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

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(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-M1033, M1060-M1306, M1311-M2003, M2010, M2020-M2200, GG0100-GG0170
Start of care—further visits planned	
Resumption of Care ----------	M0032, M0080-M0110, M1000-M1033, M1060-M1306, M1311-M2003, M2010, M2020-M2200, GG0100-GG0170
Resumption of care (after inpatient stay)	
Follow-Up ----------	M0080-M0100, M0110, M1021- M1023, M1030-M1033, M1200-M1306, M1311-M1400, M1610-M1630, M1800-M1840, M1850-M1860, M2030, M2200, GG0130-GG0170
Recertification (follow-up) assessment Other follow-up assessment	
Transfer to an Inpatient Facility----------	M0080-M0100, M1041-M1056, M2005, M2016, M2301-M2410, M0906, J1800-J1900
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, M0906, J1800-J1900
Discharge from agency----------	M0080-M0100, M1041-M1056, M1242-M1311, M1324-M1330, M1334-M1600, M1620, M1700-M1720, M1740-M1870, M2005, M2016-M2020, M2102, M2301-M2420, M0906, GG0130-J1900

CLINICAL RECORD ITEMS

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

(M0090) Date Assessment Completed:

☐☐ / ☐☐ / ☐☐☐☐
month day year

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

CLINICAL RECORD ITEMS, continued

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

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

☐ NA - No specific SOC date ordered by physician

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

☐☐ / ☐☐ / ☐☐☐☐
month day year

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

PATIENT HISTORY AND DIAGNOSES

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

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

(M1005) Inpatient Discharge Date (most recent):

☐☐ / ☐☐ / ☐☐☐☐
month day year

☐ UK - Unknown

PATIENT HISTORY AND DIAGNOSES, continued

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

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

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

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

Rate the degree of symptom control for the condition listed in Column 1. Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code. Choose one value that represents the degree of symptom control appropriate for each diagnosis using the following scale:

0 - Asymptomatic, no treatment needed at this time
1 - Symptoms well controlled with current therapy
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
4 - Symptoms poorly controlled; history of re-hospitalizations

Note that the rating for symptom control in Column 2 should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide.

(Form on next page)

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

(M1028) Active Diagnoses- Comorbidities and Co-existing Conditions – Check all that apply

See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

- ☐ 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- ☐ 2 - Diabetes Mellitus (DM)
- ☐ 3 - None of the above

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

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

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

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

(M1041) Influenza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

Enter Code ☐

0 No ***[Go to M1051]***
1 Yes

(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?

Enter Code ☐

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

(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?

Enter Code ☐

0 No
1 Yes **[*Go to M2005 at TRN; Go to M1242 at DC*]**

(M1056) Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:

Enter Code ☐

1 Offered and declined
2 Assessed and determined to have medical contraindication(s)
3 Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine
4 None of the above

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

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

LIVING ARRANGEMENTS

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

	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.

(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 at SOC/ROC/FU; Go to M1324 at DC*]** 1 Yes
(M1307) The **Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers)	
Enter Code ☐	1 Was present at the most recent SOC/ROC assessment 2 Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: ☐☐ / ☐☐ / ☐☐☐☐ month day year NA No Stage 2 pressure ulcers are present at discharge

SOC/ROC/FU

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with 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/injuries due to non-removable dressing/device**	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury**	☐

INTEGUMENTARY STATUS, continued

Discharge

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with 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, Stage 3]*** **A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** ***[If 0 - Go to M1311C1, Stage 4]*** **B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** ***[If 0 - Go to M1311D1, Unstageable: Non-removable dressing/device]*** **C2. Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** ***[If 0 - Go to M1311E1, Unstageable: Slough and/or eschar]*** **D2. Number of <u>these</u> unstageable pressure ulcers/injuries that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** ***[If 0 - Go to M1311F1, Unstageable: Deep tissue injury]*** **E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury** ***[If 0 - Go to M1324]*** **F2. Number of <u>these</u> unstageable pressure 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 Injuries: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Enter Code ☐

0
1
2
3
4 or more

(M1324) Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable: (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)

Enter Code ☐

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

(M1330) Does this patient have a **Stasis Ulcer**?

Enter Code ☐

0 No **[*Go to M1340*]**
1 Yes, patient has BOTH observable and unobservable stasis ulcers
2 Yes, patient has observable stasis ulcers ONLY
3 Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) **[*Go to M1340*]**

(M1332) 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*]**

ELIMINATION STATUS

(M1600) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

Enter Code ☐

0 No
1 Yes
NA Patient on prophylactic treatment
UK Unknown **[*Omit "UK" option on DC*]**

(M1610) Urinary Incontinence or Urinary Catheter Presence:

Enter Code ☐

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

(M1620) Bowel Incontinence Frequency:

Enter Code ☐

0 Very rarely or never has bowel incontinence
1 Less than once weekly
2 One to three times weekly
3 Four to six times weekly
4 On a daily basis

	5	More often than once daily
	NA	Patient has ostomy for bowel elimination
	UK	Unknown **[*Omit "UK" option on FU, DC*]**
(M1630)	**Ostomy for Bowel Elimination:** Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; 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

ADL/IADLs

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

ADL/IADLs, continued

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

ADL/IADLs, continued

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.	
Enter Code ☐	0 Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device). 1 With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. 2 Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 3 Able to walk only with the supervision or assistance of another person at all times. 4 Chairfast, unable to ambulate but is able to wheel self independently. 5 Chairfast, unable to ambulate and is unable to wheel self. 6 Bedfast, unable to ambulate or be up in a chair.
(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.	
Enter Code ☐	0 Able to independently feed self. 1 Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet. 2 Unable to feed self and must be assisted or supervised throughout the meal/snack. 3 Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. 4 Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. 5 Unable to take in nutrients orally or by tube feeding.
(M1910) Has this patient had a multi-factor **Falls Risk Assessment** using a standardized, validated assessment tool?	
Enter Code ☐	0 No. 1 Yes, and it does not indicate a risk for falls. 2 Yes, and it does indicate a risk for falls.

MEDICATIONS

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?	
Enter Code ☐	0 No - No issues found during review **[*Go to M2010*]** 1 Yes - Issues found during review 9 NA - Patient is not taking any medications **[*Go to M2102*]**
(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?	
Enter Code ☐	0 No 1 Yes
(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.

CARE MANAGEMENT

SOC/ROC

(M2102)	**Types and Sources of Assistance:** Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

Discharge

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

THERAPY NEED AND PLAN OF CARE

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

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

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

EMERGENT CARE

(M2301)	**Emergent Care:** At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?	
Enter Code ☐	0	No **[*Go to M2401*]**
	1	Yes, used hospital emergency department WITHOUT hospital admission
	2	Yes, used hospital emergency department WITH hospital admission
	UK	Unknown **[*Go to M2401*]**

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

- ☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 19 - Other than above reasons
- ☐ UK - Reason unknown

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

(M2401) Intervention Synopsis: (Check only **one** box in each row.) At the time of or at any time since the most recent SOC/ROC assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐ 0	☐ 1	☐ NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
b. Falls prevention interventions	☐ 0	☐ 1	☐ NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐ 0	☐ 1	☐ NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	☐ 0	☐ 1	☐ NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	☐ 0	☐ 1	☐ NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	☐ 0	☐ 1	☐ NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

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

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

☐☐ / ☐☐ / ☐☐☐☐
month day year

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

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

Coding:
3. Independent – Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. Needed Some Help – Patient needed partial assistance from another person to complete activities.
1. Dependent – A helper completed the activities for the patient.
8. Unknown
9. Not Applicable

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

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

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

Section GG: Self-Care

SOC/ROC

GG0130. Self-Care
Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).
Coding: **Safety** and **Quality of Performance –** If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 1. **Independent** – Patient completes the activity by him/herself with no assistance from a helper. 1. **Setup or clean-up assistance –** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity. 1. **Supervision or touching assistance –** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 1. **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. 1. **Substantial/maximal assistance –** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 1. **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:** 2. **Patient refused** 1. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury. 2. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 1. **Not attempted due to medical conditions or safety concerns**

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

GG0130. Self-Care	
Code the patient's usual performance at Follow-Up for each activity using the 6-point scale. If activity was not attempted at Follow-Up, code the reason.	
Coding: **Safety** and **Quality of Performance –** If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 1. **Independent** – Patient completes the activity by him/herself with no assistance from a helper. 1. **Setup or clean-up assistance –** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity. 1. **Supervision or touching assistance –** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 1. **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. 1. **Substantial/maximal assistance –** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 1. **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:** 1. **Patient refused** 1. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury. 2. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 88. **Not attempted due to medical conditions or safety concerns**	
4. Follow-Up Performance	
↓ Enter Codes in Boxes	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy,include wiping the opening but not managing equipment.

Discharge

GG0130. Self-Care	
Code the patient's usual performance at Discharge for each activity using the 6-point scale. If activity was not attempted at Discharge, code the reason.	
Coding: **Safety** and **Quality of Performance –** If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 6. **Independent** – Patient completes the activity by him/herself with no assistance from a helper. 5. **Setup or clean-up assistance –** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity. 2. **Supervision or touching assistance –** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 2. **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. 2. **Substantial/maximal assistance –** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 1. **Dependent –** Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. **If activity was not attempted, code reason:** 07. **Patient refused** 09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury. 1. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 1. **Not attempted due to medical conditions or safety concerns**	
3. Discharge Performance	
↓ Enter Codes in Boxes	
	A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal placed before the patient.
	B. Oral Hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
	C. Toileting Hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy,include wiping the opening but not managing equipment.
	A. Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
	B. Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.
	C. Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear.
	D. Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Section GG: Mobility

GG0170. Mobility

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

Coding:

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

Activities may be completed with or without assistive devices.

1. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
1. **Setup or clean-up assistance –** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
1. **Supervision or touching assistance –** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
1. **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.
1. **Substantial/maximal assistance –** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **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:

1. **Patient refused**
1. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
1. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
1. **Not attempted due to medical conditions or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet tranfer:** The ability to get on and off a toilet or commode.
☐☐	☐☐	**G. Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	☐☐	**A. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88 →skip to GG0170M, 1 step (curb)*
☐☐	☐☐	**B. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	☐☐	**C. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐☐	☐☐	**D. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	**E. 1 step (curb):** The ability to go up and down a curb and/or up and down one step .
☐☐	☐☐	**F. 4 steps:** The ability to go up and down four steps with or without a rail.
☐☐	☐☐	**G. 12 steps:** The ability to go and down 12 steps with or without a rail.
☐☐	☐☐	**H. Picking up object**: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	☐	**Q. Does patient use wheelchair/scooter?** **0. No → [*Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS*].** **1. Yes → [*Continue to GG0170R, Wheel 50 feet with two turns*].**

		R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.	
			RR1. Indicate the type of wheelchair or scooter used. **1. Manual** 2. **Motorized**
		S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.	
			SS1. Indicate the type of wheelchair or scooter used. 1. **Manual** 2. **Motorized**

Follow-Up

GG0170. Mobility

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

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

Activities may be completed with or without assistive devices.

1. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
1. **Setup or clean-up assistance –** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
1. **Supervision or touching assistance –** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
1. **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.
1. **Substantial/maximal assistance –** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **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:

1. **Patient refused**
1. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
1. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
1. **Not attempted due to medical conditions or safety concerns**

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

		Q. Does patient use wheelchair/scooter? **0. No → *[Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS].*** **1. Yes → *[Continue to GG0170R, Wheel 50 feet with two turns].***
		R. **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

Discharge

GG0170. Mobility

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

Coding:

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

Activities may be completed with or without assistive devices.

1. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
1. **Setup or clean-up assistance –** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
1. **Supervision or touching assistance –** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
1. **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.
1. **Substantial/maximal assistance –** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
1. **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:

1. **Patient refused**
1. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
2. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

3. Discharge Performance	
↓ Enter Codes in Boxes	
	A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
	B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
	C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
	D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
	E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
	F. Toilet tranfer: The ability to get on and off a toilet or commode.
	G. Car Transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
	I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. ***[If discharge performance is coded 07, 09, 10 or 88 →skip to GG0170M, 1 step (curb)].***
	J. Walk 50 feet with two turns: Once standing, the ability to walk 50 feet and make two turns.
	K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.
	L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
	M. 1 step (curb): The ability to go up and down a curb and/or up and down one step .
	N. 4 steps: The ability to go up and down four steps with or without a rail.

	O. 12 steps: The ability to go and down 12 steps with or without a rail.
	P. Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	Q. Does patient use wheelchair/scooter? **0. No →** ***[Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS].*** **1. Yes →** ***[Continue to GG0170R, Wheel 50 feet with two turns].***
	R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	RR3. Indicate the type of wheelchair or scooter used. **1.Manual** **2.Motorized**
	S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	SS3. Indicate the type of wheelchair or scooter used. **1.Manual** **2.Motorized**

Section J: Health Conditions

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

J1900. Number of Falls Since SOC/ROC, whichever is more recent		
CODING: 1. None 2. One 3. Two or more	↓ **Enter Codes in Boxes**	
		A. No injury: No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
		B. Injury (except major): Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
		C. Major injury: Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma