home Health Compare)	Measure Description	Measure Focus (Numerator)	OASIS Items Used in Measure Calculation
Timely Initiation of Care	How often the home health team began their patients' care in a timely manner.	Percentage of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later.	Number of home health episodes of care in which the start or resumption of care date was either on the physician-specified date or within 2 days of the referral date or inpatient discharge date, whichever is later. For a resumption of care, per the Medicare Conditions of Participation, the patient must be seen within two days of inpatient discharge, even if the physician specifies a later date.	Items Used to Compute Care Processes: (M0102) Date of Physician-ordered Start of Care (M0104) Date of Referral (M0030) Start of Care Date (M0032) Resumption of Care Date (M1000) Inpatient Facility discharge (M1005) Inpatient Discharge Date

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

The complete list of home health quality measures can be in the Home Health Quality Measures Tables found on the CMS Home Health Quality Initiative website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html

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 this OASIS-based measures, we use the OASIS items for this calculation. To calculate quality measures, we also need to understand the measure definition (as found in the Home Health Measures Tables) including the numerator, denominator, and measure exclusions.

Example: Improvement in Dyspnea

Measure Definition: Per the Home Health Measures Tables, 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 who improved (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 are also calculated for "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 at https://www.qtso.com/hhatrain.html.

Report Title	Report Description	Report Uses
1. Agency Patient-Related Characteristics 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 reference mean values for the same period.	Agencies can use this report as a companion to their Risk Adjusted Outcome Report and their Process Measures Report.
2. Agency Patient-Related Characteristics Analysis Summary Report	The average value of each case mix attribute, by outcome measure, for a specified time frame, for patients who have achieved the outcome, the average value of each case mix attribute for patients who have not achieved the outcome, and the difference between the two calculations.	Agencies can use this report to assist in investigating unfavorable OASIS-based outcome measures.
3. Home Health Agency (HHA) Trend Analysis Report	The actual OBQI measure rates versus risk adjusted rates and state and national percentile rankings by measure including a 12-month graph.	Agencies can use this report for trending their OASIS-based outcome measures.
4. Home Health Hospitalization by Reason Report	This is a companion report to the HHA Trend Analysis Report and is depicted when the measure of Acute Care Hospitalization is selected.	Agencies can use this report to identify the reason for hospitalization trends as identified on their agency's OASIS.
5. Risk Adjusted Outcome Report **(*) (**)**	Thirty-three End Results Outcome measures, three Utilization Outcome measures, and four 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); 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. This report is used in the CMS Home Health Agency Survey Process.

Report Title	Report Description	Report Uses
6. Risk Adjusted Potentially Avoidable Event Report **(*)**	Lists each of the twelve 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. This report is used in the CMS Home Health Agency Survey Process.
7. Potentially Avoidable Event - Patient Listing Report **(*)**	Lists each of the twelve 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. This report is used in the CMS Home Health Agency Survey Process.
8. All Patients' Process Quality 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 reference percentages 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.
9. Tally – Agency Patient-Related Characteristics 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-Related Characteristics Report.
10. Tally Outcome Report **(*)**	Details the episodes of care that ended during a specified period for a select agency and were used to calculate the Outcome: Risk Adjusted 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 Risk Adjusted Outcome Report. Agencies may find this report useful in investigating unfavorable OASIS-based outcome measures.
11. Tally Process 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 All Patients' Process Quality Measures Report. Agencies may find this report useful in investigating unfavorable OASIS-based process measures.
12. 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 3 months prior to the Home Health Compare update to allow the agency to preview their report and contact CMS with any potential data issues.

Report Title	Report Description	Report Uses
13. 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 3 months prior to the Home Health Compare update to allow the agency to preview their report and contact CMS with any potential data issues.
14. Quality Assessment Only (QAO) Metric	This report provides agencies with an indication of their pay-for-reporting compliance and is used for informational purposes only.	Agencies can use this report to monitor their compliance with Home Health pay-for-reporting requirements.

(*) Sample reports are provided in Figures 1-7 (p.x-x).
(**) Agencies may select this report as either a 2-bar report (comparing their current performance to a risk adjusted national reference rate) or a 3-bar report (comparing their current performance to their prior performance and to a risk adjusted national reference rate).

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 assessments from the OASIS assessments from Medicare FFS, Medicare Advantage, Medicaid and Medicaid Managed care. For each of these quality measures a logistic regression prediction model is created. Each prediction model has on average approximate 100 risk factors selected from among more than 400 possible risk factors using a rigorous, multi-step process 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 probably of obtaining a positive outcome (expected value) given the patient's clinical and functional status at the start of care. For more details regarding the methodology used to construct these prediction models, please review the materials available at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html.

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 the CMS Website: 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 (HHC) 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 Risk Adjusted 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. 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: Agencyobs= (# 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. 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).

The OASIS-based outcome measures are all risk adjusted. This is indicated on the report titles: Risk Adjusted Outcome Report and the Risk Adjusted Potentially Avoidable Event Report. The OASIS-based process measures are not risk adjusted.

Sample Reports

Sample Report 1: Agency Patient-Related Characteristics Report

Agency Patient-Related Characteristics Report

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999 Branch: All
Medicaid Number: 00000000
Date Report Printed: 03/31/2016

Requested Current Period: 01/2015 - 12/2015
Request Prior Period: 01/2014 - 12/2014
Actual Current Period: 01/2015 - 12/2015
Actual Prior Period: 01/2014 - 12/2014
Cases: Curr 2549 Prior 2466
Number of Cases in Reference Sample: 6583620

	Current Mean	Prior Mean	Ref. Mean
PATIENT HISTORY			
Demographics			
Age (years)	75.03	73.91 ++	74.68
Gender: Female (%)	60.10%	59.98%	61.20%
Race: Black (%)	14.06%	14.07%	13.91%
Race: White (%)	75.16%	75.01%	75.88%
Race: Other (%)	10.78%	10.92%	10.49%
Payment Source			
Any Medicare (%)	94.63%	93.27% +	93.18% *
Any Medicaid (%)	6.67%	9.29% ++	9.67% **
Any HMO (%)	45.66%	44.61%	27.67% **
Medicare HMO (%)	39.70%	38.00%	23.21% **
Other (%)	2.75%	3.00%	3.80% *
Episode Start			
Episode timing: Early (%)	60.26%	93.95% ++	88.62% **
Episode timing: Later (%)	3.08%	6.05% ++	7.42% **
Episode timing: Unknown (%)	36.65%	0.00% ++	3.96% **
Inpatient Discharge / Medical Regimen			
Long-term nursing facility (%)	0.43%	0.53%	0.78%
Skilled nursing facility (%)	23.34%	22.34%	14.72% **
Short-stay acute hospital (%)	56.61%	57.62%	50.80% **
Long-term care hospital (%)	0.27%	0.16%	0.66% *
Inpatient rehab hospital/unit (%)	5.49%	5.60%	6.06%
Psychiatric hospital/unit (%)	0.78%	0.65%	0.46%
Medical Regimen Change (%)	99.92%	99.96%	89.36% **
Prior Conditions			
Urinary incontinence (%)	44.23%	43.59%	38.94% **
Indwelling/suprapubic catheter (%)	10.99%	9.21% +	2.86% **
Intractable pain (%)	46.82%	55.72% ++	15.90% **
Impaired decision-making (%)	25.12%	23.68%	20.03% **
Disruptive/Inappropriate behav. (%)	3.77%	5.27% ++	1.92% **
Memory loss (%)	18.92%	19.46%	13.25% **
None listed (%)	16.88%	16.46%	41.70% **
No inpatient dc / No med. regimen chg. (%)	0.04%	0.00%	5.65% **
Therapies			
IV/infusion therapy (%)	3.92%	3.16%	3.29%
Parenteral nutrition (%)	0.31%	0.24%	0.24%
Enteral nutrition (%)	1.22%	0.85%	1.55%
GENERAL HEALTH STATUS			
Hospitalization Risks			
Recent decline mental/emot/behav (%)	33.70%	29.60% ++	16.40% **
Multiple hospitalizations (%)	40.41%	47.61% ++	33.81% **
History of falls (%)	37.50%	40.23% +	31.96% **
5 or more medications (%)	97.65%	97.00%	88.36% **
Frailty factors (%)	70.85%	93.43% ++	34.34% **
Other (%)	88.00%	65.61% ++	38.38% **
None (%)	0.04%	0.08%	2.84% **
Overall Status			
Overall Status (0-3)	1.60	1.66 ++	1.35 **
Unknown / Unclear (%)	0.00%	0.24% ++	0.19% *
Other Risk Factors			
Smoking (%)	41.40%	39.20%	19.77% **
Obesity (%)	42.14%	41.24%	21.67% **
Alcohol dependency (%)	3.69%	3.42%	3.50%
Drug dependency (%)	1.61%	1.46%	1.76%
None (%)	32.99%	35.10%	61.45% **
LIVING ARRANGEMENT / ASSISTANCE			
Current Situation			
Lives alone (%)	30.60%	30.09%	24.16% **
Lives with others (%)	63.79%	65.00%	65.31%
Lives in congregate situation (%)	5.61%	4.91%	10.54% **
Availability			
Around the clock (%)	63.04%	65.98% +	76.19% **
Regular daytime (%)	2.16%	3.33% ++	4.04% **
Regular nighttime (%)	3.88%	4.54%	5.21% *
Occasional (%)	30.48%	25.55% ++	13.65% **
None (%)	0.43%	0.61%	0.91% *
CARE MANAGEMENT			
ADLs			
None needed (%)	1.88%	2.19%	7.00% **
Caregiver currently provides (%)	23.38%	20.32% ++	58.03% **
Caregiver training needed (%)	67.71%	71.05% ++	27.91% **
Uncertain/Unlikely to be provided (%)	5.14%	3.33% ++	3.61% **
Needed, but not available (%)	1.88%	3.12% ++	3.45% **
IADLs			
None needed (%)	0.43%	0.28%	2.58% **
Caregiver provides (%)	70.97%	66.83% ++	79.01% **
Caregiver training needed (%)	25.58%	29.60% ++	13.73% **
Uncertain/Unlikely to be provided (%)	2.12%	1.82%	2.09%
Needed, but not available (%)	0.90%	1.46%	2.59% **
Frequency of ADL / IADL (1-5)	1.18	1.20	1.31 **
Medication Administration			
None needed (%)	1.61%	3.16% ++	19.45% **
Caregiver provides (%)	4.47%	5.07%	49.00% **
Caregiver training needed (%)	88.23%	85.89% +	26.81% **
Uncertain/Unlikely to be provided (%)	3.84%	3.37%	2.38% **
Needed, but not available (%)	1.84%	2.51%	2.35%
Medical Procedures			
None needed (%)	1.22%	2.43% ++	40.06% **
Caregiver provides (%)	1.10%	1.38%	23.03% **
Caregiver training needed (%)	88.62%	87.10%	28.46% **
Uncertain/Unlikely to be provided (%)	6.24%	4.66% +	4.86% **
Needed, but not available (%)	2.82%	4.42% ++	3.59%
Management of Equipment			
None needed (%)	2.55%	3.53% +	61.57% **
Caregiver provides (%)	1.22%	2.03% +	21.66% **
Caregiver training needed (%)	87.60%	86.37%	14.46% **
Uncertain/Unlikely to be provided (%)	5.85%	4.06% ++	1.35% **
Needed, but not available (%)	2.79%	4.01% +	0.96% **
Supervision / Safety			
None needed (%)	0.20%	0.93% ++	29.10% **
Caregiver provides (%)	5.88%	9.33% ++	50.56% **
Caregiver training needed (%)	86.70%	83.29% ++	17.13% **
Uncertain/Unlikely to be provided (%)	5.77%	3.41% ++	1.63% **
Needed, but not available (%)	1.45%	3.04% ++	1.59%
Advocacy			
None needed (%)	0.35%	0.45%	5.35% **
Caregiver provides (%)	63.36%	55.84% ++	82.57% **
Caregiver training needed (%)	33.19%	39.58% ++	8.96% **
Uncertain/Unlikely to be provided (%)	2.31%	2.31%	1.52% **
Needed, but not available (%)	0.78%	1.82% ++	1.60% **
SENSORY STATUS			
Sensory Status			
Vision impairment (0-2)	0.16	0.16	0.29 **
Hearing impairment (0-2)	0.35	0.36	0.38 *
Verbal content understanding (0-3)	0.34	0.31 +	0.52 **
Speech/language (0-5)	0.23	0.25	0.59 **
Pain interfering with activity (0-4)	2.09	2.21 ++	2.34 **

This sample report is for illustrative purposes only.

Agency Patient-Related Characteristics Report

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999 Branch: All
Medicaid Number: 00000000
Date Report Printed: 03/31/2016

Requested Current Period: 01/2015 - 12/2015
Request Prior Period: 01/2014 - 12/2014
Actual Current Period: 01/2015 - 12/2015
Actual Prior Period: 01/2014 - 12/2014
Cases: Curr 2549 Prior 2466
Number of Cases in Reference Sample: 6583620

	Current Mean	Prior Mean	Ref. Mean
INTEGUMENTARY STATUS			
Pressure Ulcers			
Pressure ulcer risk (%)	17.12%	18.09%	42.38% **
Pressure ulcer present (%)	6.08%	7.26%	5.18%
Stage II pressure ulcer count (#)	0.04	0.05	0.05
Stage III pressure ulcer count (#)	0.02	0.02	0.01 **
Stage IV pressure ulcer count (#)	0.01	0.00	0.01
Unstageable pressure ulcer count (#)	0.02	0.03 ++	0.02
Status most problematic PU (0-3)	2.52	2.50	2.88 **
Stage I pressure ulcers count (0-4)	0.02	0.03	0.03
Stage most problematic PU (1-4)	2.16	2.05	2.10
Stasis Ulcers			
Stasis ulcer indicator (%)	1.49%	1.26%	1.72%
Stasis ulcer count (0-4)	0.03	0.03	0.03
Status most problematic stasis (0-3)	2.91	2.82	2.68
Surgical Wounds			
Surgical wound indicator (%)	31.54%	34.87% ++	25.49% **
Status most problematic surg. (0-3)	2.04	2.03	1.71 **
Other			
Skin lesion with intervention (%)	55.63%	56.97%	24.68% **
PHYSIOLOGICAL STATUS			
Respiratory			
Dyspnea (0-4)	0.94	0.98	1.42 **
Oxygen therapy (%)	19.97%	19.51%	15.38% **
Ventilator therapy (%)	0.08%	0.04%	0.16%
CPAP / BPAP therapy (%)	5.92%	6.20%	3.09% **
Elimination Status			
Urinary Tract Infection (%)	11.76%	10.99%	10.47%
Urinary incontinence/catheter (%)	51.35%	51.09%	55.88% **
Urinary incontinence frequency (0-4)	2.26	2.44 ++	2.47 **
Bowel incontinence (0-5)	0.22	0.24	0.39 **
Bowel ostomy (%)	3.06%	3.57%	2.04% **
NEURO / EMOTIONAL / BEHAVIORAL			
Cognition			
Cognitive deficit (0-4)	0.32	0.38 ++	0.68 **
Confusion frequency (0-4)	0.50	0.55 +	0.88 **
Emotional			
Anxiety level (0-3)	0.40	0.41	0.75 **
Depression evaluation indicator (%)	5.06%	5.49%	5.77%
PHQ-2: Interest/Pleasure (0-3)	0.14	0.16	0.27 **
PHQ-2: Down/Depressed (0-3)	0.27	0.26	0.29
Behavioral			
Memory deficit (%)	19.89%	20.19%	17.16% **
Impaired decision-making (%)	20.13%	21.45%	22.79% *
Verbal disruption (%)	1.53%	2.11%	1.48%
Physical aggression (%)	0.55%	0.61%	0.74%
Disruptive/Inappropriate behavior (%)	0.47%	1.09% +	0.88%
Delusional, hallucinatory, etc. (%)	1.37%	2.31% +	1.42%
None demonstrated (%)	71.83%	71.82%	69.91%
Frequency of behavioral problems (0-5)	0.41	0.61 ++	0.79 **
Psychiatric nursing (%)	1.84%	5.47% ++	1.55%
ACTIVITIES OF DAILY LIVING			
SOC / ROC Status			
Grooming (0-3)	1.17	1.15	1.36 **
Dress upper body (0-3)	1.26	1.28	1.49 **
Dress lower body (0-3)	1.76	1.77	1.82 **
Bathing (0-6)	3.40	3.44	3.20 **
Toilet transfer (0-4)	1.18	1.13 +	1.17
Toileting hygiene (0-3)	1.28	1.21 ++	1.36 **
Bed transferring (0-5)	1.53	1.34 ++	1.44 **
Ambulation (0-6)	2.97	2.82 ++	2.61 **
Eating (0-5)	0.32	0.27 ++	0.72 **
Status Prior to SOC/ROC			
Prior Self Care (0-2)	0.69	0.67	0.71
Prior Ambulation (0-2)	0.70	0.68	0.66 **
Prior Transfer (0-2)	0.68	0.63 ++	0.60 **
IADLs, MEDICATIONS, OTHER			
IADLs			
Light meal prep (0-2)	1.51	1.51	1.28 **
Phone use (0-5)	0.92	0.79 ++	0.92
Prior Household (0-2)	1.27	1.24	1.11 **
Falls Risk			
At risk of falls (%)	98.25%	97.35% +	92.15% **
Medication Status			
Drug regimen: problem found (%)	10.56%	14.97% ++	21.71% **
Mgmt. oral medications (0-3)	1.96	1.91	1.64 **
Mgmt. oral medications: NA (%)	0.43%	0.41%	0.53%
Mgmt. injected medications (0-3)	2.01	1.93	1.80 **
Mgmt. injected medications: NA (%)	74.50%	74.90%	77.76% **
Prior mgmt. oral medications (0-2)	0.88	0.89	0.82 **
Prior mgmt. oral medications: NA (%)	0.55%	0.45%	1.95% **
Prior mgmt. injected medications (0-2)	1.03	1.01	0.95
Prior mgmt. injected medications: NA (%)	78.07%	78.35%	77.13%
THERAPY / PLAN OF CARE			
Therapy Visits			
# Therapy visits indicated (#)	8.17	9.42 ++	7.21 **
PATIENT DIAGNOSTIC INFORMATION			
Acute Conditions			
Orthopedic (%)	27.70%	34.27% ++	37.87% **
Neurologic (%)	18.83%	20.68%	12.58% **
Open wounds/lesions (%)	7.61%	8.88%	6.70%
Cardiac/peripheral vascular (%)	32.91%	34.06%	30.39% *
Pulmonary (%)	21.03%	21.13%	17.67% **
Diabetes mellitus (%)	8.55%	11.39% ++	10.20% *
Gastrointestinal disorder (%)	14.04%	15.17%	11.04% **
Contagious/communicable (%)	6.20%	4.70% +	3.64% **
Urinary incontinence/catheter (%)	3.41%	4.87% ++	14.22% **
Mental/emotional (%)	1.84%	5.47% ++	1.55%
Oxygen therapy (%)	19.97%	19.51%	15.38% **
IV/infusion therapy (%)	3.92%	3.16%	3.29%
Enteral/parenteral nutrition (%)	1.53%	1.09%	1.77%
Ventilator (%)	0.08%	0.04%	0.16%
Chronic Conditions			
Dependence in living skills (%)	55.00%	53.41%	39.14% **
Dependence in personal care (%)	56.53%	54.91%	51.14% **
Impaired ambulation/mobility (%)	65.05%	61.44% ++	55.44% **
Urinary incontinence/catheter (%)	47.94%	46.23%	41.64% **
Dependence in med. admin. (%)	65.75%	64.52%	61.14% **
Chronic pain (%)	40.02%	45.26% ++	18.49% **
Cognitive/mental/behavioral (%)	24.56%	23.80%	21.76% **
Chronic pt. with caregiver (%)	62.81%	65.69% +	69.34% **
Home Care Diagnoses			
Infections/parasitic diseases (%)	5.69%	4.30% +	4.36% **
Neoplasms (%)	12.51%	13.34%	8.51% **
Endocrine/nutrit./metabolic (%)	51.31%	50.93%	42.66% **
Blood diseases (%)	10.24%	14.19% ++	8.16% **
Mental diseases (%)	28.05%	35.08% ++	27.08%
Nervous system diseases (%)	33.27%	37.23% ++	25.97% **

This sample report is for illustrative purposes only.

Agency Patient-Related Characteristics Report

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999 Branch: All
Medicaid Number: 00000000
Date Report Printed: 03/31/2016

Requested Current Period: 01/2015 - 12/2015
Request Prior Period: 01/2014 - 12/2014
Actual Current Period: 01/2015 - 12/2015
Actual Prior Period: 01/2014 - 12/2014
Cases: Curr 2549 Prior 2466
Number of Cases in Reference Sample: 6583620

	Current Mean	Prior Mean	Ref. Mean	
Home Care Diagnoses				
Circulatory system diseases (%)	83.95%	81.75%+	77.22%	**
Respiratory system diseases (%)	27.11%	26.12%	24.59%	*
Digestive system diseases (%)	12.36%	14.92%++	11.73%	
Genitourinary sys. diseases (%)	30.40%	27.74%+	19.42%	**
Skin/subcutaneous diseases (%)	13.65%	14.03%	11.66%	*
Musculoskeletal sys. diseases (%)	27.93%	29.64%	47.97%	**
Ill-defined conditions (%)	21.38%	26.72%++	32.35%	**
Fractures (%)	6.83%	8.31%+	6.10%	
Intracranial injury (%)	0.43%	0.41%	0.33%	
Other injury (%)	4.28%	4.58%	4.67%	
Adverse reactions and complications (%)	5.37%	5.03%	3.64%	**
PATIENT DISCHARGE INFORMATION				
Length of Stay				
LOS until discharge (in days)	36.25	36.33	59.20	**
LOS from 1 to 30 days (%)	64.30%	64.11%	46.74%	**
LOS from 31 to 60 days (%)	25.93%	25.63%	33.70%	**
LOS from 61 to 120 days (%)	6.87%	7.79%	11.13%	**
LOS from 121 to 180 days (%)	1.49%	1.34%	3.55%	**
LOS more than 180 days (%)	1.41%	1.14%	4.87%	**
Reason for Emergent Care				
Improper medications (%)	0.85%	0.26%	1.06%	
Injury from fall (%)	4.87%	5.66%	7.83%	
Respiratory infection (%)	6.78%	8.74%	8.67%	
Other respiratory (%)	12.08%	11.57%	11.27%	
Heart failure (%)	9.75%	10.54%	7.45%	
Cardiac dysrhythmia (%)	3.39%	4.37%	2.76%	
Myocardial infarction (%)	2.97%	2.83%	3.47%	
Other heart disease (%)	0.85%	1.29%	1.92%	
Stroke (CVA) or TIA (%)	2.12%	2.06%	2.29%	
Hypo/Hyperglycemia (%)	2.12%	1.29%	1.75%	
GI bleeding, obstruction, etc. (%)	4.45%	1.80%+	3.76%	
Dehydration, malnutrition (%)	2.12%	6.43%++	4.28%	
Urinary tract infection (%)	5.93%	6.68%	6.97%	
IV catheter-related infection (%)	1.06%	0.51%	0.39%	
Wound infection (%)	5.51%	4.63%	4.16%	
Uncontrolled pain (%)	3.81%	3.60%	5.49%	
Acute mental/behav. problem (%)	2.54%	4.37%	3.41%	
Deep vein thrombosis (%)	0.42%	1.29%	1.16%	
Other (%)	37.29%	35.73%	37.25%	
No emergent care (%)	80.12%	82.04%	77.43%	**
Reason for Hospitalization				
Improper medications (%)	0.52%	0.00%	0.79%	
Injury from fall (%)	3.26%	4.48%	5.87%	*
Respiratory infection (%)	6.70%	8.15%	8.84%	
Other respiratory (%)	12.03%	10.39%	10.91%	
Heart failure (%)	9.97%	9.98%	7.55%	
Cardiac dysrhythmia (%)	2.75%	3.87%	2.64%	
Myocardial infarction (%)	1.89%	2.44%	3.23%	
Other heart disease (%)	1.20%	1.02%	1.94%	
Stroke (CVA) or TIA (%)	2.58%	2.24%	2.29%	
Hypo/Hyperglycemia (%)	1.20%	1.02%	1.62%	
GI bleeding, obstruction, etc. (%)	3.95%	1.83%+	3.53%	
Dehydration, malnutrition (%)	2.06%	5.70%++	4.05%	
Urinary tract infection (%)	5.33%	6.11%	6.64%	
IV catheter-related infection (%)	0.52%	0.61%	0.26%	
Wound infection (%)	5.67%	6.11%	5.08%	
Uncontrolled pain (%)	3.61%	1.83%	4.05%	
Acute mental/behav. Problem (%)	2.06%	4.28%+	3.48%	
Deep vein thrombosis (%)	0.34%	1.43%	1.11%	

	Current Mean	Prior Mean	Ref. Mean	
Scheduled visit (%)	4.64%	4.07%	5.51%	
Other (%)	36.43%	34.83%	35.92%	
No hospitalization (%)	75.98%	77.66%	73.82%	*

The pluses represent the significance levels of current and prior data comparisons.

+ The probability is 5% or less that the difference is due to chance, and 95% or more that the difference is real.

++ The probability is 1% or less that the difference is due to chance, and 99% or more that the difference is real.

Asterisks represent significance levels of current and national data comparisons.

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** The probability is 0.1% or less that this difference is due to chance, and 99.9% or more that the difference is real.

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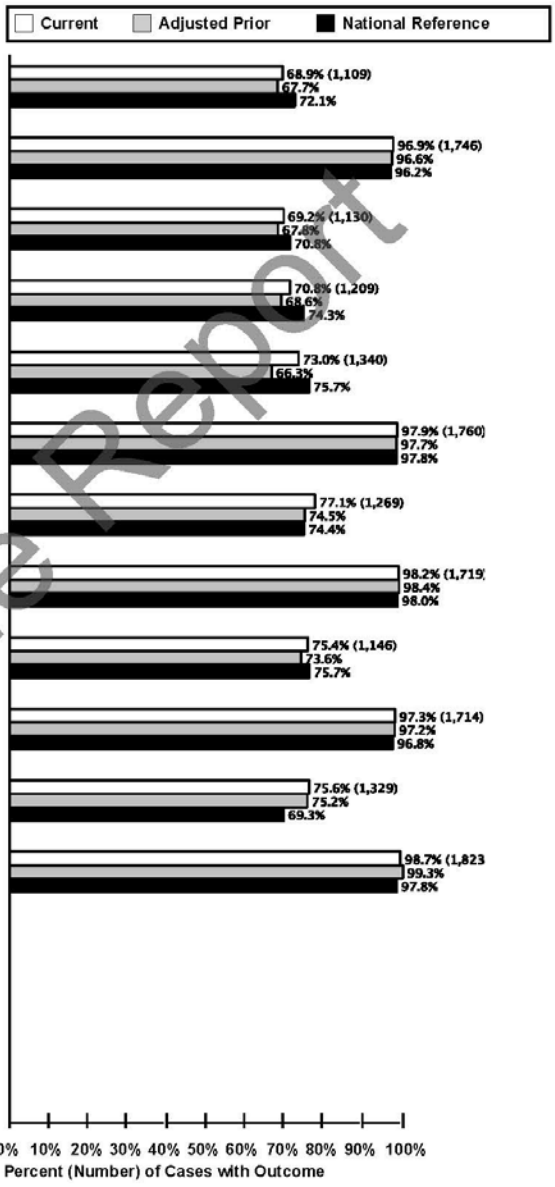
Sample Report 2: Risk Adjusted Outcome Report

Risk Adjusted Outcome Report

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999 Branch: All
Medicaid Number: 00000000
Date Report Printed: 03/31/2016

Requested Current Period: 01/2015 - 12/2015
Requested Prior Period: 01/2014 - 12/2014
Actual Current Period: 01/2015 - 12/2015
Actual Prior Period: 01/2014 - 12/2014
Cases Curr: 1857 Prior: 1856
Number of Cases in Reference Sample: 475029

End Result Outcomes:	Elig. Cases	Signif.
Improvement in Grooming	1609	
	1551	0.51
	3992555	0.01 **
Stabilization in Grooming	1802	
	1792	0.68
	4397291	0.14
Improvement in Upper Body Dressing	1632	
	1595	0.39
	4166757	0.15
Improvement in Lower Body Dressing	1707	
	1671	0.18
	4305575	0 **
Improvement in Bathing	1836	
	1810	0.0 ++
	4570127	0.01 **
Stabilization in Bathing	1797	
	1788	0.71
	4440581	0.62
Improvement in Toilet Transferring	1645	
	1452	0.09 +
	3583918	0.01 **
Stabilization in Toilet Transferring	1750	
	1729	0.83
	4427255	0.44
Improvement in Toileting Hygiene	1521	
	1487	0.28
	3789453	0.72
Stabilization in Toileting Hygiene	1761	
	1770	0.94
	4329947	0.2
Improvement in Bed Transferring	1758	
	1659	0.8
	4287111	0 **
Stabilization in Bed Transferring	1847	
	1842	0.1 +
	4656242	0 **



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# This outcome has been risk adjusted. However, the predictive model for this outcome is less robust than the other predictive models.

Note: When a measure value is calculated using less than 10 Episodes of care, the statistical significance level will not be displayed on the report.

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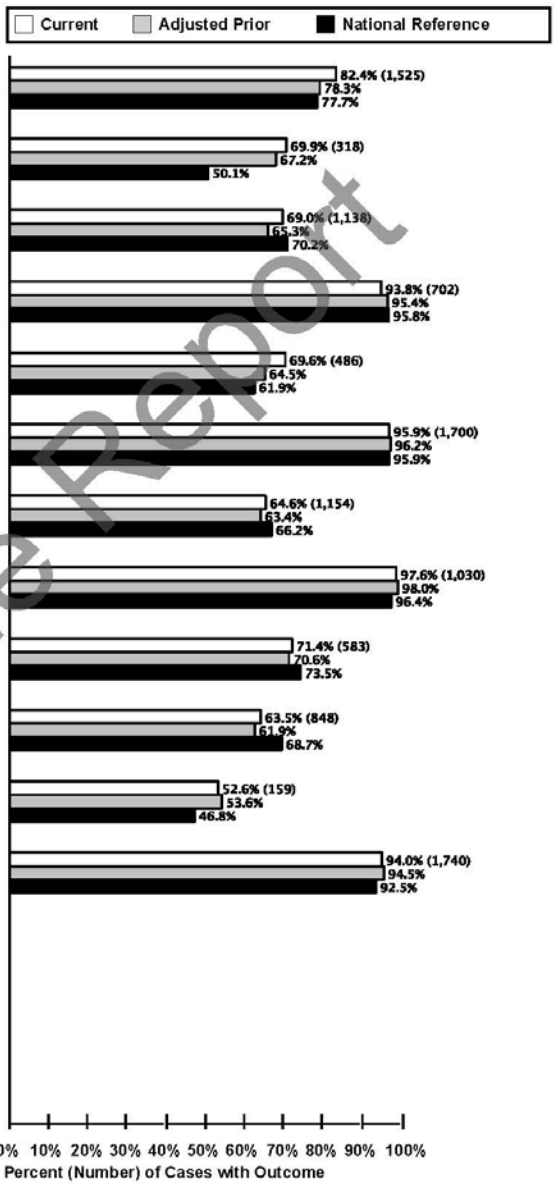
This report has not been approved to meet privacy requirements and can only be used by the home health agency and state agency for defined purposes.

Risk Adjusted Outcome Report

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999 Branch: All
Medicaid Number: 00000000
Date Report Printed: 03/31/2016

Requested Current Period: 01/2015 - 12/2015
Requested Prior Period: 01/2014 - 12/2014
Actual Current Period: 01/2015 - 12/2015
Actual Prior Period: 01/2014 - 12/2014
Cases Curr: 1857 Prior: 1856
Number of Cases in Reference Sample: 475029

End Result Outcomes:	Elig. Cases	Signif.
Improvement in Ambulation/Locomotion	1850	
	1804	0.0 ++
	4491589	0 **
Improvement in Eating	455	
	356	0.45
	2820813	0 **
Improvement in Light Meal Preparation	1650	
	1631	0.03 ++
	3997422	0.28
Stabilization in Light Meal Preparation	748	
	759	0.23
	2851831	0.01 **
Improvement in Phone Use	698	
	581	0.06 +
	1506703	0 **
Stabilization in Phone Use	1773	
	1761	0.7
	4403833	1
Improvement in Management of Oral Medications	1785	
	1701	0.48
	3582036	0.17
Stabilization in Management of Oral Medications	1055	
	1092	0.68
	3160164	0.02 **
Improvement in Dyspnea	817	
	811	0.75
	3312735	0.16
Improvement in Pain Interfering with Activity #	1336	
	1415	0.42
	3824254	0 **
Improvement in Speech and Language	302	
	275	0.91
	1893911	0.04 **
Stabilization in Speech and Language	1851	
	1840	0.55
	4690787	0.01 **



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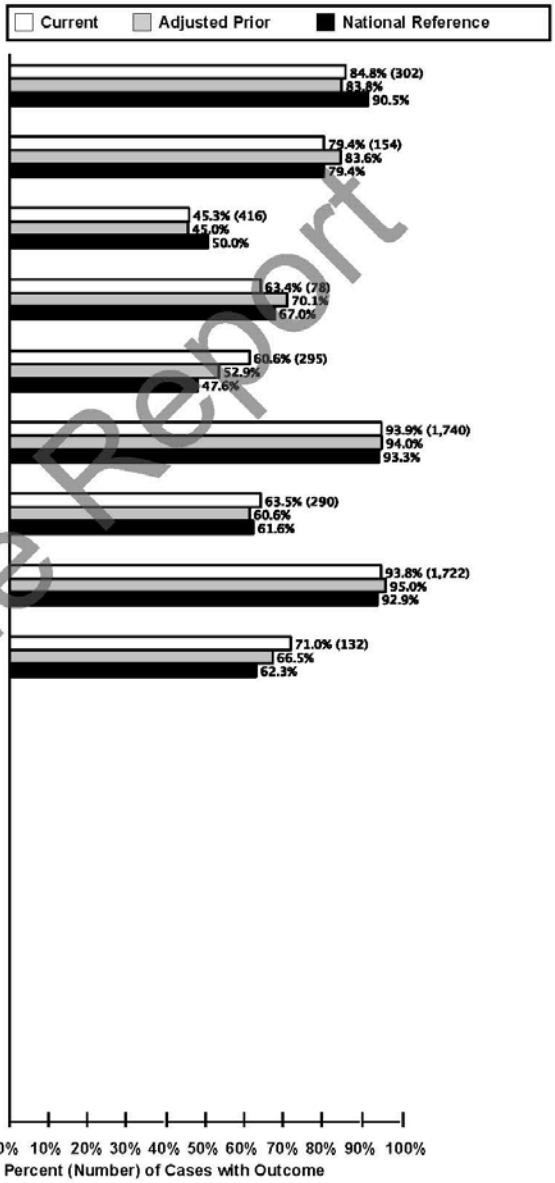
Risk Adjusted Outcome Report

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999 Branch: All
Medicaid Number: 00000000
Date Report Printed: 03/31/2016

Requested Current Period: 01/2015 - 12/2015
Requested Prior Period: 01/2014 - 12/2014
Actual Current Period: 01/2015 - 12/2015
Actual Prior Period: 01/2014 - 12/2014
Cases Curr: 1857 Prior: 1856
Number of Cases in Reference Sample: 475029

End Result Outcomes:	Elig. Cases	Signif.
Improvement in Status of Surgical Wounds #	356	
	395	0.77
	672076	0 **
Improvement in Urinary Tract Infection #	194	
	192	0.32
	424515	1
Improvement in Urinary Incontinence #	918	
	909	0.93
	2483618	0 **
Improvement in Bowel Incontinence	123	
	133	0.33
	621660	0.4
Improvement in Confusion Frequency	487	
	473	0.02 ++
	2492882	0 **
Stabilization in Cognitive Functioning	1853	
	1846	0.97
	4699089	0.3
Improvement in Anxiety Level #	457	
	440	0.39
	2272777	0.42
Stabilization in Anxiety Level	1836	
	1814	0.14
	4612977	0.14
Improvement in Behavior Problem Frequency #	186	
	260	0.37
	913069	0.01 **



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# This outcome has been risk adjusted. However, the predictive model for this outcome is less robust than the other predictive models.

Note: When a measure value is calculated using less than 10 Episodes of care, the statistical significance level will not be displayed on the report.

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Risk Adjusted Outcome Report

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999 Branch: All
Medicaid Number: 00000000
Date Report Printed: 03/31/2016

Requested Current Period: 01/2015 - 12/2015
Requested Prior Period: 01/2014 - 12/2014
Actual Current Period: 01/2015 - 12/2015
Actual Prior Period: 01/2014 - 12/2014
Cases Curr: 2549 Prior: 2466
Number of Cases in Reference Sample: 658362

Utilization Outcomes:	Elig. Cases	Signif.
Emergency Department w/ Hospitalization	2490	
	2389	0.41
	6428994	0 **
Discharged to Community	2536	
	2451	0.01 ++
	6449329	0 **
Acute Care Hospitalization	2544	
	2457	0.1 +
	6528107	0 **

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++ The probability is 5% or less that this difference is chance, and 95% or more that the difference is real.
# This outcome has been risk adjusted. However, the predictive model for this outcome is less robust than the other predictive models.

Note: When a measure value is calculated using less than 10 Episodes of care, the statistical significance level will not be displayed on the report.

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Risk Adjusted Outcome Report

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999 Branch: All
Medicaid Number: 00000000
Date Report Printed: 03/31/2016

Requested Current Period 07/2014 - 06/2015
Requested Prior Period (Claims): 07/2013 - 06/2014
Actual Current Period (Claims): 07/2014 - 06/2015
Actual Prior Period (Claims): 07/2013 - 06/2014
Cases Curr 836 Prior 914
Number of Cases in Reference Sample 273170

Claims Based Outcomes:	Elig. Cases	Signif.
Acute Care Hospitalization During the First 60 Days of Home Health	836	
	914	0.98
	2731701	0.29
Emergency Department w/o Hospitalization During the First 60 Days of Home Health	836	
	914	0.65
	2731701	0.16
Rehospitalization During the First 30 Days of Home Health	284	
	336	0.62
	815794	0.72
Emergency Department Use Without Hospital Readmission During First 30 Days of Home Health	284	
	336	0.87
	815794	0.28

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++ The probability is 5% or less that this difference is chance, and 95% or more that the difference is real.
\# This outcome has been risk adjusted. However, the predictive model for this outcome is less robust than the other predictive models.

Note: When a measure value is calculated using less than 10 Episodes of care, the statistical significance level will not be displayed on the report.

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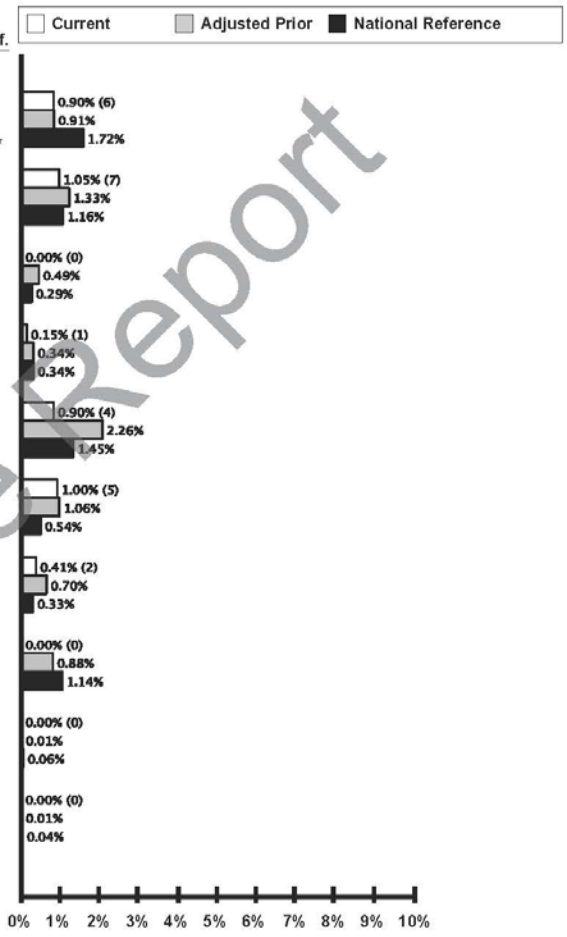
Sample Report 3: Risk Adjusted Potentially Avoidable Event Report

Risk-Adjusted Potentially Avoidable Event Report

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999 Branch: All
Medicaid Number: 00000000
Date Report Printed: 03/31/2016

Requested Current Period: 10/2015 - 12/2015
Requested Prior Period: 07/2015 - 09/2015
Actual Current Period: 10/2015 - 12/2015
Actual Prior Period: 07/2015 - 09/2015
Cases: Curr 678 Prior 626
Number of Cases in Reference Sample: 165610

Potentially Avoidable Event:	Elig. Cases	Signif.
Emergent Care for Injury Caused by Fall	665	
	604	1
	158451	0.09 *
Emergent Care for Wound Infections, Deteriorating Wound Status	665	
	604	0.8
	158451	0.84
Emergent Care for Improper Medication Administration, Medication Side Effects	665	
	604	0.11
	158451	0.15
Emergent Care for Hypo/Hyperglycemia	665	
	604	0.61
	158451	0.44
Development of Urinary Tract Infection #	443	
	407	0.16
	106790	0.34
Increase in Number of Pressure Ulcers	501	
	456	1
	119919	0.19
Substantial Decline in 3 or More Activities of Daily Living	486	
	444	0.67
	115425	0.68
Substantial Decline in Management of Oral Medications	9	
	19	
	254016	
Discharged to the Community Needing Wound Care or Medication Assistance	501	
	456	
	119919	0.75
Discharged to the Community Needing Toileting Assistance	501	
	456	
	119919	0.83



Percent (Number) of Cases with Potentially Avoidable

Values above 10% are not graphed to scale.

* The probability is 10% or less that this difference is due to chance, and 90% or more that the difference is real.
** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.
\+ The probability is 10% or less that this difference is due to chance, and 90% or more that the difference is real.
++ The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.
# This outcome has been risk adjusted. However, the predictive model for this outcome is less robust than the other predictive models.
Note: When a measure value is calculated using less than 10 Episodes of care, the statistical significance level will not be displayed on the report.

This sample report is for illustrative purposes only.

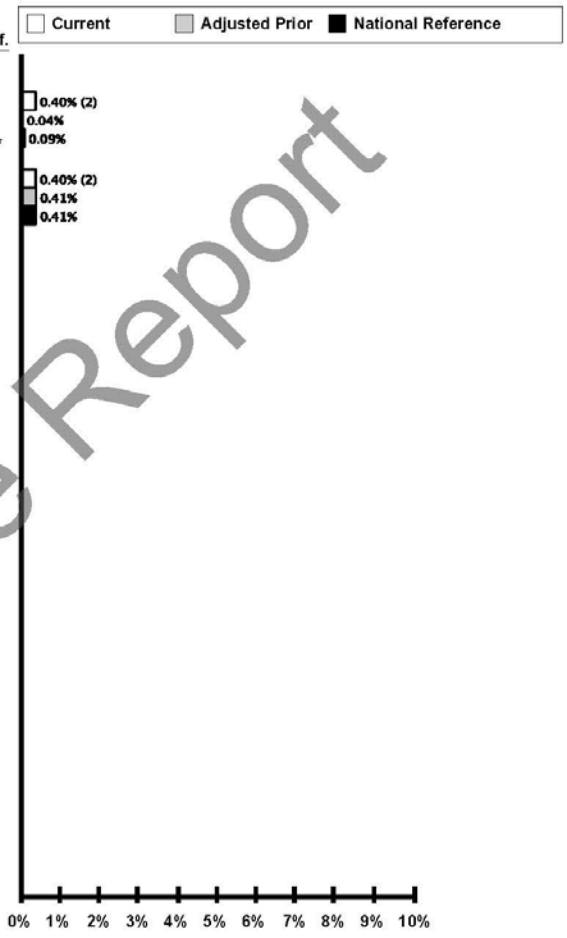
This report has not been approved to meet privacy requirements and can only be used by the home health agency and state agency for defined purposes.

Risk-Adjusted Potentially Avoidable Event Report

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999 **Branch:** All
Medicaid Number: 00000000
Date Report Printed: 03/31/2016

Requested Current Period: 10/2015 - 12/2015
Requested Prior Period: 07/2015 - 09/2015
Actual Current Period: 10/2015 - 12/2015
Actual Prior Period: 07/2015 - 09/2015
 # Cases: Curr 678 **Prior** 626
Number of Cases in Reference Sample: 165610

Potentially Avoidable Event:	Elig. Cases	Signif.
Discharged to the Community with Behavioral Problems	501	
	456	0.5
	119919	0.09 *
Discharged to the Community with an Unhealed Stage II Pressure Ulcer	501	
	456	1
	119919	1



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++ The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.
\# This outcome has been risk adjusted. However, the predictive model for this outcome is less robust than the other predictive models.
Note: When a measure value is calculated using less than 10 Episodes of care, the statistical significance level will not be displayed on the report.

This sample report is for illustrative purposes only.

This report has not been approved to meet privacy requirements and can only be used by the home health agency and state agency for defined purposes.

Sample Report 4: Potentially Avoidable Event Report: Patient Listing

Potentially Avoidable Event Report: Patient Listing

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999
Medicaid Number: 00000000

Requested Current Period: 10/2015 - 12/2015
Actual Current Period: 10/2015 - 12/2015
Number of Cases in Current Period: 678
Number of Cases in Reference Sample: 165610
Date Report Printed: 03/31/2016

Emergent Care for Injury Caused by Fall

Complete Data Cases: 665 | Number of Events: 6 | Agency Incidence: 0.90% | Adjusted Reference Incidence: 1.72%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
2378	#1	Patient	F	05/16/1950	08/15/2015	11/30/2015	001/001
1256	#2	Patient	F	01/15/1929	09/10/2015	10/10/2015	001/001
9011	#3	Patient	M	05/16/1944	06/15/2015	11/12/2015	002/002
1417	#4	Patient	M	08/22/1939	08/30/2015	10/22/2015	003/003
2022	#5	Patient	F	09/10/1922	07/22/2015	12/31/2015	002/002
2526	#6	Patient	M	06/23/1922	08/01/2015	10/10/2015	001/001

Emergent Care for Wound Infections, Deteriorating Wound Status

Complete Data Cases: 665 | Number of Events: 7 | Agency Incidence: 1.05% | Adjusted Reference Incidence: 1.16%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
2378	#1	Patient	F	05/16/1950	08/15/2015	11/30/2015	001/001
1256	#2	Patient	F	01/15/1929	09/10/2015	10/10/2015	001/001
9011	#3	Patient	M	05/16/1944	06/15/2015	11/12/2015	002/002
1417	#4	Patient	M	08/22/1939	08/30/2015	10/22/2015	003/003
2022	#5	Patient	F	09/10/1922	07/22/2015	12/31/2015	002/002
2526	#6	Patient	M	06/23/1922	08/01/2015	10/10/2015	001/001
2930	#7	Patient	F	07/4/1925	09/30/2015	11/15/2015	004/004

Emergent Care for Improper Medication Administration, Medication Side Effects

Complete Data Cases: 665 | Number of Events: 0 | Agency Incidence: 0.00% | Adjusted Reference Incidence: 0.29%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
No Patient							

Emergent Care for Hypo/Hyperglycemia

Complete Data Cases: 665 | Number of Events: 1 | Agency Incidence: 0.15% | Adjusted Reference Incidence: 0.34%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
9011	#3	Patient	M	05/16/1944	06/15/2015	11/12/2015	002/002

This report contains confidential information to be used only by the Home Health Agency and State Agency and is not be shared with any other individuals, in accordance with 42 CFR 484.11.
Condition of Participation: Release of patient identifiable info.

This sample report is for illustrative purposes only.

Potentially Avoidable Event Report: Patient Listing

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999
Medicaid Number: 00000000

Requested Current Period: 10/2015 - 12/2015
Actual Current Period: 10/2015 - 12/2015
Number of Cases in Current Period: 678
Number of Cases in Reference Sample: 165610
Date Report Printed: 03/31/2016

Development of Urinary Tract Infection

Complete Data Cases: 443 Number of Events: 4 Agency Incidence: 0.90% Adjusted Reference Incidence: 1.45%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
1256	#2	Patient	F	01/15/1929	09/10/2015	10/10/2015	**001**/001
1417	#4	Patient	M	08/22/1939	08/30/2015	10/22/2015	**003**/003
2526	#6	Patient	M	06/23/1922	08/1/2015	10/10/2015	**001**/001
2930	#7	Patient	F	07/04/1925	09/30/2015	11/15/2015	**004**/004

Increase in Number of Pressure Ulcers

Complete Data Cases: 501 Number of Events: 5 Agency Incidence: 1.00% Adjusted Reference Incidence: 0.54%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
1256	#2	Patient	F	01/15/1929	09/10/2015	10/10/2015	**001**/001
1417	#4	Patient	M	08/22/1939	08/30/2015	10/22/2015	**003**/003
2526	#6	Patient	M	06/26/1922	08/01/2015	10/12/2015	**001**/001
2930	#7	Patient	F	07/04/1925	09/30/2015	11/15/2015	**004**/004
3334	#8	Patient	M	02/11/1919	04/12/2015	12/10/2015	**001**/001

Substantial Decline in 3 or More Activities of Daily Living

Complete Data Cases: 486 Number of Events: 2 Agency Incidence: 0.41% Adjusted Reference Incidence: 0.33%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
1526	#2	Patient	F	01/15/1929	09/10/2015	10/10/2015	**001**/001
1417	#4	Patient	M	08/22/1939	08/30/2015	10/22/2015	**003**/003

Substantial Decline in Management of Oral Medications

Complete Data Cases: 9 Number of Events: 0 Agency Incidence: 0.000% Adjusted Reference Incidence: 1.14%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
No Patient							

Discharged to the Community Needing Wound Care or Medication Assistance

Complete Data Cases: 501 Number of Events: 0 Agency Incidence: 0.00% Adjusted Reference Incidence: 0.06%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
No Patient							

Potentially Avoidable Event Report: Patient Listing

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999
Medicaid Number: 0000

Requested Current Period: 10/2015 - 12/2015
Actual Current Period: 10/2015 - 12/2015
Number of Cases in Current Period: 678
Number of Cases in Reference Sample: 165610
Date Report Printed: 03/31/2016

Discharged to the Community Needing Toileting Assistance

Complete Data Cases: 501 Number of Events: 0 Agency Incidence: 0.00% !!!!!!!Adjusted Reference Incidence: 0.04%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
No Patient							

Discharged to the Community with Behavioral Problems

Complete Data Cases: 501 Number of Events: 2 Agency Incidence: 0.40% Adjusted Reference Incidence: 0.09%

Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
3334	#8	Patient	M	02/11/1919	04/12/2015	12/10/2015	**001**/001
3738	#9	Patient	M	04/30/1942	01/15/2013	11/30/2015	**002**/002

Discharged to the Community with an Unhealed Stage II Pressure Ulcer

Completed Data Cases: 501 Number of Events: 2 Agency Incidence: 0.40% Adjusted Reference Incidence: 0.41%

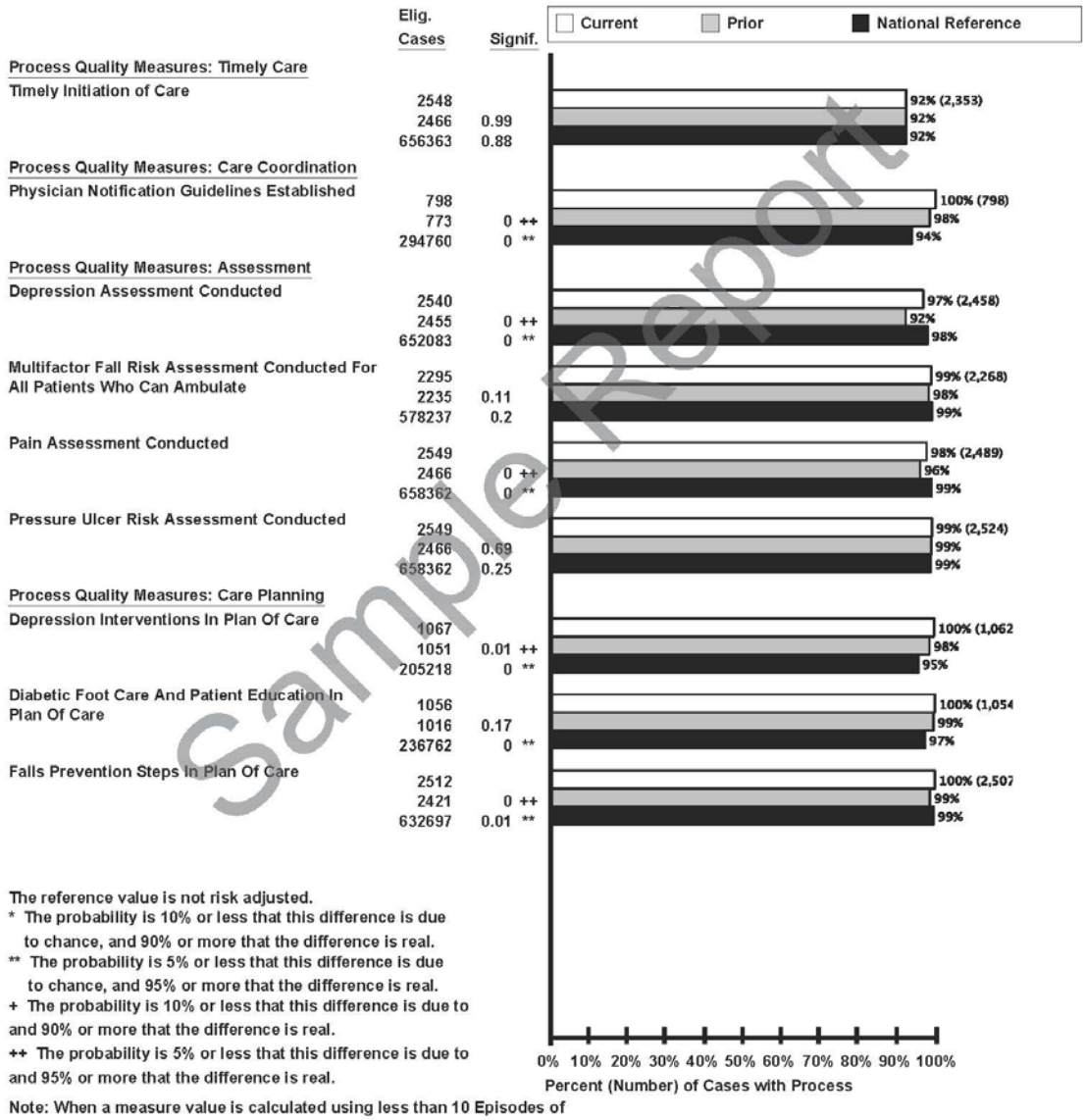
Patient ID	Last Name	First Name	Gender	Birth Date	SOC/ROC	DC/TRANSFER	SOC/EOC Branch ID
1256	#2	Patient	F	01/15/1929	09/10/2015	10/10/2015	**001**/001
1417	#4	Patient	M	08/22/1939	08/30/2015	10/22/2015	**003**/003

Sample Report 5: All Patients' Process Quality Measures Report

All Patients' Process Quality Measures Report

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999 **Branch:** All
Medicaid Number: 00000000
Date Report Printed: 03/31/2016

Requested Current Period: 01/2015 - 12/2015
Requested Prior Period: 01/2014 - 12/2014
Actual Current Period: 01/2015 - 12/2015
Actual Prior Period: 01/2014 - 12/2014
 # Cases: Curr 2549 **Prior** 2466
Number of Cases in Reference Sample: 658362



The reference value is not risk adjusted.
* The probability is 10% or less that this difference is due to chance, and 90% or more that the difference is real.
** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is real.
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Note: When a measure value is calculated using less than 10 Episodes of the statistical significance level will not be displayed on the report.

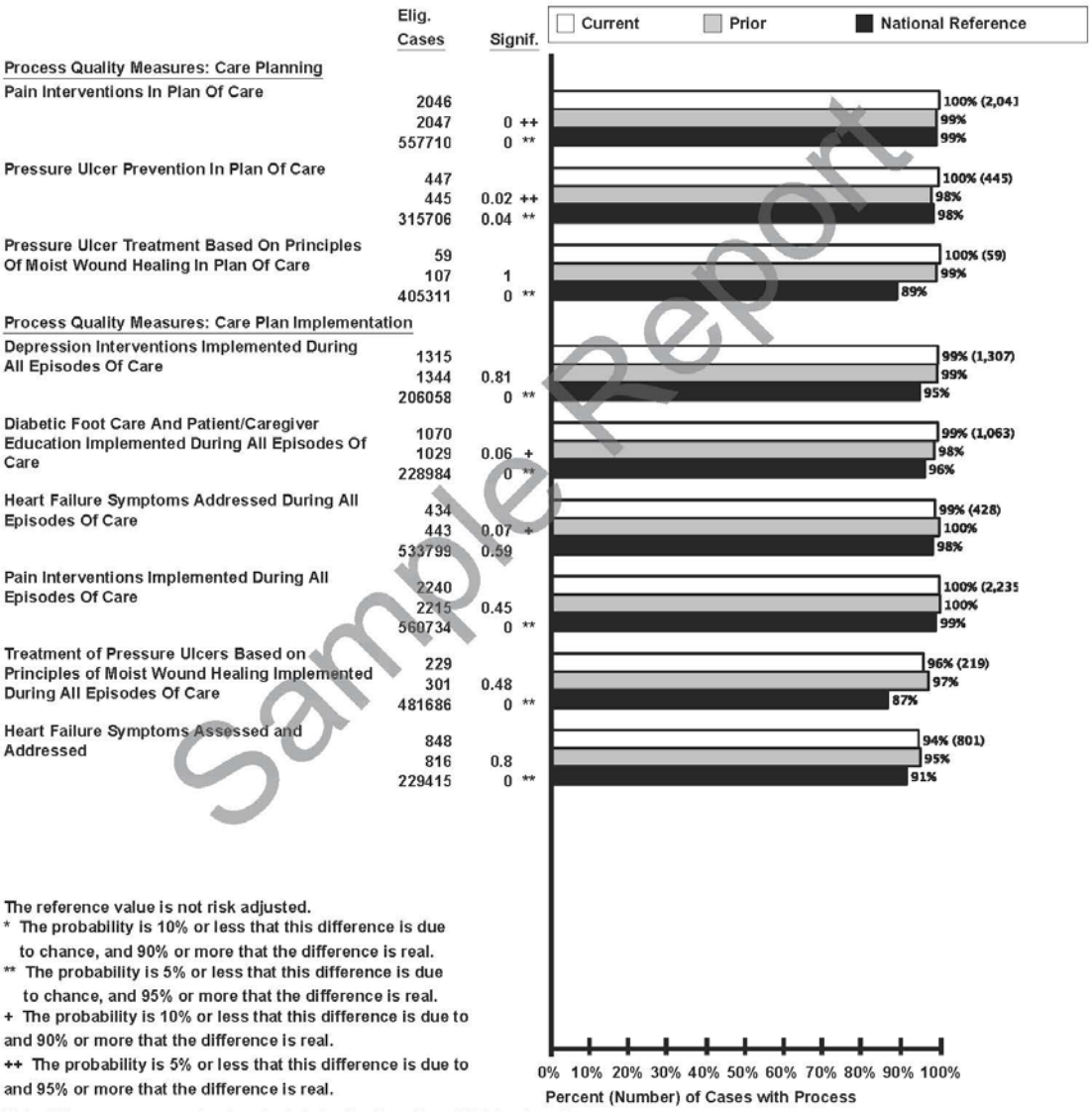
This report has not been approved to meet privacy requirements and can only be used by home health agency and state agency for defined purposes.

This sample report is for illustrative purposes only.

All Patients' Process Quality Measures Report

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State
CCN: 999999 **Branch:** All
Medicaid Number: 00000000
Date Report Printed: 03/31/2016

Requested Current Period: 01/2015 - 12/2015
Requested Prior Period: 01/2014 - 12/2014
Actual Current Period: 01/2015 - 12/2015
Actual Prior Period: 01/2014 - 12/2014
 # Cases: Curr 2549 **Prior** 2466
Number of Cases in Reference Sample: 658362



	Elig. Cases	Signif.	Current	Prior	National Reference
Process Quality Measures: Care Planning					
Pain Interventions In Plan Of Care	2046				100% (2,041)
	2047	0 ++			99%
	557710	0 **			99%
Pressure Ulcer Prevention In Plan Of Care	447				100% (445)
	445	0.02 ++			98%
	315706	0.04 **			98%
Pressure Ulcer Treatment Based On Principles Of Moist Wound Healing In Plan Of Care	59				100% (59)
	107	1			99%
	405311	0 **			89%
Process Quality Measures: Care Plan Implementation					
Depression Interventions Implemented During All Episodes Of Care	1315				99% (1,307)
	1344	0.81			99%
	206058	0 **			95%
Diabetic Foot Care And Patient/Caregiver Education Implemented During All Episodes Of Care	1070				99% (1,063)
	1029	0.06 +			98%
	228984	0 **			96%
Heart Failure Symptoms Addressed During All Episodes Of Care	434				99% (428)
	443	0.07 +			100%
	533799	0.59			98%
Pain Interventions Implemented During All Episodes Of Care	2240				100% (2,235)
	2215	0.45			100%
	560734	0 **			99%
Treatment of Pressure Ulcers Based on Principles of Moist Wound Healing Implemented During All Episodes Of Care	229				96% (219)
	301	0.48			97%
	481686	0 **			87%
Heart Failure Symptoms Assessed and Addressed	848				94% (801)
	816	0.8			95%
	229415	0 **			91%

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Note: When a measure value is calculated using less than 10 Episodes of the statistical significance level will not be displayed on the report.

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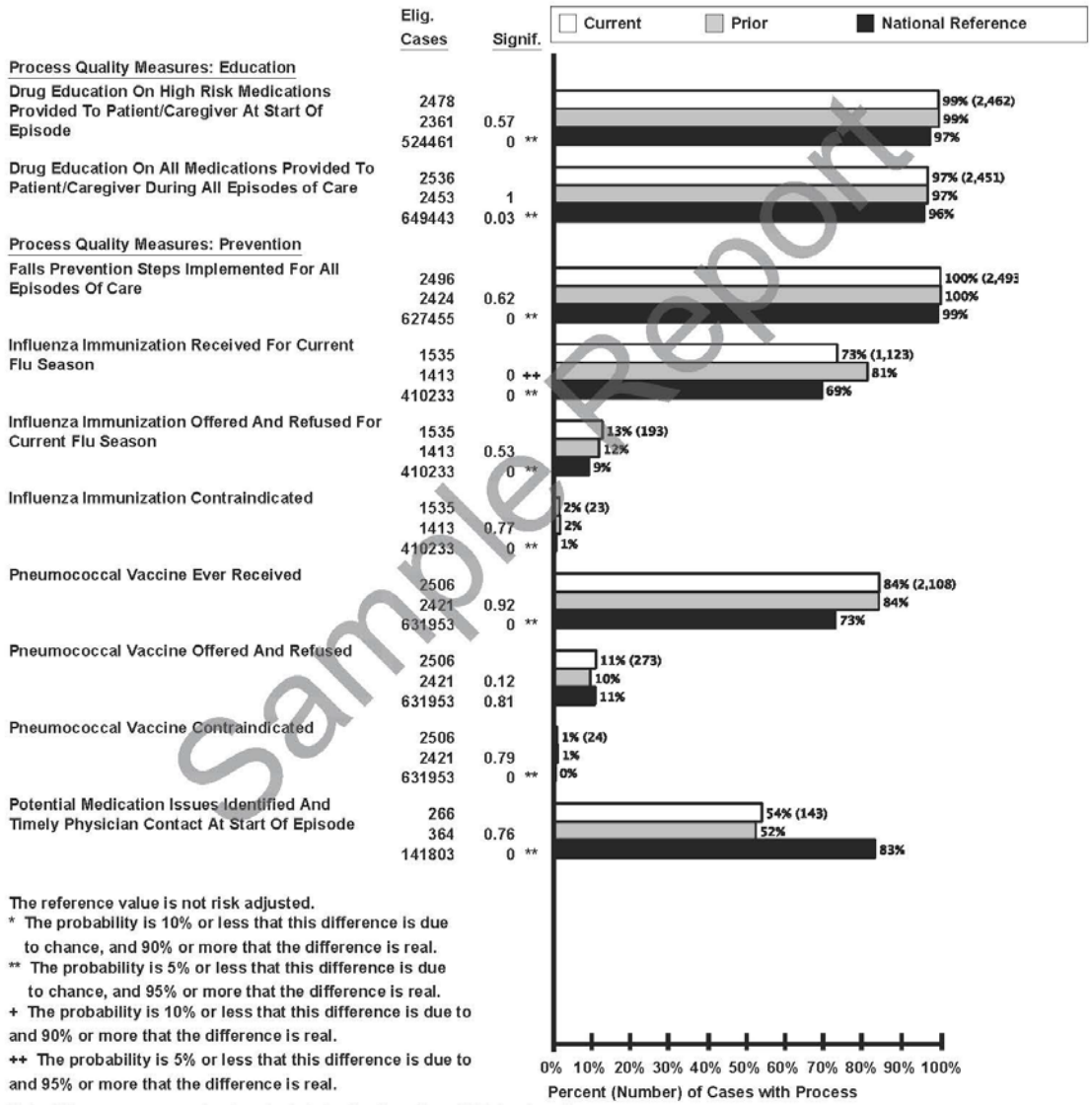
This sample report is for illustrative purposes only.

All Patients' Process Quality Measures Report

Agency Name:
Agency ID:
Location:
CCN: Branch: All
Medicaid Number:
Date Report Printed:

Requested Current Period: 01/2015 - 12/2015
Requested Prior Period: 01/2014 - 12/2014
Actual Current Period: 01/2015 - 12/2015
Actual Prior Period: 01/2014 - 12/2014
Cases: Curr 2549 Prior 2466
Number of Cases in Reference Sample: 658362



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Note: When a measure value is calculated using less than 10 Episodes of the statistical significance level will not be displayed on the report.

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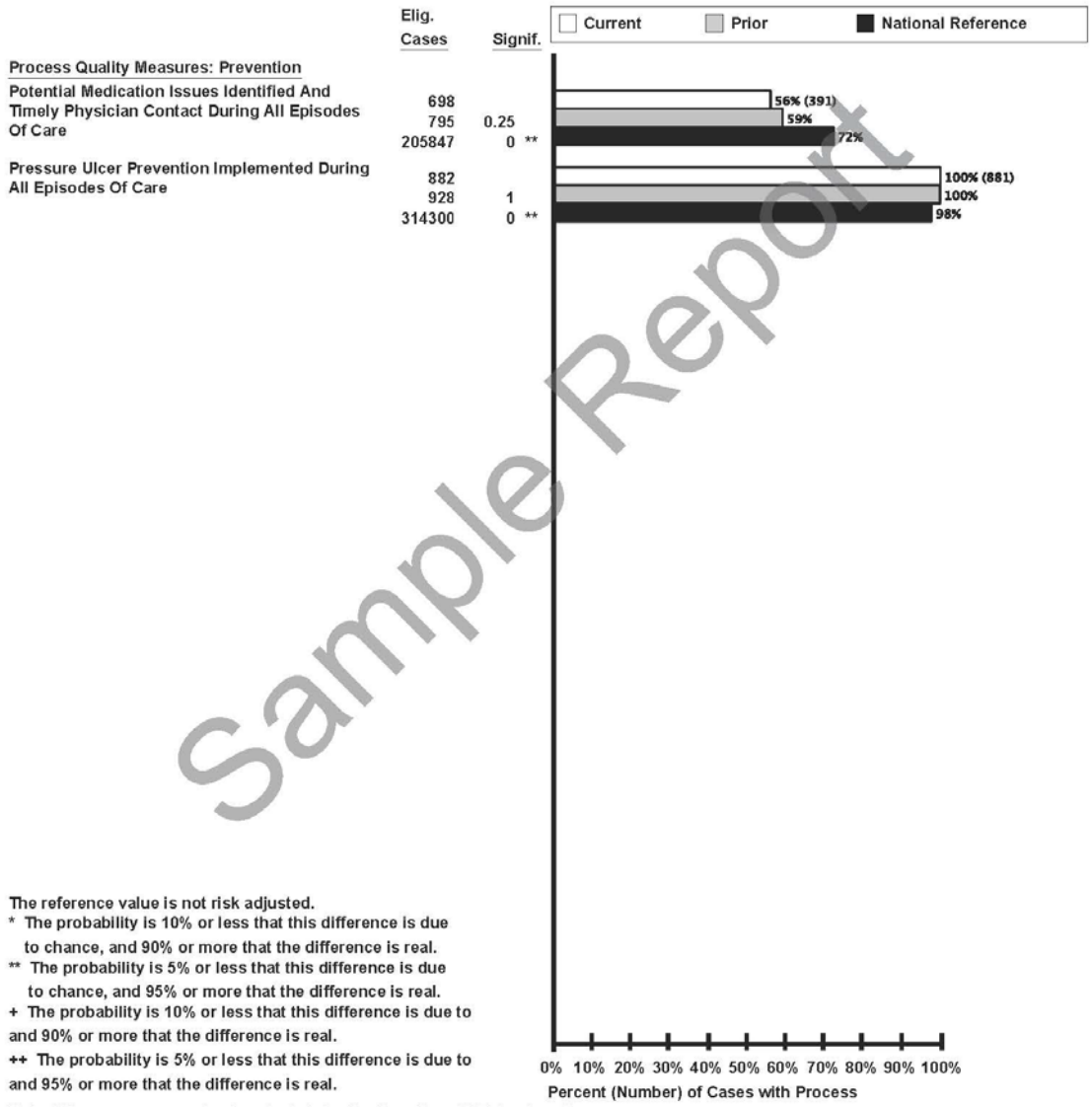
This sample report is for illustrative purposes only.

All Patients' Process Quality Measures Report

Agency Name:
Agency ID:
Location:
CCN: Branch: All
Medicaid Number:
Date Report Printed:

Requested Current Period: 01/2015 - 12/2015
Requested Prior Period: 01/2014 - 12/2014
Actual Current Period: 01/2015 - 12/2015
Actual Prior Period: 01/2014 - 12/2014
Cases: Curr 2549 Prior 2466
Number of Cases in Reference Sample: 658362



The reference value is not risk adjusted.
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Note: When a measure value is calculated using less than 10 Episodes of the statistical significance level will not be displayed on the report.

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Sample Report 6: Outcome Tally Report

This sample report contains only page 1 of the report.

Outcome Tally Report

Page 1 of 31 - A

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State

CCN: 999999
Medicaid Number: 00000000
Date Reported: 03/31/2016

Report Period: 10/2015 - 12/2015

Functional Outcomes

Legend:
x = Patient achieved outcome
o = Patient did not achieve outcome
U = Outcome not computed for patient
y = Yes n = No

Patient Name	SOC/ROC Date	SOC/EOC Branch ID	Activities of Daily Living: Improvement in Grooming	Stabilization in Grooming	Improvement in Upper Body Dressing	Improvement in Lower Body Dressing	Improvement in Bathing	Stabilization in Bathing	Improvement in Toilet Transferring	Stabilization in Toilet Transferring	Improvement in Toileting Hygiene	Stabilization in Toileting Hygiene	Improvement in Bed Transferring	Stabilization in Bed Transferring	Improvement in Ambulation/Locomotion	Improvement in Eating	IADLs: Improvement in Light Meal	Stabilization in Light Meal Preparation	Improvement in Phone Use	Stabilization in Phone Use	Improvement in Management of Oral Medications	Stabilization in Management of Oral Medications
#1. Patient	08/15/2015	001/001	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	U	U	x	x	x
#2, Patient	09/10/2015	001/001	x	x	x	x	x	x	o	x	x	x	x	x	x	U	x	U	x	x	x	U
#3, Patient	06/15/2015	002/002	o	x	o	o	o	x	o	x	o	x	o	x	o	o	o	x	o	x	o	o
#4, Patient	08/30/2015	003/003	x	U	x	o	x	U	o	U	o	U	o	o	o	o	o	U	x	x	x	U
#5, Patient	07/22/2015	002/002	o	o	o	o	o	x	o	x	o	o	o	x	o	o	o	x	o	x	o	x
#6, Patient	08/01/2015	001/001	x	x	x	o	o	x	x	x	x	x	x	x	o	U	x	U	U	U	U	U
#7,Patient	09/30/2015	004/004	x	x	x	o	x	x	x	x	x	x	o	o	x	U	U	U	U	U	U	U
#8, Patient	04/12/2015	001/001	x	x	x	x	x	x	o	x	x	x	x	x	x	U	x	x	x	x	x	x
#9, Patient	01/15/2013	002/002	U	x	x	x	x	x	U	x	U	x	U	x	x	U	x	U	U	x	x	x
#10, Patient	09/15/2015	002/002	x	x	x	x	x	x	x	x	x	x	x	x	x	U	x	x	U	x	x	x
#11,Patient	10/12/2014	001/001	x	x	x	x	x	x	x	x	x	x	x	x	x	U	x	U	U	x	x	U
#12, Patient	05/15/2015	004/004	x	x	x	o	x	x	x	x	x	x	x	x	x	x	x	U	x	x	o	x
#13,Patient	08/16/2015	002/002	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
#14, Patient	06/29/2014	001/004	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
#15,Patient	01/04/2015	003/003	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
#16, Patient	06/29/2015	002/002	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
#17, Patient	10/12/2015	001/001	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U
#18, Patient	07/19/2015	004/004	U	x	U	U	x	x	U	x	U	x	x	x	x	U	o	x	U	x	x	x
#19, Patient	11/15/2015	003/003	x	x	x	o	x	x	x	x	x	x	o	x	x	U	o	x	x	x	x	x
#20, Patient	11/22/2015	003/003	o	x	x	x	x	x	x	x	o	x	x	x	x	U	x	U	o	x	x	U
#21, Patient	12/02/2015	003/001	U	x	x	o	o	x	x	x	x	x	o	x	x	o	o	U	o	x	o	U
#22, Patient	11/26/2015	001/001	o	x	x	x	x	x	x	x	x	x	x	x	x	U	x	U	x	x	x	U

This report contains confidential information to be used only by the Home Health Agency and State Agency and is not to be shared with any other individuals, in accordance with 42 CFR 484.11 Condition of Participation: Release of patient identifiable info. This sample report is for illustrative purposes only.

Sample Report 7: Process Tally Report

CASPER Report
HHA Process Measures Tally Report

This sample report contains only page 1 of the report.

Agency Name: No Name Home Health Agency
Agency ID: 0000
Location: City, State

CCN: 999999
Medicaid Number: 00000000
Report Date: 03/31/2016

Report Period: 10/2015 - 12/2015

			Process Quality Measures																		
			Timely Care	Care Coord-ination	Assessment				Care Planning						Care Plan Implementation						
Legend: SOE = Start Of Episode POC = Plan Of Care SOC = Start Of Care ROC = Resumption Of Care EOC = Episodes Of Care x = Triggered o = Not triggered U = No Data Collected For This Item Patient Name	SOC/ROC Date	SOC/EOC Branch ID	Timely Initiation Of Care	Physician Notification Guidelines Established	Depression Assessment Conducted	Multifactor Fall Risk Assessment Conducted For All Patients Who Can Ambulate	Pain Assessment Conducted	Pressure Ulcer Risk Assessment Conducted	Depression Interventions In POC	Diabetic Foot Care And Patient Education In POC	Falls Prevention Steps In POC	Pain Interventions In POC	Pressure Ulcer Prevention In POC	Pressure Ulcer Treatment Based On Principles Of Moist Wound Healing In POC	Depression Interventions Implemented During All EOC	Diabetic Foot Care And Patient/Caregiver Education Implemented During All EOC	Heart Failure Symptoms Addressed During All Episodes Of Care	Pain Interventions Implemented During All Episodes Of Care	Treatment Of Pressure Ulcers Based On Principles Of Moist Wound Healing For All EOC	Heart Failure Symptoms Assessed And Addressed
#1, Patient	08/15/2015	001/001	x	U	x	x	x	x	U	U	x	x	U	U	U	U	U	x	U	U
#2, Patient	09/10/2015	001/001	x	U	x	x	x	x	U	U	x	U	U	U	U	U	x	x	U	x
#3, Patient	06/15/2015	002/002	x	U	x	U	x	x	U	U	x	x	x	U	x	U	U	x	U	x
#4, Patient	08/30/2015	003/003	x	U	o	U	x	x	U	U	x	x	U	U	U	U	U	x	U	U
#5, Patient	07/22/2015	002/002	x	U	x	x	x	x	U	x	x	U	U	U	U	x	U	U	U	o
#6, Patient	08/01/2015	001/001	x	U	x	x	x	x	U	x	x	x	U	U	U	x	U	U	U	x
#7, Patient	09/30/2015	004/004	x	x	x	x	x	x	U	x	x	x	U	U	U	U	U	x	U	U
#8, Patient	04/12/2015	001/001	o	U	o	o	o	o	U	x	x	x	U	U	U	x	U	x	U	x
#9, Patient	01/15/2013	002/002	x	x	x	x	x	x	U	x	x	x	U	U	U	x	U	x	U	U
#10, Patient	09/15/2015	002/002	x	U	x	x	x	x	U	x	x	x	U	U	U	x	U	x	U	U
#11, Patient	10/12/2014	001/001	x	x	x	x	x	x	x	x	x	x	U	U	x	x	U	x	U	U
#12, Patient	05/15/2015	004/004	x	U	x	x	x	x	x	U	x	U	U	U	x	U	U	x	U	U

This report contains confidential information to be used only by the Home Health Agency and State Agency and is not to be shared with any other individuals, in accordance with 42 CFR 484.11 Condition of Participation: Release of Patient identifiable info. This sample report is for illustrative purposes only.

Table G.1 presents an overview of changes made to the OASIS items and Guidance Manual for the transition from OASIS-C1/ICD-10 to OASIS-C2. The table columns and headings are explained below.

1. **OASIS-C1/ICD-10 item number**: Item number in the OASIS-C1/ICD-10.
2. **OASIS-C2 item number**: Item number in the OASIS-C2.
3. **Item Description**: A brief description of the item.
4. **Item Change**: Provides an at a glance categorization of the changes in 7 categories explained below.
    - Convert response spaces to box(es) – if the item response entry format has changed from lines to boxes, or from multiple check boxes to a single box for response entry, "X" will appear in this column
    - Item text – if the item text is changed, "X" will appear in this column
    - Item number – If the item number is changed, "X" will appear in this column. If item text, response options or guidance is significantly changed, a new number will be assigned to the item in OASIS-C2.
    - Response option(s) – if the text for the response option(s) is changed, "X" will appear in this column
    - New Item/IMPACT Act Item – if a new item is added to satisfy requirements of the IMPACT Act of 2014, "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 Directions - 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 4 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.
    - 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-C1/ICD-10 to OASIS-C2

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M0010	M0010	CMS Certification Number	X	-	-	-	-	-	-	-	-	-	-	-
M0014	M0014	Branch State	X	-	-	-	-	-	-	-	-	-	-	-
M0016	M0016	Branch ID Number	X	-	-	-	-	-	-	-	-	-	-	-
M0018	M0018	National Provider Identifier (NPI) physician who signed plan of care	X	-	-	-	-	-	-	-	-	-	-	-
M0020	M0020	Patient ID Number	X	-	-	-	-	-	-	-	-	-	-	-
M0030	M0030	Start of Care Date	X	-	-	-	-	-	-	-	-	-	X	-
M0032	M0032	Resumption of Care Date	X	-	-	-	-	-	-	-	-	-	X	-
M0040	M0040	Patient Name	X	-	-	-	-	-	-	-	-	-	-	-
M0050	M0050	Patient State of Residence	X	-	-	-	-	-	-	-	-	-	-	-
M0060	M0060	Patient Zip Code	X	-	-	-	-	-	-	-	-	-	-	-
M0063	M0063	Medicare Number	X	-	-	-	-	-	-	-	-	-	-	-
M0064	M0064	Social Security Number	X	-	-	-	-	-	-	-	-	-	-	-
M0065	M0065	Medicaid Number	X	-	-	-	-	-	-	-	-	-	-	-
M0066	M0066	Birth Date	X	-	-	-	-	-	-	-	-	-	X	-
M0069	M0069	Gender	X	-	-	-	-	-	-	-	-	-	-	X
M0080	M0080	Discipline of Person Completing Assessment	X	-	-	-	-	-	-	-	-	-	-	-
M0090	M0090	Date Assessment Completed	X	-	-	-	-	-	-	-	-	-	X	-
M0100	M0100	This Assessment is Currently Being Completed for the Following Reason:	X	-	-	-	-	-	-	-	-	-	-	-

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M0102	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.	X	-	-	-	-	-	-	-	-	-	X	-
M0104	M0104	Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.	X	-	-	-	-	-	-	-	-	-	X	-
M0110	M0110	Episode Timing	X	-	-	-	-	-	-	-	-	-	X	-
M0140	M0140	Race/Ethnicity	-	-	-	-	-	-	-	-	-	-	-	-
M0150	M0150	Current Payment Sources for Home Care	-	-	-	-	-	-	-	-	-	-	-	-
M0903	M0903	Date of Last (Most Recent) Home Visit	X	-	-	-	-	-	-	-	X	-	X	-
M0906	M0906	Discharge/Transfer/Death Date	X	-	-	-	-	-	-	-	-	-	-	-
M1000	M1000	From which of the following Inpatient Facilities was the patient discharged within the past 14 days? (Mark all that apply.)	-	-	-	-	-	-	-	-	-	-	X	-
M1005	M1005	Inpatient Discharge Date (most recent)	X	-	-	-	-	-	-	-	-	-	X	-
M1011	M1011	List each Inpatient Diagnosis and ICD-10-C M code at the level of highest specificity for only those conditions actively treated during an inpatient stay within the last 14 days	X	-	-	-	-	-	-	-	-	-	X	-

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M1017	M1017	Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days	X	-	-	-	-	-	-	-	-	-	X	-
M1018	M1018	Conditions Prior to Regimen Change or Inpatient Stay Within Past 14 Days	-	-	-	-	-	-	-	-	-	-	X	-
M1021	M1021	Primary Diagnosis & Degree of Symptom Control	X	-	-	-	-	-	-	-	-	-	X	-
M1023	M1023	Other Diagnoses & Degree of Symptom Control	X	-	-	-	-	-	-	-	-	-	X	-
M1025	M1025	Optional Diagnoses (OPTIONAL) (not used for payment)	X	-	-	-	-	-	-	-	-	-	X	-
-	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.	-	-	-	-	X	X	-	-	New guidance content and format for new item.			
M1030	M1030	Therapies the patient receives at home	-	-	-	-	-	-	-	-	-	-	-	-
M1033	M1033	Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)	-	-	-	-	-	-	-	-	-	-	-	-
M1034	M1034	Overall Status	X	-	-	-	-	-	-	-	-	-	X	--
M1036	M1036	Risk Factors	-	-	-	-	-	-	-	-	-	-	-	-

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M1041	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?	X	-	-	-	-	-	-	-	-	-	-	-
M1046	M1046	Influenza Vaccine Received: did the patient receive the influenza vaccine for this year's flu season?	X	-	-	-	-	-	-	-	-	-	X	-
M1051	M1051	Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, Pneumovax)?	X	-	-	-	-	-	-	-	-	-	X	-
M1056	M1056	Reason PPV not received: If patient has never received the pneumococcal vaccination (for example, Pneumovax), state reason.	X	-	-	-	-	-	-	-	-	-	X	-
-	M1060	Height and Weight – While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up	-	-	-	-	X	X	-	-	-	-	-	-
M1100	M1100	Patient Living Situation Which of the following best describes the patient's residential circumstance and availability of assistance? (Check one box only.)	-	-	-	-	-	-	-	-	-	-	X	-
M1200	M1200	Vision (with corrective lenses if the patient usually wears them)	X	-	-	-	-	-	-	-	-	-	X	-
M1210	M1210	Ability to Hear (with hearing aid or hearing appliance if normally used):	X	-	-	-	-	-	-	-	-	-		-

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M1220	M1220	Understanding of Verbal Content in patient's own language (with hearing aid or device if used):	X	-	-	-	-	-	-	-	-	-	-	-
M1230	M1230	Speech and Oral (Verbal) Expression of Language (in patient's own language):	X	-	-	-	-	-	-	-	-	-	-	-
M1240	M1240	Has this patient had a formal Pain Assessment using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?	X	-	-	-	-	-	-	-	-	-	X	-
M1242	M1242	Frequency of Pain Interfering with patient's activity or movement:	X	-	-	-	-	-	-	-	-	-	-	-
M1300	M1300	Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?	X	-	-	-	-	-	-	-	-	-	-	X
M1302	M1302	Does this patient have a Risk of Developing Pressure Ulcers	X	-	-	-	-	-	-	-	-	-	-	X
M1306	M1306	Does this patient have at least one Unhealed Pressure Ulcer at Stage 2 or Higher or designated as "unstageable"? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)	X	X	-	-	-	-	-	Changed Roman numerals to Arabic numerals	X	-	X	-
M1307	M1307	The Oldest Non-epithelialized Stage 2 Pressure Ulcer that is present at discharge (Excludes healed Stage 2 pressure ulcers)	X	X	-	X	-	-	-	Changed Roman numerals to Arabic numerals	-	-	X	X

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M1308	M1311	Current Number of Unhealed Pressure Ulcers at Each Stage	X	X	X	X	-	-	X	Changed Roman numerals to Arabic numerals; response options relabeled for clarity; each response has two parts (except for SOC/ROC)	-	-	X	-
M1309	M1313	Worsening in Pressure Ulcer Status since SOC/ROC: Indicate the number of current pressure ulcers that were not present or were at a lesser stage at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.	X	X	X	X	X	X	-	Item description clarified; Changed Roman numerals to Arabic numerals; added responses for all types unstageable ulcers	-	-	X	-

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M1320	M1320	Status of Most Problematic Pressure Ulcer that is Observable	X	-	-	-	-	-	-		-	-	X	X
M1322	M1322	Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.	X	X	-	-	-	-	-	Sentence added to description to address dark skin tones; Changed Roman numerals to Arabic numerals	-	-	X	X
M1324	M1324	Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable	X	-	-	X	-	-	-	Changed Roman numerals to Arabic numerals for ulcer stages	-	-	X	-
M1330	M1330	Does this patient have a Stasis Ulcer?	X	-	-	-	-	-	-	-	-	-	-	-
M1332	M1332	Current Number of (Observable) Stasis Ulcer(s)	X	-	-	-	-	-	-	-	-	-	-	-
M1334	M1334	Status of Most Problematic Stasis Ulcer that is Observable	X	-	-	-	-	-	-	-	-	-	-	-
M1340	M1340	Does this patient have a Surgical Wound?	X	-	-	-	-	-	-	-	-	-	X	-
M1342	M1342	Status of Most Problematic Surgical Wound that is Observable	X	-	-	-	-	-	-	-	-	-	X	-

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M1350	M1350	Does this patient have a Skin Lesion or Open Wound (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency?	X	-	-	-	-	-	-	-	X	-	-	-
M1400	M1400	When is the patient dyspneic or noticeably Short of Breath?	X	-	-	-	-	-	-	-	-	-	-	-
M1410	M1410	Respiratory Treatments utilized at home: (Mark all that apply.)	-	-	-	-	-	-	-	-	-	-	-	-
M1500	M1501	Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the most recent SOC/ROC assessment?	X	X	X	-	-	-	X	Change wording in the item from "previous OASIS assessment" to "most recent SOC/ROC assessment"	-	-	X	-
M1510	M1511	Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? (Mark all that apply.)	-	X	X	-	-	-	-	Change wording in the item from "previous OASIS assessment" to "most recent SOC/ROC assessment"	-	-	-	-
M1600	M1600	Has this patient been treated for a Urinary Tract Infection in the past 14 days?	X	-	-	-	-		-	-	-	-	X	-

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M1610	M1610	Urinary Incontinence or Urinary Catheter Presence	X	-	-	-	-		-	-	-	-	-	-
M1615	M1615	When does Urinary Incontinence occur?	X	-	-	-	-		-	-	-	-	-	-
M1620	M1620	Bowel Incontinence Frequency	X	-	-	-	-		-	-	-	-	-	-
M1630	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?	X	-	-	-	-	-	-	-	-	-	X	-
M1700	M1700	Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.	X	-	-	-	-	-	-	-	-	-	X	-
M1710	M1710	When Confused (Reported or Observed Within the Last 14 Days)	X	-	-	-	-	-	-	-	-	-	X	-
M1720	M1720	When Anxious (Reported or Observed Within the Last 14 Days)	X	-	-	-	-	-	-	-	-	-	X	-
M1730	M1730	Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool?	X	-	-	-	-	-	-	-	-	-	-	-
M1740	M1740	Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)	-	-	-	-	-	-	-	-	-	-	X	-

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M1745	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.	X	-	-	-	-	-	-	-	-	-	X	-
M1750	M1750	Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?	X	-	-	-	-	-	-	-	-	-	-	-
M1800	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).	X	-	-	-	-	-	-	-	-	-	-	-
M1810	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:	X	-	-	-	-	-	-	-	-	-	-	-
M1820	M1820	Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:	X	-	-	-	-	-	-	-	-	-	X	-
M1830	M1830	Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).	X	-	-	-	-	-	-	-	-	-	-	-

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M1840	M1840	Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.	X	-	-	-	-	-	-	-	-	-	X	-
M1845	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.	X	-	-	-	-	-	-	-	-	-	-	-
M1850	M1850	Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.	X	-	-	-	-	-	-	-	-	-	-	-
M1860	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.	X	-	-	-	-	-	-	-	-	-	-	-
M1870	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.	X	-	-	-	-	-	-	-	-	-	-	-
M1880	M1880	Current Ability to Plan and Prepare Light Meals (for example, cereal, sandwich) or reheat delivered meals safely:	X	-	-	-	-	-	-	-	-	-	-	-

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M1890	M1890	Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.	X	-	-	-	-	-	-	-	-	-	-	-
M1900	M1900	Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury.	X	-	-	-	-	-	-	Format of response options are changed, but text is the same	-	-	X	-
M1910	M1910	Has this patient had a multi-factor Falls Risk Assessment using a standardized, validated assessment tool?	X	-	-	-	-	-	-	-	-	-	-	-
M2000	M2001	Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?	X	X	X	X	X	X	-	Examples taken out of item stem; Not assessed/not reviewed is no longer an option for response; slight changes to wording in response options – "problems" to "issues"; response N/A is now response 9 – N/A.	X	-	X	-

Item Information			Item Change Guidance Change							Change Description	Guidance Manual Change			
OASIS-C1/ ICD-10 Item #	OASIS-C2 Item #	Item Description	Converted response spaces to box(es)	Item text	Item number	Response option(s)	New item/ Impact Act Item	(-) dash is a valid response	Skip Directions	Change(s)	Item intent	Time Point Collected	Response Specific instructions	Data sources and resources
M2002	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?	-	-	-	-	-	-	-	Within one calendar day clarified as by midnight of the next calendar day; all issues are labeled “potential clinically significant medication issues” for consistency; contact physician AND complete interventions required	X	-	X	-

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M2004	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?	-	-	-	-	-	-	-	Contact physician AND complete interventions; each time issues identified; in one calendar day changed to by midnight of next calendar day; since previous OASIS changed to since the SOC/ROC; includes response for patient not taking medications	X	X	X	-
M2010	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?	X	-	-	-	-	-	-	-	-	-	-	-

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M2015	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?	X	X	X	-	-	-	-	Change wording in the item from “previous OASIS assessment” to “most recent SOC/ROC assessment”	-	-	X	-
M2020	M2020	Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)	X	-	-	-	-	-	-	-	-	-	X	-
M2030	M2030	Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.	X	-	-	-	-	-	-	-	-	-	X	-

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M2040	M2040	Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation or injury.	X	X	-	-	-	-	-	Response options reformatted but text has not changed	-	-	X	-
M2102	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.	X	X	-	-	-	-	-	Response options reformatted but text has not changed	-	-	X	-
M2110	M2110	How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?	X	-	-	-	-	-	-	-	-	-	-	-
M2200	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.)	X	-	-	-	-	-	-	-	-	-	X	-
M2250	M2250	Plan of Care Synopsis: (Check only one box in each row.) Does the physician-ordered plan of care include the following:	-	-	-	-	-	-	-	-	-	-	-	-

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M2300	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)?	X	X	X	-	-	-	X	Change wording in the stem from "previous OASIS assessment" to "most recent SOC/ROC assessment"	-	-	X	-
M2310	M2310	Reason for Emergent Care: For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)?	-	-	-	-	-	-	-	-	-	-	X	-

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M2400	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?	-	X	X	X	-	-	-	Change wording in the stem from "previous OASIS assessment" to "most recent SOC/ROC assessment"; Change wording in NA response column for rows b, c, d, & e from "last OASIS assessment" to "most recent SOC/ROC assessment"	-	-	-	-
M2410	M2410	To which Inpatient Facility has the patient been admitted?	X	-	-	-	-	-	-	-	-	-	-	-
M2420	M2420	Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.)	X	-	-	-	-	-	-	-	-	-	-	-

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M2430	M2430	Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)	-	-	-	-	-	-	-	-	-	-	-	-
-	GG 0170C	Mobility – Lying to sitting on side of bed: Admission performance and discharge goal	-	-	-	-	X	X	-	-	New guidance content and format for new item.			