



OASIS-C

Background & History of OASIS-C



Learning Objectives

At the conclusion of this lesson, you will be able to:

- Describe the rationale for revisions to the existing OASIS B1 instrument
- Identify the timeline/steps taken by CMS to develop OASIS-C
- Describe the findings of CMS OASIS-C testing



What is OASIS?

- Outcome and Assessment Information Set
- A set of data items designed to enable systematic comparative measurement of home health care patient outcomes at two points in time
- Includes items used for:
 - Risk-adjusted comparisons over time and
 - National benchmarking data



Initiation of OASIS Data Collection

In 1999, Medicare-certified HHAs began collecting and submitting OASIS data related to all adult (18 years or older) non-maternity patients receiving skilled services with Medicare or Medicaid as a payer source



Purpose of OASIS

- OASIS data are used for multiple purposes
 - Guidance to surveyors
 - Payment algorithms
 - Publicly Reported Quality Measures (HH Compare)
- CMS has provided these reports to HHAs to help guide quality/performance improvement efforts
 - Risk-adjusted outcome reports (OBQI)
 - Potentially avoidable event (adverse event outcomes) reports (OBQM)
 - Agency/patient related characteristics (agency case mix) reports
 - Patient tally reports



OASIS Evolution

- The OASIS items have been revised several times since 1999 to address the burden of data collection, refine items for payment algorithms, and enhance outcome reporting
- Hundreds of comments have been submitted from the industry, providers, professional organizations and researchers in the 10 years since OASIS was initiated



OASIS Evolution (cont.)

- Since 1999, health care quality experts have made recommendations for framing and expanding national quality measurement efforts. These recommendations, along with work occurring in two CMS-funded demonstration projects, set the stage for OASIS revisions
- The next 3 slides provide a timeline of important events that have led up to the OASIS-C revisions



Timeline of Events Leading to OASIS Revisions₁

- 2001 – Institute of Medicine (IOM) identified 6 aims for health care quality improvement (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity)
- 2003 – Home Health Compare launched
- 2005 – National Quality Forum (NQF) endorsed the initial set of home health quality measures for public reporting and recommended future changes to the measures



Timeline of Events Leading to OASIS Revisions₂

- 2006 – Medicare Payment Advisory Commission (MedPAC) Report to Congress included recommendations for expanding home health quality measures to:
 - A. Broaden the patient population covered by the OASIS
 - B. Capture safety as an aspect of quality
 - C. Capture an aspect of care directly under providers' influence
 - D. Reduce variation in practice



Timeline of Events Leading to OASIS Revisions₃

- 2006 - CMS funded the development of the CARE instrument as part of the Medicare Post-Acute Care Payment Reform Initiative
- 2007 – CMS funded the Home Health Pay for Performance Demonstration
- 2008 – NQF developed a new set of guidelines/frameworks for measures and priorities



OASIS Revisions

- Based on these events, CMS began a large-scale effort to revise OASIS for three reasons:
 - A. To address issues raised by the HHA provider community for specific OASIS items
 - B. To address suggestions made by MedPAC and NQF, including the measurement of selected processes of care to supplement the measurement of outcomes, and
 - C. To align OASIS measures and items with other instruments being developed to measure care across post-acute care settings (i.e., the nursing home Minimum Data Set [MDS] and the Continuity Assessment Record Evaluation [CARE])



Examples of Harmonization

- Coordination of care across settings
- Post-acute CARE demo (PAC-PRD)
- The National Quality Forum (NQF) developed harmonization of influenza and pneumonia immunization assessment items
- NQF also working to develop a framework for measuring pressure ulcers across provider settings





OASIS-C

OASIS-C Development & Testing



Development of OASIS–C

- From the first version of OASIS, CMS anticipated that the data set would evolve in response to scientific advances, population trends, payment changes, and other industry and system needs
- To oversee the evolution of OASIS, CMS convened a series of TEPs to recommend potential revisions, based provider comments along with recommendations from MedPAC and National Quality Forum (NQF)



Draft OASIS-C

- A draft version of OASIS-C was developed and tested for inter-rater reliability and burden estimates in 11 HHAs in three States: Ohio, Massachusetts and Colorado
- The instrument was extensively revised based on both quantitative findings and provider feedback, then posted by the Office of Management and Budget (OMB) for public comment
- During that time, a set of 55 new or refined outcome and process measures that could be calculated from OASIS-C items was submitted to the National Quality Forum (NQF) for endorsement
- OASIS-C items were further revised based on the public comments to the OMB notice and feedback obtained during the NQF endorsement process



OASIS-C Changes

Major areas:

- Elimination of existing items not used for payment, quality or risk adjustment
- Addition of new items to support process measures (e.g., screening for depression)
- Revisions to existing items (e.g., changes to scales, rewording for clarity or harmonization)



OASIS–C Field Testing

May – September 2008



Purpose of Field Testing

- Time analysis
- Inter-rater reliability
- Determine which items needed revision



Field Testing₁

- 11 agencies from three states
- Purposely selected to represent various agency sizes, types and locations
- Used both electronic data collection and paper-based OASIS instruments
- Encouraged to select patients with conditions targeted by OASIS-C process items; e.g., diabetes, heart failure and pressure ulcers.



Field Testing₂

- 68 RNs and PTs participated in data collection
- 370 OASIS-C assessments conducted on 183 patients
- 177 full OASIS-C assessments used for time analysis



Time Required for OASIS-C₁

- SOC/ROC ranged from 20 to 125 minutes, with a mean of 49.61 minutes.
- Recertification ranged from 10 to 75 minutes, with a mean of 33.45 minutes.
- Transfer ranged from 2 to 40 minutes, with a mean of 17.44 minutes.
- Discharge ranged from 8 to 80 minutes, with a mean of 26.31 minutes.





Time Required for OASIS-C₂

- OASIS-C times similar to previous estimates for OASIS-B1
- Exception is Transfer when items have been added for calculation of process measures

Caveat: The field tested version was substantially longer than what was submitted to OMB in March 2009 and the final version approved.





Inter-Rater Reliability

- Clinician #1 did a follow up visit, completed OASIS-C for time analysis
- Clinician #2 went in the next day (at the most the second day) and collected just the OASIS-C items
- Purpose: compare how closely the items correspond



Reliability Test Results

- Agreement between raters ranged from slight to almost perfect
- For some items like flu vaccine, high prevalence of “NA” response or small sample made it difficult to draw conclusions regarding reliability
- Items that did not demonstrate good reliability were revised to improve clarity



Clinician Discussion Groups

- Met with clinicians who participated in the field test to get their feedback on the new items
- Received very helpful comments on item clarity, issues of burden and work flow
- Comments incorporated into OASIS-C revision process



OASIS-C

Public Comments to OMB Posting



Public Comments₁

- The staff of the Centers for Medicare & Medicaid Services (CMS) and the OASIS–C development team are pleased to have received so many comments from home care clinicians, agencies and organizations interested in the OASIS-C
- We received 142 responses, and each of them included comments on multiple topics and items



Public Comments₂

- Many expressed their support for proposed changes to the OASIS data set
- Others made numerous useful recommendations for modifications to improve the OASIS-C
- All of these suggestions were considered by CMS and in many cases they were incorporated into the revised OASIS-C



Public Comments₃

- Also voiced specific questions about the content, format and purpose of some of the new and revised items
- Expressed concerns about the impact of the OASIS-C on their practice and agency functioning
- In each instance we have attempted to address these comments, questions and concerns and hope that our responses provide clarity



Public Comment Examples₁

- We can see that CMS has put effort into improving many of the OASIS items and making them more practical for use with the home care patient to improve the delivery of home care*
- The OASIS–C should improve the data we collect, making it more specific with less room for inconsistencies*
- Some questions are consolidated and the wording of other questions is improved*

**Quotes from comments submitted from public review of Draft OASIS-C*



Public Comment Examples₂

- There are many changes and additions that will improve patient outcome and monitoring statistics. Overall the assessment appears to be more comprehensive in nature and provide better detail for outcomes analysis*
- While change will be challenging, the new questions have a clarity and patient-centered focus that will help to better serve patients in the home setting*

**Quotes from comments submitted from public review of Draft OASIS-C*



Public Comment Examples₃

- We appreciate CMS's response to industry input including the deletion of items not used for payment, quality, or risk adjustment*
- We especially thank you for eliminating the prior status column on the ADL/IADL questions which was not helpful and prone to misinformation*

**Quotes from comments submitted from public review of Draft OASIS-C*



Public Comment Examples₄

- We are particularly supportive of the re-definition of emergent care as a visit to the ER only. The decision to exclude all but emergency room visits in the Emergent Care item will provide more realistic data on the true incidence of emergent care. This is a more helpful and reflective of health care cost than the current OASIS-B interpretation*
- We are very pleased with the proposed expansion on the list of reasons for emergent care and hospitalization. These are much more specific responses and will be helpful for chart review and aggregate data. The expansion of the inpatient diagnoses is welcome for many patients have multiple co-morbidities that should be considered in the risk adjustment*

**Quotes from comments submitted from public review of Draft OASIS-C*



Public Comment Examples₅

- In general, the wound care questions are better phrased and the integumentary assessment has been greatly expanded and improved to include risk factors and measurements*
- Thanks for bringing the language up to date allow for a more descriptive portrayal of pressure ulcers*
- It is greatly appreciated by us that the question regarding the presence of a wound has been edited to specify wound that are receiving assessment and/or intervention*
- Being able to show that ulcers and surgical wounds have re-epithelialized is valuable*

**Quotes from comments submitted from public review of Draft OASIS-C*



Public Comment Examples₆

- The increased specificity in the functional limitations assessments is welcome*
- The word “safely” added to many of the functional domain questions is felt by us to go a long way to improve data ... so everyone understands it is the ability to perform safely, including getting in and out of the tub*
- Several items have modified wording or response categories to clarify and show progress. Change in response options for Ambulation/Locomotion should better reflect the more subtle changes that can occur during an episode of care. The new item better reflects the progress someone would make from a walker to a cane during an episode*
- Toileting: New answers make a lot more sense and the separation of toileting ability from hygiene ability is greatly supported*

**Quotes from comments submitted from public review of Draft OASIS-C*



Public Comment Examples₇

- Urinary incontinence: the new answers are more appropriate.*
- Frailty Indicators and Stability Prognosis (now Risk for Hospitalization and Overall Status): these are clearer and more comprehensive than previous questions. We appreciate having more options to define prognosis.*
- The separation of hearing and understanding is an improvement.*
- We like the proposed changes to the coding section.*

**Quotes from comments submitted from public review of draft OASIS-C.*



Public Comment Examples

- I believe that the new process questions are, for the most part, very appropriate quality indicators.*
- The incorporated clinical process measures that support evidence-based practice are vital as the industry treats a sicker, more complex patient population with numerous comorbidities.*
- We are pleased to see the inclusion of process measures that will highlight the critical role home health plays in areas such as diabetes care, congestive heart failure, falls risk assessment and other areas of critical concern to the Medicare and Medicaid programs and our nation's seniors.*
- We strongly support the added emphasis on depression in the Medicare home health patient population.*
- Risk of Developing Pressure Ulcers is a good addition to the assessment tool.*

**Quotes from comments submitted from public review of draft OASIS-C.*



OASIS-C

Post-Field Test Revisions



Post-Field Test Revisions

OASIS-C revisions were based on:

- Feedback from field testing
- Internal review to increase harmonization
- Input from National Quality Forum
- 60 day public comment period: Nov '08 – Jan '09
- Public comments received from over 140 individuals and organizations in response to OMB posting



Final Version of OASIS-C

- OASIS-C 12.2 was submitted to OMB March 9, 2009
- The instrument was minimally revised to correct identified problems (i.e. skip patterns, etc.) and the final version was approved by OMB on 7/27/09
- The OASIS-C Guidance Manual contains the OASIS-C data collection instruments for each time point



OASIS-C Timeline

- Where we are now:
 - Fall 2009:
 - Training of OASIS Education Coordinators/State
 - Train-the-Trainer and resource materials prepared for home health agencies (Medicare Learning Network)
 - Special Open Door Forum and/or National Provider Call
 - Jan 2010: Anticipated implementation date for OASIS-C
 - Dec 2010: Anticipated Process Measures for HH Compare/OBQI
 - June 2011: Anticipated Outcome Measures for HH Compare/OBQI



OASIS-C

Manual



OASIS Implementation Manual

- The OASIS Implementation Manual, originally developed in 1999, was intended to serve as a resource for HHAs implementing the new OASIS data collection requirements
- Many of the chapters of the OASIS Implementation Manual primarily were relevant only to new HHAs seeking Medicare certification
- While the manual has been revised several times over the past decade to reflect changes to the OASIS, the basic structure of the manual has not changed



OASIS Guidance Manual₁

- This revised manual, the OASIS Guidance Manual, is a consolidated version of the original manual that now contains content more relevant for HHAs experienced with OASIS requirements, with an emphasis on OASIS item guidance
- Selected content from the OASIS Implementation Manual has been incorporated into the appendices to provide additional context for OASIS data collection requirements
- Sections relevant to first-time implementation of OASIS data have been deleted



OASIS Guidance Manual₂

- In addition to streamlining the manual contents, the format of the manual has changed to facilitate future updates and to decrease burden for those who access OASIS guidance electronically
- Item-specific guidance is no longer contained in a single document, but has been divided into sections that can be accessed through individual links
- Thus, when accessing guidance for a specific OASIS item, the user can more easily locate the OASIS question, rather than scrolling through a large document



OASIS Guidance Manual Reference

All manual sections can be viewed online or printed

Data Sets:

http://www.cms.hhs.gov/HomeHealthQualityInits/12_HHQIOASISDataSet.asp#TopOfPage

Manual: by 9-21-09

http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPageby

All B1 to be archived in late December:

http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage



Questions?





OASIS BASICS

Foundational Concepts for Data Collection



Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify the common uses for OASIS data
- Identify the elements of the comprehensive assessment Condition of Participation and compliance with the CoP
- Describe tasks associated with comprehensive assessment
- Explain the value of the comprehensive assessment
- Describe the general OASIS- and ADL/IADL- specific conventions



Content

- What is OASIS?
- Why is it important?
- Which patients need OASIS data collection?
- How does it fit into the comprehensive & initial assessments?
- Who can collect the OASIS?
- When does OASIS get collected?
- OASIS items detail
 - What is it?
 - How are the items organized?
 - How are the responses organized?
 - What are the rules that must be followed?
 - Conventions
 - OASIS Item Time Periods
 - Guidance specific to ADLs/IADLs
- Where can I find more information?



What Is OASIS?

- Outcome and Assessment Information Set
- Data collection tool
- 114 items/questions used to collect patient-specific information
- Medicare/Medicaid data are submitted to the State



Why OASIS Is Important

- Data are used by CMS & agency to measure quality
 - Outcome Based Quality Improvement or OBQI
 - Outcome Based Quality Monitoring or OBQM/Adverse Events
 - Process Measure Reporting
- Data are used by CMS & other payers for payment
 - Prospective Payment System or PPS
 - Other payers payment models



Why OASIS Is Important (cont.)

- **Data are used for survey & audits**
 - State surveyors focus survey action based on agency level reports
 - Office of Inspector General & other auditors use data for potential error or fraud detection
- **Data are used by consumers**
 - Home Health Compare data helps patients decide which agency to select as their home care provider
- **Data are used by the agency**
 - Case Mix Report directs agency decisions about program development and quality improvement focus.
 - Patient outcomes direct quality initiatives; improve patient care
 - Agency's good outcomes can attract business and potential employees



Why OASIS Is Important (cont.)

- Data describes current health status and measures change over time
- Change over time = patient outcome
 - Example: End Result Outcome – Improvement in Bathing
 - The patient's ability to bathe at start of care compared to their ability to bathe at discharge.
- As an agency, how are our patients doing with bathing?
- What % of our patients improve in their ability to bathe?



OASIS Required Populations

- CMS requires OASIS data collection on skilled Medicare and Medicaid patients
 - Not pediatric, maternity, known one-visit or personal care patients UNLESS the payer needs the Home Health Resource Group (HHRG) for payment
- OASIS data collection on private pay patients is optional
 - Agency policy may require OASIS on private pay
- If private pay and Medicare/Medicaid
 - OASIS required

(CMS Q&As Cat 2 Q44 & Cat 1 Q2.1, Comprehensive Assessment Requirements for MC-Approved HHAs)



Comprehensive Assessment of Patients Regulation

- 484.55 Conditions of Participation: Comprehensive Assessment of Patients
- Published January 1999
- 5 Standards
 - (a) Initial assessment visit
 - (b) Completion of the comprehensive assessment
 - (c) Drug regimen review
 - (d) Update of the comprehensive assessment
 - (e) Incorporation of OASIS data items



Comprehensive Assessment

- Patient-specific assessment
- Reflects current health status & information that can be used to demonstrate progress toward goals
- Identify continuing need for home care
- Meet patient's medical, nursing, rehabilitative, social and DC planning needs
- For Medicare, verify eligibility & homebound
- Must incorporate current version of OASIS

(Conditions of Participation 484.55)



OASIS and the Comprehensive Assessment

- The Comprehensive Assessment includes:
 - OASIS Assessment Items
 - For the OASIS required patient population
 - The agency's core comprehensive assessment items
 - Varies from agency to agency
 - Examples: Immunization record, vital signs, medication profile, falls risk assessment
 - The agency's discipline specific assessment items
 - Varies from agency to agency and from discipline to discipline
 - Examples: In-depth assessments of gait/balance, swallowing, perceptual awareness and motor integration



Comprehensive Assessment

- Condition of Participation 484.55 Comprehensive Assessment of Patients
- Must be completed in timely manner
 - Consistent with patient's immediate needs
 - No later than 5 days after SOC
 - SOC = "day 0"
 - SOC = date of the first billable service
 - May **not** be completed **before** the SOC date
 - Does not have to be started or completed on the SOC date, but usually is

(CMS OASIS Q&As Cat 2 Q51 & Cat 4b Q23.1)



Comprehensive Assessment Patient Population Requirements

- Provide ALL patients with a **Comprehensive Assessment** except:
 - Clients receiving services entirely limited to housekeeping or chore services
 - OASIS will be a required part of the Comprehensive Assessment for *some* patients and not for others
 - Example: OASIS required for Medicare/Medicaid skilled patient but not for maternity patient (unless payer requires it for payment purposes)

(CMS Q&As Cat 2 Q44)



Who Completes the Comprehensive Assessment?

- At SOC, if nursing is ordered, the RN must complete the comprehensive assessment
- If no nursing orders exist, PT or SLP may complete the assessment on Medicare patients
- OT may complete it on non-Medicare patients at SOC, if payer allows.
- After SOC, any discipline may complete the subsequent assessments
- Agency policy may be more restrictive than the federal regulations
 - Example: Agency may require all comprehensive assessments be completed by RNs

(Conditions of Participation 484.55, CMS OASIS Q&As Cat 2 Q51)



Completing the Assessment

Must be completed by one clinician

- If two clinicians are seeing the patient at the same time,
 - Reasonable to confer about the interpretation of assessment data
 - May confer about plan of care interventions in order to answer Process Measure items
 - To be counted, assessment/screening must have been completed by clinician completing the assessment
 - Reasonable for the clinician performing the assessment to follow-up on any observations of patient status reported by other agency staff
- Clerical staff may enter demographic and agency ID items – assessing clinician must verify accuracy
- Assessment, however, is the responsibility of **one clinician – RN, PT, OT, or SLP**

(CMS OASIS Q&As Cat 2 Q52)



What's an Initial Assessment?

- Condition of Participation 484.55 Comprehensive Assessment of Patients
- First (*initial*) time patient is seen by agency staff
- Purpose is to determine immediate care and support needs of patient
 - What does this patient need?
 - Can our agency meet the patient's identified needs?
 - Should we admit this patient?
- If Medicare patient, determines eligibility for benefit and homebound status
- Must be conducted within 48 hours of referral or return home from inpatient facility or on physician ordered SOC date.

(Conditions of Participation 484.55)



Who Performs the Initial Assessment?

- If orders are present for skilled nursing at SOC, RN must conduct the initial assessment visit
- If therapy only
 - Appropriate therapy may perform initial assessment
 - OT may only complete assessment if need for OT establishes program eligibility
 - Not for Medicare
 - Possible for other payers



Initial versus Comprehensive Assessment

- Initial assessment begins to occur when the patient opens their door
 - Determines the patient's immediate care & support needs, if the patient meets both the agency's admission criteria and the payer's benefit requirements
- If time allows, the comprehensive assessment is completed during the same visit
- If unable to complete comprehensive assessment on the first visit,
 - e.g. very late at night & patient is exhausted,
- It must be completed within 5 days after the SOC, as long as the patient's immediate needs are met in a timely manner



When Does OASIS Get Collected?

- Time points regulated by the Conditions of Participation & OASIS data collection requirements

OASIS Reasons for Assessment or RFAs

- Start of Care (RFA 1)
- Resumption of Care (RFA 3)
- **Follow-up**
 - Recertification (RFA 4)
 - Other Follow-up (RFA 5)
- **Transfer to Inpatient Facility**
 - Not Discharged (RFA 6)
 - Discharged (RFA 7)
- **Discharge from Agency: Not to an Inpatient Facility**
 - Death at Home (RFA 8)
 - Discharge from Agency (RFA 9)



RFA 1 - Start of Care

- OASIS data items are part of the Start of Care comprehensive assessment
- Must be conducted during a home visit
- Completed within 5 days after SOC date
 - SOC date = Day 0

(CMS OASIS Q&As Cat 4b)



RFA 3 - Resumption of Care

- Following an inpatient stay of 24 hours or longer
- For reasons other than diagnostic tests
- Requires home visit
- Must be completed within 2 calendar days of patient's return home (or knowledge of the patient's return home)

(OASIS Assessment Reference Sheet)
(CMS Q&As Cat. 2 Q2)



RFA 4 - Recertification (Follow-up)

- Comprehensive assessment during the last five days of the 60-day certification period
- Requires a home visit
- If agency misses recert window, but still provides care
 - Do not discharge & readmit
 - **Make a visit** and complete Recertification assessment as soon as oversight identified
 - M0090 = the date the assessment
 - A warning message will result
 - Explain circumstances in clinical documentation

(CMS Q&As Cat 3 Q11)



RFA 5 - Other Follow-up

- Comprehensive assessment due to a major decline or improvement in patient condition
 - At time other than during last 5 days of the episode or when another OASIS assessment is due
 - Requires a home visit
 - Updates the patient's plan of care
 - Policies regarding trigger for RFA 5 must be determined by individual agencies

(CMS Q&As Cat 3 Q12)

- Must be completed within 2 calendar days of identification of major change in patient's condition
- Agency may call this a "SCIC" assessment
 - Significant Change in Condition
 - SCIC dropped from PPS in 2008

(OASIS Assessment Reference Sheet)



RFA 6 - Transfer to Inpatient Facility, (*Not Discharged*)

- All 3 criteria must be met:
 - Transferred and admitted to inpatient facility
 - Stay of 24 hours or longer (in the inpatient bed, not ER)
 - Reasons other than diagnostic tests
- Must be completed within 2 calendar days of Transfer date (M0906) or knowledge of transfer that meets criteria
- Agency's choice to place "on hold" (vs. D/C)
- Does not require a home visit
- If patient does not return to HHA after inpatient admission, no further assessment required
- This data collection triggers the Acute Care Hospitalization utilization outcome measure



RFA 6 - Transfer to Inpatient Facility, (*Not Discharged*)

- You make a routine visit and discover the patient had a qualifying stay in an inpatient facility and did not inform you
 - Within 2 calendar days of knowledge of transfer
 - Complete the RFA 6 – Transfer to Inpatient Facility
 - Then, complete the RFA 3 – Resumption of Care

(CMS OASIS Q&As Cat 4b)



RFA 7 - Transfer to Inpatient Facility, (Discharged from Agency)

- Same as RFA 6, but agency decides to discharge patient
 - May be close to end of 60-day episode and patient condition is such that return home during episode is highly unlikely



RFA 8 - Death at Home

- RFA 8 Death at Home = Death anywhere except:
 - Inpatient facility, or
 - The emergency department

(OASIS Assessment Reference Sheet)

- If patient dies in ER or in inpatient facility (before or after 24 hours)
 - NOT an RFA 8 Death at Home
 - Complete RFA 7 Transfer to Inpatient Facility
 - Usual requirements for RFA 7 waived
 - » Admission to an inpatient facility
 - » 24 hours or greater
 - » for reasons other than diagnostic testing (CMS Q&As Cat. 2 Q22)



RFA 8 – Death at Home (cont.)

- Must be completed within 2 calendar days of death date (M0906)
- Does not require a home visit



Discharge from Agency

- Not due to an inpatient facility admission
- Not due to death
- Must be completed within 2 calendar days of discharge date (M0906) or knowledge of discharge
- Visit is required to complete this assessment



Unexpected or Unplanned Discharge from Agency

- Examples
 - Patient sees physician and physician orders discharge from agency
 - Patient refuses further home care and won't allow final discharge visit
 - Patient moves unexpectedly



Unexpected or Unplanned Discharge from Agency (cont.)

- Requirements must be met
 - Discharge assessment must report patient status at an actual visit– *not on information gathered during a telephone call*
 - Assessment data should be based on the last visit conducted by a qualified clinician - RN, PT, OT, SLP
 - Don't include events that occurred after the last visit by a qualified clinician, e.g. ER visit, Foley DC

(CMS Q&As Cat 2 Q37[3] & Cat 4b)



OASIS Data Items

- Standardized items provide ability to measure outcomes and make comparisons across agencies.
- Tested to ensure validity and reliability
- Incorporated into the agency's comprehensive assessment
- Identified by a number beginning with "M"
 - OASIS-B1 called "M0" or "MO" items
 - OASIS-C "M items"
- Organized by domain



OASIS Item Domains

Patient Tracking Items	M0010 – M0069; M0140 – M0150
Clinical Record Items	M0080 – M0110
Patient History and Diagnoses	M1000s
Living Arrangements	M1100
Sensory Status	M1200s
Integumentary Status	M1300s
Respiratory Status	M1400s
Cardiac Status	M1500s
Elimination Status	M1600s
Neuro/Emotional/Behavioral Status	M1700s
ADLs/IADLs	M1800s + M1900s
Medications	M2000s
Care Management	M2100s
Therapy Need and Plan of Care	M2200s
Emergent Care	M2300s
Data Collected at Transfer/Discharge	M2400s, M0903+M0906



OASIS Item

(M1242) Frequency of Pain interfering with patient's activity or movement:

- 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 the time



OASIS Item Responses

- “0” Response **usually** represents the least impaired or most independent or optimal status or ability
 - Example: M1850 **Transferring**
0 = Able to independently transfer
- Response options **usually** progress to most impaired or dependent or least optimal status or ability
 - Example: M1850 **Transferring**
5 = Bedfast, unable to transfer and is
unable to turn and position self
- Some items require a simple Yes or No
 - Example: 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?
0 = No; 1= Yes



OASIS Item Responses

- NA means the item is not applicable to this patient
- M1890 Ability to Use Telephone
 - NA-Patient does not have a telephone
- M1620 Bowel Incontinence Frequency
 - NA-Patient has ostomy for bowel elimination
- M1320 Status of Most Problematic (Observable Pressure Ulcer)
 - NA-No observable pressure ulcer
- M1710 When Confused
 - NA-Patient nonresponsive



NA - Nonresponsive

- Nonresponsive has an OASIS specific definition
- Unresponsive means unconscious or unable to voluntarily respond or responds in a way that you can't make a clinical judgment about the patient's level of orientation
 - A patient with language or cognitive deficits are not automatically considered “unresponsive”
 - May respond by blinking eyes or raising finger
 - A refusal to answer questions is not = “unresponsive”
 - Complete comprehensive assessment and select correct responses based on observation and caregiver interview
 - Selection of NA-Nonresponsive for Confusion or Anxiety means the patient episode is not included in the OBQI report

(CMS OASIS Q&As Cat 4b)



Getting it Right

- You can't just read the M item and think you know what it means
- You must understand & follow the data collection rules
 - Chapter 3, OASIS-C Guidance Manual
 - Additional guidance provided through Q&As
 - CMS OASIS Q&As at www.qtso.com website
 - CMS OASIS OCCB Q&As at www.oasiscertificate.org website
 - The OASIS OCCB Q&As prior to 09/09 have been integrated into the 09/09 CMS OASIS Q&As



Rules & Guidance

OASIS Item Guidance	Cardiac Status
OASIS ITEM	
<p>(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?</p> <p> <input type="checkbox"/> 0 - No [<i>Go to M2004 at TRN; Go to M1600 at DC</i>] <input type="checkbox"/> 1 - Yes <input type="checkbox"/> 2 - Not assessed [<i>Go to M2004 at TRN; Go to M1600 at DC</i>] <input type="checkbox"/> NA - Patient does not have diagnosis of heart failure [<i>Go to M1732 at TRN; Go to M1600 at DC</i>] </p>	
ITEM INTENT	
<p>Identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of heart failure at the time of the most recent OASIS assessment or since that time.</p> <p>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.</p>	
TIME POINTS ITEM(S) COMPLETED	
<p>Transfer to inpatient facility Discharge from agency – not to inpatient facility</p>	
RESPONSE—SPECIFIC INSTRUCTIONS	
<ul style="list-style-type: none"> • Select only response options 0, 1, or 2 if the patient has a diagnosis of heart failure in any one or all of: <ul style="list-style-type: none"> – M1010: Inpatient Diagnoses, – M1016: Diagnoses Causing Change in Treatment, or – M01020/1022/1024: Primary/Secondary diagnoses for home care. • Select "NA" if the patient does not have a diagnosis of heart failure. • Consider any new or ongoing heart failure symptoms that occurred at the time of the previous OASIS assessment or since that time. 	
DATA SOURCES / RESOURCES	
<ul style="list-style-type: none"> • Review of clinical record including physical assessment data, weight trends, clinical notes using HHA systems put into place to accomplish such a review (e.g., flow sheets, reports from electronic health record data). • A complete list of symptoms of heart failure can be found in clinical heart failure guidelines in Chapter 5 of this manual. 	



Chapter 3 – Item-Specific Guidance

OASIS Item Guidance	Cardiac Status
OASIS ITEM	
<p>(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - No [<i>Go to M2004 at TRN; Go to M1600 at DC</i>] <input type="checkbox"/> 1 - Yes <input type="checkbox"/> 2 - Not assessed [<i>Go to M2004 at TRN; Go to M1600 at DC</i>] <input type="checkbox"/> NA - Patient does not have diagnosis of heart failure [<i>Go to M1732 at TRN; Go to M1600 at DC</i>] 	
ITEM INTENT	
<p>Identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of heart failure at the time of the most recent OASIS assessment or since that time.</p> <p>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.</p>	
TIME POINTS ITEM(S) COMPLETED	



Chapter 3 – Item-Specific Guidance (cont.)

TIME POINTS ITEM(S) COMPLETED
<p>Transfer to inpatient facility</p> <p>Discharge from agency – not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> • Select only response options 0, 1, or 2 if the patient has a diagnosis of heart failure in any one or all of: <ul style="list-style-type: none"> - M1010: Inpatient Diagnoses, - M1016: Diagnoses Causing Change in Treatment, or - M01020/1022/1024: Primary/Secondary diagnoses for home care. • Select “NA” if the patient does not have a diagnosis of heart failure. • Consider any new or ongoing heart failure symptoms that occurred at the time of the previous OASIS assessment or since that time.
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> • Review of clinical record including physical assessment data, weight trends, <u>clinical notes</u> using HHA systems put into place to accomplish such a review (e.g., flow sheets, reports from electronic health record data). • A complete list of symptoms of heart failure can be found in clinical heart failure guidelines in Chapter 5 of this manual.



General OASIS Conventions

- Located in Chapter 1 of the OASIS-C Guidance Manual
 - 15 conventions that apply generally across all items
 - 3 conventions that apply specifically to the ADL and IADL items
- Must be followed to standardize data collection and score accurately



General OASIS Conventions (cont.)

- 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
 - Each M item has a specific assessment time period
 - Most are “Day of Assessment”
 - Multiple other assessment time periods

(CMS Q&As Cat 4a)



M Item Assessment Time Periods

- **Day of assessment** = 24 hours preceding and including the assessment visit
- OASIS scoring is based on the patient's usual status, circumstance, or condition
- **Example:** M1400, Dyspnea

(CMS Q&As Cat 4a)



OASIS ITEM:

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 (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- 4 - At rest (during day or night)

Select response that reflects level of exertion that caused dyspnea during the 24 hours before you walked in the home and include dyspnea you observed while in the home



M Item Assessment Time Periods

- **Day of assessment** - Include a new therapy or service which will occur based on the current assessment
 - Example: Enteral nutrition will be initiated, psych nursing orders will be received, or antibiotics are ordered to treat a UTI, then the new therapy or service should be reported on the applicable OASIS item
 - The new therapy or service does not have to begin on the day of the assessment, as long as an order for the new service/treatment needs was obtained on the day of the assessment (or up to 5 days after the SOC date, if allowed by agency policy), in order for it to be included in the OASIS reporting



M Item Assessment Time Periods (cont.)

- **Day of Assessment & Recent Pertinent Past**
- **Example:** M1242, Frequency of Pain
- Report pain observed during assessment visit
- Report pain reported by patient or caregiver
- You know you have to go into the recent pertinent past because one of the response options is “2-Less often than daily”



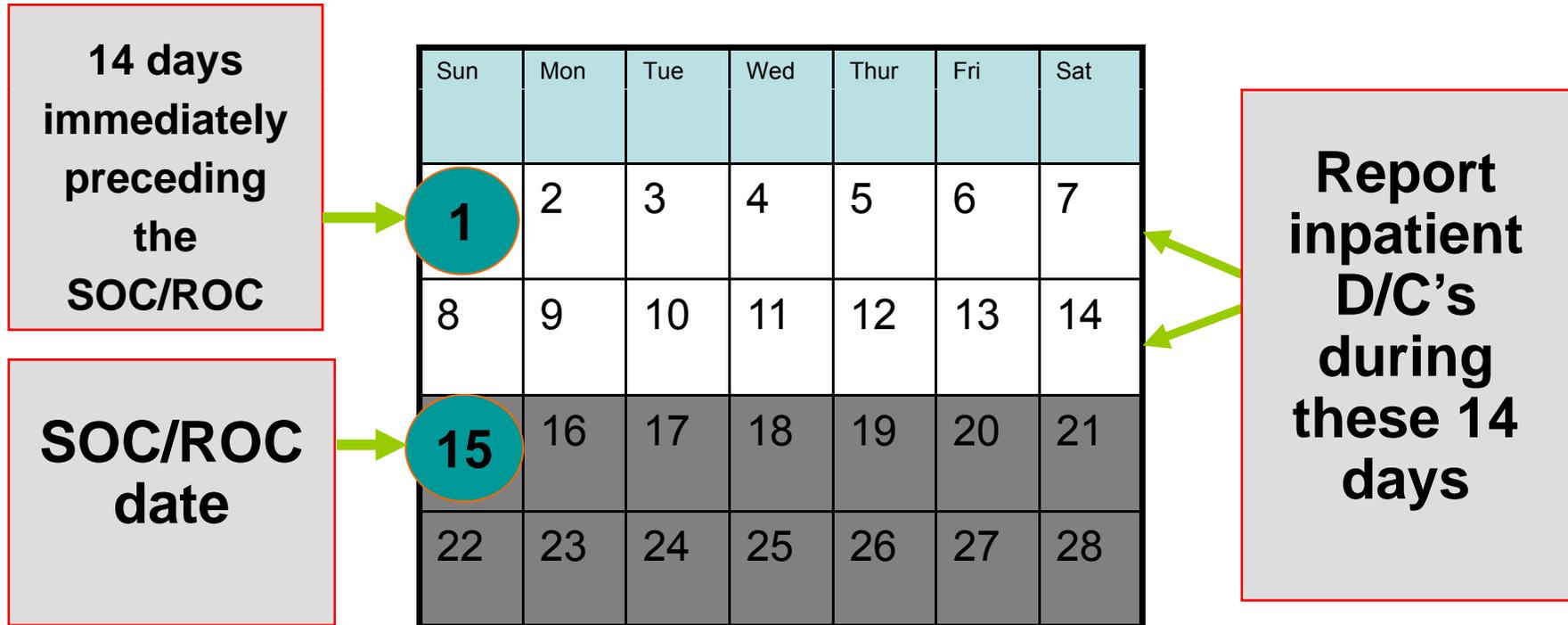
M Item Assessment Time Periods (cont.)

- During the Past 14 Days - 14-Day Period Immediately Preceding the date of the Assessment
- OASIS scoring should be based on events or circumstances that occurred within the 14-day period (span of 14 days) immediately preceding the date of assessment.
- **Example:** M1600 – Urinary Tract Infection
- Determine 14 day timeframe by counting back 14 days from the SOC, ROC, or Discharge assessment date
- In addition to the preceding 14 days, events or circumstances occurring on the Day of the Assessment (Day 0) should also be considered in this item
- Anxiety & Confusion, under OASIS-C, include “Last 14 Days”



M Item Assessment Time Periods (cont.)

AT SOC/ROC: “14-Day Period Immediately Preceding the SOC/ROC”



Note: Also include DC from inpatient facilities that occur on same day as SOC/ROC



M Item Assessment Time Periods (cont.)

- **Since the Last Time OASIS Data Were Collected**
- OASIS scoring should be based on events or circumstances which occurred since the last OASIS data collection time point
- This time period could include a period of up to 60 days
- **Examples:** M2300 – Emergent Care



M Item Assessment Time Periods (cont.)

- **Since the Previous OASIS Assessment**
- Defined as at the time of the previous OASIS assessment **or** since that time
- **Example:** M2400 – Intervention Synopsis



M Item Assessment Time Periods (cont.)

- **Prior to the Inpatient Stay or Prior to the Change in Medical or Treatment Regimen**
- OASIS scoring should be based on events, circumstances or status of the patient prior to the specific events identified
- **Example:** M1018 – Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days



M Item Assessment Time Periods (cont.)

- **Prior**
- OASIS scoring should be based on the patient's status prior to this current illness, exacerbation, or injury
- **Example:** M1900 – Prior Functioning ADL/IADL



M Item Assessment Time Periods (cont.)

- **Current 60-Day Episode or Subsequent 60-Day Episode**
- OASIS scoring should be based on the prediction of events/utilization during an upcoming time period
- **Example:** M2200, Therapy Need [time period under consideration is either the current 60-day episode, or the subsequent 60-day episode]



General OASIS Conventions

- 2. If the patient's ability or status varies on day of the assessment, report patient's "usual status" or what is true greater than 50% of the assessment timeframe,
 - **Unless** the item specifies differently (e.g., for M2020 Management of Oral Medications, M2030 Management of Injectable Medications and M2100e Management of Equipment, instead of "usual status" or "greater than 50% of the time," consider the medication or equipment for which **the most assistance is needed**)



OASIS Conventions

- Usual Status/Most of the Time
 - Report patient's usual status during assessment timeframe
 - The patient's status may change from day to day or during a given day
 - If ability varies, select response reflecting what's true most of the time during the day under consideration
 - Greater than 50% of the time



OASIS Conventions (cont.)

- 3. Minimize the Use of NA/Unknown
 - Only use when no other response is possible or appropriate
 - If patient refuses to answer, don't automatically select NA/Unknown
 - If NA/Unknown response selected, patient outcome can't be computed
 - **Example:** M1620 Bowel Incontinence Frequency – NA appropriate when patient has an ostomy for bowel elimination



General OASIS Conventions

- 4. 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**
 - Unless collection of the item includes review of the care episode (e.g., process items)



OASIS Conventions

- No Reference to Prior Assessments
 - To standardize data collection each assessment should be an independent observation at the time point
 - Looking back at prior assessments may bias clinician and influence M response selected
 - **Example:** M1342 Status of Most Problematic (Observable) Surgical Wound
 - **Exception:** Historical data that cannot be obtained through assessment and certain process measure items
 - **Example:** M1510, Heart Failure Follow-up



General OASIS Conventions

- 5. Combine observation, interview, and other relevant strategies to complete OASIS data items as needed
 - (e.g., 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



OASIS Conventions

- Direct Observation is Preferred
 - The more you observe, the more accurate the assessment
 - When the assessment is accurate, payment and quality outcomes are accurate
 - Problems with relying solely on interview
 - Patients don't truly understand question
 - Patients are not skilled at clinical assessment
 - Patients may consciously or unconsciously mislead clinician
 - Combined observation-interview approach may be needed
 - M1720, When Anxious Patient or in-home caregiver primary source for interview



General OASIS Conventions

- 6. When an OASIS item refers to assistance, this means assistance from another person unless otherwise specified within the item
- Assistance is not limited to physical contact and includes both verbal cues and supervision
 - (Contact guard, stand by assist, reminders, hands-on)

(CMS Q&As Cat. 4b)



General OASIS Conventions (cont.)

- 7. Complete OASIS items accurately and comprehensively, and adhere to skip patterns
- Skip Patterns
 - Skips items not relevant to patient
 - Quicker completion
- **Example:** M1040 Influenza Vaccine
 - Response 1 – Yes [Go to M1050]
 - Skip M1045 Reason Influenza Vaccine not received



General OASIS Conventions (cont.)

- 8. Understand what tasks are included and excluded in each item
- Score item based only on what is included
 - Some items are more inclusive than what you might expect
 - Surgical wounds
 - Some items are less inclusive than what you might expect
 - Bathing



General OASIS Conventions (cont.)

- 9. Consider medical restrictions when determining ability
 - For example, if the physician has ordered activity restrictions, these should be considered when selecting the best response to functional items related to ambulation, transferring, etc.



General OASIS Conventions (cont.)

- 10. Understand the definitions of words as used in the OASIS
 - Home care and OASIS language distinctive
 - Learning the language decreases frustration & increases accuracy
- Some words in OASIS defined differently than in common English usage
 - **Example:** Bathing
 - Common usage – Gathering supplies, preparing water, getting into a tub/shower, washing body, shampooing hair, stepping out of tub/shower, drying off
 - OASIS – Only transferring into and out of the tub shower and washing the entire body once in a tub/shower is included



General OASIS Conventions (cont.)

- 11. Follow rules included in the Item-Specific Guidance
 - Clinician must know the rules & follow them to score accurately

- 12. Stay current with evolving CMS OASIS guidance updates
 - Additional clarifications will be needed
 - Q&As released on a quarterly basis
 - Other notices posted at CMS OASIS Websites



General OASIS Conventions (cont.)

- 13. Only one clinician takes responsibility for accurately completing a comprehensive assessment,
 - Although for selected items, collaboration is appropriate (e.g., Medication items M2000 – M2004)
 - These exceptions are noted in the Item-Specific Guidance



General OASIS Conventions (cont.)

- 14. When the OASIS item includes language specifying “one calendar day” this means until the end of the next calendar day
- **Example:** M2002 Medication Follow-up



General OASIS Conventions (cont.)

OASIS ITEM:

(M2002) Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

- | | | | |
|--------------------------|---|---|-----|
| <input type="checkbox"/> | 0 | - | No |
| <input type="checkbox"/> | 1 | - | Yes |



General OASIS Conventions (cont.)

- 15. **The use of i.e.**, means “only in these circumstances” or “that is”, scoring of the item should be limited to the examples listed
 - **Example:** M1610, Urinary Incontinence or Urinary Catheter Presence, Response 2-Patient requires a urinary catheter (i.e. external, indwelling, intermittent, suprapubic)
- **The use of e.g.**, means “for example” and the clinician may consider other relevant examples when scoring this item
 - **Example:** M2100, Types and Sources of Assistance, c. Medication administration (e.g., oral, inhaled or injectable)



Additional Conventions Specific to ADLs/IADLs

- 1. Report the patient's ability, not actual performance or willingness, to perform a task
- While the presence or absence of a caregiver may impact actual performance of activities, it does not impact the patient's **ability** to perform a task



Ability, Not Performance

- Patient's **ability**, not necessarily willingness or actual performance

Example

- *(M1880) Plan & Prepare Light Meals: Ability to plan and prepare...*
 - “0” – *(a) Able to independently plan and prepare all light meals for self or reheat delivered meals;*
OR
(b) Physically, cognitively and mentally able to prepare light meals on a regular basis but has not routinely performed light meal prep in the past...



Ability, Not Performance (cont.)

- Ability may be **temporarily** or **permanently** limited by:
 - Physical impairments
 - Emotional/cognitive/behavioral impairments
 - Sensory impairments
 - Environmental barriers
 - Medical restriction

(Ch. 3, Each ADL/IADL item)



Caregiver Doesn't Impact Ability

- Disregard presence/absence of caregiver when determining ability to complete tasks
 - Score based on the patient's ability
 - Care plan when a patient doesn't have the caregiver present in the home that allows them to perform to the level of their ability

(CMS Q&As Cat 4b)



Additional Conventions Specific to ADLs/IADLs

- 2. The level of ability refers to the patient's ability to **safely** complete specified activities
- Patient's *ability* to **safely** perform ADL/IADL tasks
 - Determine safety through skilled observation
 - Evaluate:
 - Technique used, equipment used and
 - Risk for injury



Additional Conventions Specific to ADLs/IADLs (cont.)

- 3. 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



Need to Know Item Specific Guidance

- Follow rules and conventions generally
- After mastering the basics of OASIS data collection, you'll next learn guidance that is specific to certain items
- Guidance found in Chapter 3 and the Q&As



Where to Find More Information

- OASIS-C Guidance Manual
 - Chapter 1 – Introduction
 - Collecting OASIS-C data
 - Eligible Patients
 - Time Points
 - Who Completes OASIS-C
 - Comprehensive Assessment and Plan of Care
 - Process Data Items
 - OASIS Data Accuracy
 - OASIS Data Encoding & Transmission
 - Chapter 3 – OASIS Item Guidance
- Background & History of OASIS-C**
- Appendices A-G



Where to Find More Information (cont.)

- Conditions of Participation – CoPs
 - 484.55 Comprehensive Assessment of Patients
 - Initial Assessment Visit
 - Completion of the Comprehensive Assessment
 - Drug Regimen Review
 - Update of the Comprehensive Assessment
 - Incorporation of the OASIS Data Items

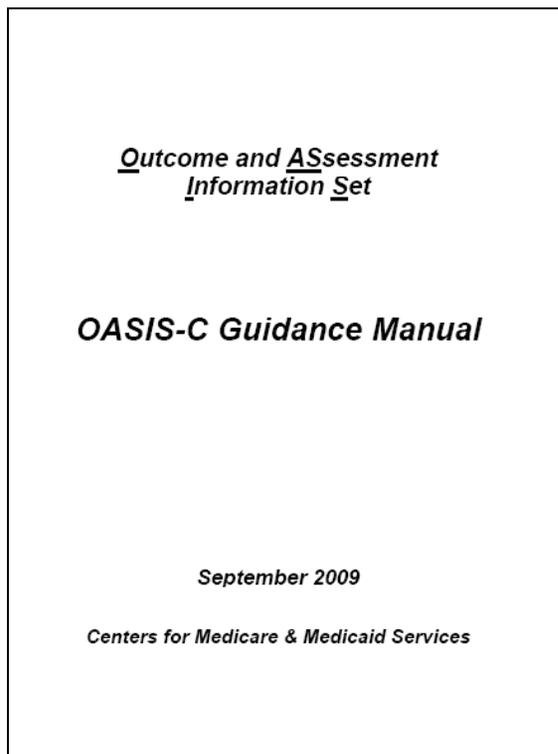


Where to Find More Information (cont.)

- Further Clarification of the Rules or Guidance
 - Q&As: CMS OASIS Q&As
 - <https://www.qtso.com/hhdownload.html>
 - CMS OCCB (OASIS Certificate & Competency Board) OASIS Q&As
 - Posted quarterly
 - www.oasiscertificate.org



OASIS-C Guidance Manual



OASIS-C Guidance Manual

www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage

Note: The old OASIS Implementation Manual will be stored on:

http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage



OASIS Regulation Resources

COMPREHENSIVE ASSESSMENT REQUIREMENTS FOR MEDICARE-APPROVED HHAS			
PATIENT CLASSIFICATION/PAYOR	Does OASIS Apply?	Comprehensive Assessments Only Excluding OASIS	Timing of Follow-up Comprehensive Assessment
SKILLED Medicare (traditional fee-for-service) Medicare (HMO/Managed Care) Medicaid (traditional fee-for-service) Medicaid (HMO/Managed Care)	Yes	NA	Day 56-60*
SKILLED Non-Medicare/Non-Medicaid: Workers' Compensation Title Programs Other Government Private Insurance Private HMO/Managed Care Self-pay; other: unknown	No*	Yes	Anytime after SOC assessment up to day 60; subsequent Followup assessment must be within 60 days 4
PERSONAL CARE ONLY Medicaid (traditional fee-for-service) Medicaid (HMO/Managed Care) Waiver service or HH aide services Without skilled services Non-Medicaid: Workers' Compensation Title Programs Other Government Private Insurance Private HMO/Managed Care Self-pay; other: unknown	No	Yes	Anytime after SOC assessment up to day 60; subsequent Followup assessment must be within 60 days
OASIS EXCLUDED			

		OASIS ASSESSMENT REFERENCE SHEET		
RFA * Type	RFA Description	Assessment Completed	Locked Date	Submission Timing
01	SOC - further visits planned	Within 5 calendar days after the SOC Date (SOC = Day 0)	Effective 6/21/2006 No required lock date	Effective 6/21/2006 Transmission required within 30 calendar days of completing the assessment (M0090)
03	ROC - after inpatient stay	Within 2 calendar days of the facility discharge date or knowledge of pt's return home		
04	Recertification - F/U	The last 5 days of every 60 days, i.e., days 56-60 of the current 60-day period.		
05	Other F/U	Complete assessment within 2 calendar days of identification of		

www.cms.hhs.gov/OASIS/Downloads/patientclassificationtable.pdf

www.qtso.com/download/hha/OASIS_Ref_Sheet.07.19.06.pdf



OASIS Regulation Resources (cont.)

3784 Federal Register / Vol. 64, No. 15 / Monday, January 25, 1999 / Rules and Regulations

**Conditions of Participation:
The Comprehensive Assessment of Patients**

OASIS Collection Regulation – published January 1999

Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary.

(a) *Standard: Initial assessment visit.*
(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.
(2) When rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.
(b) *Standard: Completion of the comprehensive assessment.*

assessment if the need for occupational therapy established program eligibility.

(c) *Standard: Drug regimen review.*
The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.
(d) *Standard: Update of the comprehensive assessment.* The comprehensive assessment must be

www.cms.hhs.gov/OASIS/Downloads/collection.pdf

OASIS CONSIDERATIONS FOR MEDICARE PPS PATIENTS revised August, 2004

Type of Episode or Adjustment	OASIS Assessment: M0100 & M0825* Response Selection	Comments
1. PPS Start-up for new home health patients	Start of Care: (M0100) RFA 1 and (M0825) select 0-No, 1-Yes, or NA All new Medicare patients after October 1, 2000: All applicable Medicare patients accepted for care on or after October 1 will be assessed according to the established time points at 42 CFR 484.55, i.e., a patient whose start of care date is October 15 would be re-assessed for the need to continue services for another certification period during the last 5 days of the current 60-day certification period. In this example, the follow-up assessment would be conducted during the period 12/9/04 through 12/13/04.	OASIS data elements are not required for Private Pay individuals effective December 2003. Requirements for non-Medicare patients are found in S&C Memorandum 04-26.
2. a) First 60-day episode.	Start of Care:	

www.cms.hhs.gov/OASIS/08_OASISPPS.asp#TopOfPage



CMS Q&As – by Category

CMS OASIS Q&As 8/07 will be archived at:

http://www.cms.hhs.gov/OASIS/09_HHAQA.asp#TopOfPage

OASIS Download

OASIS Downloads/Documentation	File Name
PPS Patients - OASIS Considerations - (New) 7/07/2004	42304ho6.pdf
April 23, 2004 - WOCN Satellite	C_Quick1.pdf WOCN_Q&A.pdf Handout_DDoughty_Disclaimer.pdf M0440_M0488Handout_BW.ppt OASISConsidForMedicarePPSPatRev.pdf OECWoundQ&A.pdf TranslationChart_hipps40rev_2004.xls WOCN.pdf WOCN1.pdf
Clarification of Use of Branch ID - M0016 Effective January 1, 2004	Use of Branch ID - M0016
When a parent is importing BRANCH assessments, they should not allow their Branch ID to be changed during the process. The parent should answer NO to the question regarding updating the facility data during import. (Use of Branch ID - M0016)	
CMS announces the opening of the OASIS Web-Based Training (WBT)	www.oasistraining.org
Information on the OASIS Web-Based Training Internet site	OASISWeb-basedTrainingInformation.pdf
OASIS v1.40 Final Data Specs	Oasis V1.40
QTSO Questions and Answers Worksheets (04/25/2003)	Questions Worksheet.pdf Questions Worksheet Answers.pdf

*Questions and Answers
About OASIS*

September 2009

*Department of Health and Human Services
Centers for Medicare & Medicaid Services*



CMS OCCB Q&As

OASIS Certificate and Competency Board

Resources

- [CMS OCCB Q&A July 2009](#)
- [CMS OCCB Q&A August 2004](#)
- [CMS OCCB Q&A March 2005](#)
- [CMS OCCB Q&A October 2004](#)
- [CMS Policy Change for Accurate Coding of OASIS Pressure Ulcer Items \(August 2004\)](#)
- [CMS Policy Change for Accurate Coding of Surgical Wounds \(July 2006\)](#)
- [Home Health Agency Interpretive Guidelines - Appendix B](#)
- [Medlearn Matters Number: SE410 Medicare Resources for Researching Inpatient Discharges with 14 Days of a Home Health Admission](#)

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**Updates
planned
Quarterly**

**All existing
OCCB Q&As
added to
CMS Q&As
at
www.qtso.com
Website
09/09**

www.oasiscertificate.org



OASIS-C

OASIS-C Overview of Changes & Crosswalk



Learning Objectives

At the conclusion of this lesson, you will be able to:

- Identify the major new components of the OASIS-C assessment instrument
- Describe the impacts of OASIS-C changes on agency operations
- Identify steps agencies can take to prepare for OASIS-C



OASIS-C

What's New About OASIS-C



OASIS-C Revisions: Goals

- The OASIS-C represents the most comprehensive revision to OASIS since its original release
- Changes meet CMS's goals:
 - Eliminate items not needed for quality measurement, payment or risk adjustment
 - Update terminology and concepts
 - Improve ability to accurately measure patient status and show progress
 - Add items to support measurement of care processes and clinical domains not previously addressed
- Many OASIS items were revised to reflect comments from the provider community



Appendix G

OASIS-B1 to OASIS-C Crosswalks

Appendix G.1: Comparison of OASIS-B1 to OASIS-C

M0290	(M0290) High Risk Factors characterizing this patient: (Mark all that apply.) <ul style="list-style-type: none"> • 1 - Heavy smoking • 2 - Obesity • 3 - Alcohol dependency • 4 - Drug dependency • 5 - None of the above • UK – Unknown 	M1036	Risk Factors, either present or past, likely to affect current health status and/or outcome: (Mark all that apply.) <ul style="list-style-type: none"> 1 - Smoking 2 - Obesity 3 - Alcohol dependency 4 - Drug dependency 5 - None of the above UK – Unknown <p><u>Note: No longer collected at Discharge. No change at other collection timepoints.</u></p>
	New item on OASIS-C	M1040	Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care? <ul style="list-style-type: none"> 0 - No 1 - Yes [Go to M1050] NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [Go to M1050]



Elimination of OASIS-B1 Items

- OASIS-B1 items not used for payment, quality measures (including those used in the survey process), case mix, or risk adjustment purposes were eliminated
- Examples include items related to:
 - Number of Surgical Wounds
 - Transportation
 - Shopping
 - Housekeeping
 - Laundry



Replacement of OASIS-B1 Items

- In some cases, eliminated items were replaced with items intended to capture the assessment parameter in a more efficient way
 - For example, the “prior status” items for all the ADLs/IADLs have been eliminated
 - Two new OASIS-C items were developed to capture the patient’s prior level of dependence with ADLs/IADLs (M1900) and medication management (M2040)



Updating Clinical Terminology & Concepts

Example: pressure ulcers items were revised to:

- Reflect current National Pressure Ulcer Advisory Panel (NPUAP) and Wound, Ostomy, and Continence Nurses Society (WOCN) guidance on pressure ulcer assessment
- Collect additional information considered critical to care planning (wound length, width, depth)
- Harmonize with other measures of pressure ulcers used in other settings such as nursing homes.



Improved Accuracy in Measurement of Patient Status

- **(M1845) Toileting Hygiene** was created to supplement measurement of toilet transferring (M1840) to more accurately capture toileting ability
- **(M1220) Understanding of Verbal Content** supplements the item for ability to hear (M1210) to provide a more comprehensive understanding of the patient's receptive communication ability
- **(M2020) Management of Oral Medications** now specifies that the item refers to the patient's ability to correctly manage **all** medications safely and reliably



Ability to Show Progress

- Some items have been expanded to include additional scale levels that will allow agencies to document changes in patient status with more accuracy

(M1830) Bathing:

- 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.*

(M1860) Ambulation/Locomotion:

- 1 - *With the use of a one-handed device* (e.g. 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* (e.g., 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.



Addition of “Process Items”₁

- Research has identified several evidence-based “best practice processes” (use of screening tools and interventions) relevant for home care patients
- New process data items in OASIS-C allow measurement of agency implementation of selected processes
- Focus is on high-risk, high-volume, problem-prone conditions in home health care that reflect Institute of Medicine (IOM) focus areas and MedPAC recommendations
- The process items are a logical follow-up to the Quality Improvement Organizations (QIOs) 8th Scope of Work on Best Practices ([MedQIC - HHQI Campaign](#))



Addition of “Process Items”₂

- It is anticipated that processes of care implemented according to evidence-based guidelines will ultimately lead to better clinical outcomes
- Agencies participating in reliability testing of OASIS-C felt process items gave them “credit” for excellent patient care practices already in place



Changes to Numbering System

- With the exception of the tracking items and M0903/M0906, the OASIS–C items have been renumbered
- Each section has now been assigned to a range of numbers (e.g., Integumentary Status items are numbered M1300-M1350)
- Medication management – now a separate domain, outside of the ADL/IADL section



Changes to Numbering System (cont.)

No more M0230/240/246? No more M0700?

- Necessary because new OASIS items were placed within the existing sequence of items, and other OASIS items were re-sequenced
- Renumbering was determined to be the best long-term solution
- Mirrors systems being used by the data sets in other settings and the CARE instrument



New Numbering System₁

Tracking Items	M0010 – M0150
Clinical Record Items	M0080 – M0110
Patient History and Diagnoses	M1000s
Living Arrangements	M1100
Sensory Status	M1200s
Integumentary Status	M1300s
Respiratory Status	M1400s
Cardiac Status	M1500s



New Numbering System₂

Elimination Status	M1600s
Neuro/Emotional/Behavioral Status	M1700s
ADLs/IADLs	M1800s + M1900s
Medications	M2000s
Care Management	M2100s
Therapy Need and Plan of Care	M2200
Emergent Care	M2300
Data Collected at TF/DC	M2400s, M0903+M0906



OASIS-C

Highlights of Changes by Section



Clinical Record Items

2 new items collected at SOC/ROC to support measure for timely care

- **(M0102) Date of Physician-ordered Start of Care (Resumption of Care)**
 - (If the physician indicated a specific SOC/ROC date)

- **(M0104) Date of Referral**
 - (Date that the written or verbal referral for initiation or resumption of care was received by the HHA)



Patient History & Diagnoses₁

Added option for recording inpatient procedures

- **(M1012)** List each **Inpatient Procedure** and the associated ICD-9-C M procedure code relevant to the plan of care
 - Asked at SOC/ROC
 - Useful for risk adjustment
 - Agencies only required to respond to the best of their ability



Patient History & Diagnoses₂

- **Replaced 3 OASIS–B-1 items**
 - (M0260) Overall Prognosis
 - (M0270) Rehabilitative Prognosis
 - (M0280) Life Expectancy
- **With 2 new OASIS–C items collected at SOC/ROC:**
 - **(M1032) Risk for Hospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization?
 - **(M1034) Overall Status:** Which description best fits the patient's overall status?
 - Used for risk adjustment



Patient History & Diagnoses₃

Added items to collect immunization status at discharge

- **(M1040) Influenza Vaccine**
 - (Did the patient receive the influenza vaccine from your agency for this year's influenza season?)
- **(M1045) Reason Influenza Vaccine not received**
 - (If not, why not?)
- **(M1050) Pneumococcal Vaccine**
 - (Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care?)
- **(M1055) Reason PPV not received**
 - (If not, why not?)



Living Arrangements₁

- **Replaced 6 Oasis-B1 items:**
 - (M0300) Current Residence
 - (M0340) Patient Lives With
 - (M0350) Assisting Person(s) Other than Home Care Agency Staff
 - (M0360) Primary Caregiver
 - (M0370) How often does the patient receive assistance from the primary caregiver?
 - (M0380) Type of Primary Caregiver Assistance
- **With 2 grid items collected at SOC/ROC**



Living Arrangements₂

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

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05
b. Patient lives with other person(s) in the home	<input type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
c. Patient lives in congregate situation (e.g., assisted living)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15

- **Second grid (M2100) Types and Sources of Assistance** located at the end of the OASIS-C in the Care Management Section



Sensory Status

Speech and hearing:

- OASIS–B-1 item **(M0400) Hearing and Ability to Understand Spoken Language** split out into:
 - **(M1210) Ability to hear** (with hearing aid or hearing appliance if normally used)
 - **(M1220) Understanding of Verbal Content** in patient's own language (with hearing aid or device if used)

Pain:

- Deleted - **(M0430) Intractable Pain**
- Added - **(M1240) Has this patient had a formal Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?
- Collected at SOC/ROC to support process measure



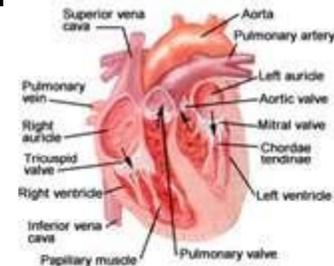
Integumentary Status

- **Pressure Ulcer Additions include:**
 - (M1300) Pressure Ulcer Assessment
 - (M1307) The Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge
 - (M1310) Pressure Ulcer Length
 - (M1312) Pressure Ulcer Width
 - (M1314) Pressure Ulcer Depth
- (M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers now includes suspected deep tissue injury in evolution
- Changes in guidance are discussed in the OASIS Guidance Manual and will be reviewed later



Cardiac Status

- **New Domain**
 - **(M1500) Symptoms in Heart Failure Patients:** If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?
 - **(M1510) Heart Failure Follow-up:** If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond?
- **Collected at transfer and discharge**
- **Support new process measures**





Neuro/ Emotional/ Behavioral Status

- **Dropped:**
 - (M0590) **Depressive Feelings** Reported or Observed in Patient
- **Added:**
 - (M1730) **Depression Screening:** Has the patient been screened for depression, using a standardized depression screening tool?
- Includes but does not require PHQ2 assessment

PHQ-2© Pfizer	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	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

- Collected at SOC/ROC
- Supports new process measure



ADL/IADLs

- Added **(M1845) Toileting Hygiene** collected at SOC/ROC and DC (supports new outcome measure)
- Added **(M1910) Fall Risk Assessment** collected at SOC/ROC (supports new process measure)
- Dropped Transportation, Shopping, Housekeeping, Laundry
- Additional responses (bathing, ambulation) and wording changes (safely) to numerous items



ADL/IADLS (cont.)

- Dropped prior status and replaced with grid

(M1900) Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (e.g., grooming, dressing, and bathing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Ambulation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Transfer	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Household tasks (e.g., light meal preparation, laundry, shopping)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2



Medications



- Now a separate domain
- Added items to support process measures:
 - (M2000) Drug Regimen Review
 - (M2002) Medication Follow-up
 - (M2004) Medication Intervention
 - (M2010) Patient/Caregiver High Risk Drug Education
 - (M2015) Patient/Caregiver Drug Education Intervention
- Added new response options to improve ability to show patient progress
 - (M2020) Management of Oral Medications
 - (M2030) Management of Injectable Medications
- Dropped questions about inhaled medications



Medications

- Replaced prior status questions with grid:

(M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> na
b. Injectable medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> na



Care Management

- **New domain**
 - **(M2100) Types and Sources of Assistance:** Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only **one** box in each row.)

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provide assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) <u>not likely</u> to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Medication administration (e.g.,)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5



Therapy Need and Plan of Care

- New grid 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient is not diabetic or is bilateral amputee
c. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na No pain identified
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient is not assessed to be at risk for 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient has no pressure ulcers with need for moist wound healing



Emergent Care

- **(M2310) Reason for Emergent Care:** For what reason(s) did the patient receive emergent care (with or without hospitalization)?
- New and reordered response options are now consistent with response options for **(M2430) Reason for Hospitalization**
- **Emergent care** also now refers exclusively to care provided in a hospital emergency department



Data Items Collected at Inpatient Facility Admission or Agency Discharge Only

- **New grid item collected at Transfer and Discharge supports measures of care process implementation**

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

Plan / Intervention	No	Yes	Not Applicable	
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment



OASIS-C

Impact of Changes



Changes in Number of OASIS Items

For those of you keeping score, that is a total of two more items across all time points!



Time Point	B1	C	Net Change (C - B1)
SOC	77	79	2
ROC	77	79	2
Follow-up	31	32	1
Transfer	11	19	8
Discharge	72	61	-11
Death at home	4	5	1
Patient Tracking	18	17	-1



Why the Increase at Transfer?

- CMS is interested in what happens at transfer as a way to focus on improvement in acute care hospitalization
- Additional items needed to:
 - (a) Calculate additional quality measures related to reasons for hospitalization
 - (b) Assess care processes that potentially can reduce the rate of acute care hospitalization.
- Critical to examine the reasons for and reduce the rate of acute care hospitalization



Time for OASIS–C vs. OASIS–B-1

- Testing to date indicates that the time required by OASIS–C will not be significantly different than OASIS–B-1
- Skip patterns reduce the number of items collected on some patients
- Field testing results are still considered to be the most useful estimate of burden associated with collection of the OASIS–C
- Follow-up is the exception - 13 fewer items than the field test version





OASIS-C Impact on HH Payment

- OASIS-C items tested to insure changes did not affect the payment algorithm
- Once OASIS-C data are collected, CMS can assess whether they could be used for refinements to the case mix adjustor
- **If** CMS develops a P4P component to the home health reimbursement system, an HHA's decision not to incorporate evidence-based practices could impact their payment



Impact on HH Quality Measurement

- The development of new quality measures has been an important force behind OASIS-C
- The National Quality Forum has reviewed proposed measures based on OASIS-C items since fall 2008
- NQF Final Report of endorsement of publicly reported measures is anticipated by August 30, 2009
- Detailed information about new process and outcome measures and the reporting schedule will be addressed in Lesson 4



OASIS-C

Potential Impacts on Agency Operations



Collecting Information at Referral

- Agencies may choose to revise what is asked and how information is collected/recorded at the time of referral
 - Referral forms can capture information useful in the OASIS–C such as status of immunizations, previous diagnosis and procedure codes and history of pressure ulcers to reduce agency burden and enable agencies to respond to those items
- How will clinicians access information efficiently?
 - Where do you record Date of Referral and Date of Physician-ordered Start or Resumption of Care?
 - If you are paper-based, is there a location in the record for this information?
 - If you are e-based, will your vendor facilitate accessing that information?



New Information at SOC/ROC

- OASIS-C has opportunities for agencies to document best practices that include screening for:
 - Depression
 - Pain
 - Falls Risk
 - Pressure Ulcer Risk



Screening Assessments

- Agencies need to decide:
 - If they are not doing now, do they want to start?
 - If they are doing now, do the screening tools they are using meet the OASIS-C criteria? (*multi-factor* falls risk assessment, *standardized* depression screening tool?)
 - How are they going to educate their staff?
- Staff may have concerns that they need special training to conduct screening assessments
- Similar concerns about other assessments such as for pressure ulcers or medications



Do Screening Assessments Require Special Skills?

- Concern: “We do not have psych nurses or wound nurses. How can we be expected to do these depression and wound items?”
- Clinicians need to know these are assessments that any health care provider can use
- E.g., the PHQ2 is only two questions that indicate whether the patient needs additional evaluation
- Depression screening done in many sites of health care (e.g. primary care)



What about PTs?

Comments from the American Physical Therapy Association (APTA)

received as part of the public response specifically addressed whether PTs can respond to new items in OASIS–C

- **Depression screening:** recommended the PHQ-9[®] Depression Scale Form in order to harmonize with data collected in other settings (i.e. MDS)
- **Medication evaluation:** it is within the scope of the PTs to perform a patient screen in which medication issues are assessed, even if the PT does not perform the specific care needed to address the medication issue
- **Heart failure items:** PTs are more than competent to complete the information needed
- **Wound care items:** PTs are permitted to perform all wound care interventions legally mandated by State licensure and defined by the education curriculum of the physical therapist, including dressings, debridement, application of topical agents; physical agents and mechanical modalities



Assessment Strategies

- OASIS-C data, like the rest of the comprehensive assessment, are collected using a variety of strategies:
 - Observation
 - Interview
 - Review of pertinent documentation (e.g., hospital discharge summaries to obtain information on inpatient facility procedures and diagnoses)
 - Discussions with other care team members where relevant (e.g., phone calls to the physician to verify diagnoses)
 - Measurement (e.g., wound length/width, intensity of pain)



Obtaining Information for Care Planning Items at the Time of SOC/ROC

- **Care planning items ask about whether interventions have been ordered:**
 - Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings
 - Diabetic foot care and education
 - Falls prevention interventions
 - Depression intervention(s)
 - Intervention(s) to prevent pressure ulcers
 - Pressure ulcer treatment based on principles of moist wound healing



Plan of Care Items at SOC/ROC

- How can we know about physician orders while we're doing the patient assessment?
 - The care plan should evolve from the findings of the assessment
 - Responding that the “current physician-ordered plan of care” includes a plan/intervention means the patient condition has been discussed and there is agreement as to the plan of care between the home health staff and the physician
 - POC orders must be in place within the 5-day SOC window or 2-day ROC window in order to meet the measure definition
 - CMS recognizes that this may not happen for all patients at all agencies
 - If window is closing and interventions not in POC, then respond “no” to relevant items



Obtaining Information for Implementation Items at TRF/DC₁

- **Process items ask about whether care practices and interventions were implemented since the last OASIS assessment:**
 - Diabetic foot care and education
 - Falls prevention interventions
 - Depression intervention(s)
 - Intervention(s) to monitor and mitigate pain
 - Intervention(s) to prevent pressure ulcers
 - Pressure ulcer treatment based on principles of moist wound healing
 - Heart failure symptoms addressed
 - Physician contacted for medication issues



Obtaining Information for Implementation Items at TRF/DC₂

- Review documentation since the last OASIS assessment to determine
 - If a condition (e.g., pain, symptoms of heart failure) was present
 - Whether interventions to address the condition were:
 - a) Incorporated into the physician-ordered plan of care
 - b) Implemented as part of patient care
- Similar process for completion of a discharge summary required by current Conditions of Participation



Obtaining Information for Implementation Items at TRF/DC₃

- Process items at TRF/DC will require knowledge of
 - Patient symptoms
 - Initial and subsequent physician's orders clinical interventions performed to address patient symptoms across the episode of care
- Must consider care provided by all disciplines during the episode, not just the discipline of the clinician completing the OASIS assessment
- Clinician completing the OASIS TRF or DC may not be familiar with the patient
- How will clinicians access this information efficiently?



Accessing Information Needed at TRF/DC

- This evaluation of the care episode can be accomplished in several different ways
 - Review clinical records, including the plan of care, updated orders, and visit notes
 - Agency may elect to create a flowsheet with the appropriate parameters that are checked off on each visit so that a review of the clinical record would be unnecessary
 - E.g. if plan to mitigate falls risk is needed, documenting the elements and when they are addressed would simplify OASIS-C data collection
 - Agencies using electronic health records can create a report template that could pull the needed information from data fields incorporated into visit notes



A Note About “Look-Back”

- The current OASIS–B-1 look back prohibition forbids the use of a prior OASIS form to complete a present OASIS form
- As with OASIS–B-1, OASIS–C data should be collected at each time point based on a unique patient assessment, not simply carried over from a previous assessment
- For OASIS–C implementation items, clinicians may need to review clinical records: *this is not the same!*



OASIS-C

Preparing for OASIS-C



Preparing for OASIS-C

- If you *choose* to do process items, identify which process items you are currently doing, if any, and which are the next most logical process items to take on
- Consider whether you need to change your workflow processes to accommodate OASIS-C requirements
- Download the guidance document and begin to work on preferred training approaches



Educating Staff on OASIS-C

- Identify your agency's preferred approach to training: "Train the trainer" who will then train the rest? Train everyone?
- Identify training resources: OASIS education coordinators and Medicare Learning Network are two resources
- Open Door Forums will be scheduled
- Training materials prepared for agencies (e.g. Medicare Learning Network)





OASIS–C Guidance Manual

- OASIS Guidance Manual (Item-by-Item, formerly known as Chapter VIII is now Chapter 3)
- Guidance prepared by CMS and OASIS–C clinician teams and with external stakeholder input
- Reviewed by 14 outside home health experts for accuracy
- Is posted on the CMS Website





OASIS–C Guidance Manual is an Essential Training and Reference Tool

- Recommended that all clinicians collecting OASIS–C have access to the guidance document, either electronic or paper versions
- Guidance document will identify how to most accurately answer the OASIS items
- Guidance now has a Resource Guide – Chapter 5, that contains links to CMS resources and additional clinical resources (e.g., for screening tools, clinical guidelines, etc.)



Links

- Access the OASIS-C Web page at:
www.cms.hhs.gov/HomeHealthQualityInits/06_OASISC.asp
- Manual:
http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPageby

All B-1 to be archived in late December:

http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage



Questions?





OASIS - C

Item Guidance



OASIS - C

Patient Tracking



M0010

- (M0010) C M S Certification Number



M0010 CMS Certification Number

- Agency's CMS Certification Number
- If not Medicare-certified – leave blank
- This is NOT the provider's NPI number
- Preprinting on clinical documentation allowed and recommended



M0014

- (M0014) Branch State

— —



M0014 Branch State

- State where the agency branch office is located
- **Leave blank if:**
 - Agency has no branches or
 - All branches are located in the same state



M0016

- (M0016) Branch I D Number

— — — — —



M0016 Branch ID Number

- Branch ID code, as assigned by CMS
- No branches, enter "N" followed by 9 blank spaces.
- A parent HHA that has branches, enter "P" followed by 9 blank spaces.
- Preprinting this number on clinical documentation is allowed and recommended.



M0018

- **(M0018) National Provider Identifier (N P I)** for the attending physician who has signed the plan of care

UK – Unknown or Not Available



M0018 National Provider Identifier

- National Provider Identifier (NPI) for the physician who will sign the POC
- Replaces UPIN of "Primary Referring Physician ID"



M0020

- **(M0020) Patient I D Number**



M0020 Patient ID Number

- **Agency-specific patient ID used for agency recordkeeping for this episode of care**
 - **May stay the same from one admission to the next**
 - **May change with each admission**
 - **Should remain constant throughout a single episode of care, e.g. SOC – DC**
- **Leave spaces at the end blank**



M0030

- **(M0030) Start of Care Date:**

___/___/___
month / day / year



M0030 Start of Care Date

- Date the first reimbursable service delivered
- If HHA policy/practice is for RN to perform SOC assessments in therapy only cases
 - The RN assessment must be same day or within 5 days after the therapy provides billable service



M0032

- **(M0032) Resumption of Care Date:**

___/___/___
month / day / year

NA - Not Applicable



M0032 ROC Date

- Resumption of Care Date (ROC)
- Date of first visit following an inpatient stay by patient currently on service
- ROC date must be updated on Patient Tracking Sheet (PTS) for each ROC



M0032

- NA at SOC
- The most recent ROC should be entered
- HHAs who always DC patients when admitted to inpatient facility will not have a ROC date



M0040

- **(M0040) Patient Name:**

(First)

(M I)

(Last)

(Suffix)



M0040 Patient Name

- Enter name exactly as it appears on Medicare or other insurance card
- Patient's legal name
- Sequence of the names may be reordered
- Update PTS if change occurs during episode



M0050

- **(M0050) Patient State of Residence**

— —



M0050 Patient State of Residence

- Where the patient is **CURRENTLY** residing while receiving home care
 - Even if not usual or legal residence
- Update if change occurs during episode



M0060

- (M0060) Patient Zip Code



M0060 Patient Zip Code

- Zip code for address where patient is receiving home care
 - **CURRENT** residence, even if not usual or legal residence
- Used on Home Health Compare to determine where HHA provided service



M0063

- **(M0063) Medicare Number:**

(including suffix)

NA – No Medicare



M0063 Medicare Number

- For Medicare (MC) patients only
 - Use RRB number for railroad retirement program
- Enter claim number from MC card
 - May or may not be Social Security number
- No MC, mark “NA-No Medicare”



M0063 Medicare Number

- If MC HMO, another MC Advantage plan or MC Part C
 - Enter MC number if available
 - If not available, mark “NA-No Medicare”
 - Do NOT enter the HMO ID number
- Leave spaces at the end blank



M0064

- **(M0064) Social Security Number**

____ - ____ - _____

UK – Unknown or Not Available



M0064 Social Security Number

- Include all nine numbers
- Mark “UK” if unknown or not available
 - Information cannot be obtained
 - Patient refused to provide information



M0065

- **(M0065) Medicaid Number**

NA – No Medicaid



M0065 Medicaid Number

- Specifies the patient's **Medicaid** (MA) #
- No MA coverage or MA coverage pending, mark "NA - No Medicaid."
- If patient has MA, complete item **whether or not** MA is reimbursement source for the home care episode.
- Number assigned by individual state
 - Found on the patient's Medicaid card



M0066

- **(M0066) Birth Date:**

___ / ___ / _____
month / day / year



M0066 Birth Date

- Month, day, and four digits for the year
 - E.g., May 4, 1930 = 05/04/1930



M0069

- **(M0069) Gender:**
 - 1 - Male
 - 2 - Female



M0069 Gender

- The easiest OASIS M item
 - 1 - Male
 - 2 - Female



M0140

- **(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



M0140 Race/Ethnicity

- Specifies groups or population to which the patient is affiliated
 - As identified by the patient or caregiver (CG)
- Used for tracking disparities
- If the patient does not self-identify
 - Referral information
 - Hospital or physician office clinical record
 - Observation



M0140 Race/Ethnicity

- Response 1: American Indian or Alaska Native.
 - Origins in any of the original peoples of North, South America & Central America
 - Maintains tribal affiliation or community attachment.



M0140 Race/Ethnicity

- Response 2: Asian.
 - Origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent
 - Examples: Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.



M0140 Race/Ethnicity

- Response 3: Black or African American
 - Origins in any of the black racial groups of Africa.
 - Terms such as “Haitian”, “Negro”, “Black” or “African American”



M0140 Race/Ethnicity

- Response 4: Hispanic or Latino.
 - Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
 - "Spanish origin," can be used in addition to "Hispanic or Latino."



M0140 Race/Ethnicity

- Response 5: Native Hawaiian or Other Pacific Islander.
 - Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- Response 6: White.
 - Origins in any of the original peoples of Europe, the Middle East, or North Africa.



M0150

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

- | | | |
|--------------------------|----|--|
| <input type="checkbox"/> | 0 | - None; no charge for current services |
| <input type="checkbox"/> | 1 | - Medicare (traditional fee-for-service) |
| <input type="checkbox"/> | 2 | - Medicare (HMO/managed care/Advantage plan) |
| <input type="checkbox"/> | 3 | - Medicaid (traditional fee-for-service) |
| <input type="checkbox"/> | 4 | - Medicaid (HMO/managed care) |
| <input type="checkbox"/> | 5 | - Workers' compensation |
| <input type="checkbox"/> | 6 | - Title programs (e.g., Title III, V, or XX) |
| <input type="checkbox"/> | 7 | - Other government (e.g., TriCare, VA, etc.) |
| <input type="checkbox"/> | 8 | - Private insurance |
| <input type="checkbox"/> | 9 | - Private HMO/managed care |
| <input type="checkbox"/> | 10 | - Self-pay |
| <input type="checkbox"/> | 11 | - Other (specify) _____ |
| <input type="checkbox"/> | UK | - Unknown |



M0150 Current Payment Sources

- 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 care agency**
- Must be accurate
 - Assessments for MC and MA patients are handled differently than for other payers



M0150 Current Payment Sources

- Mark all current pay sources
 - Primary or secondary
 - Exclude “pending” pay sources
- Multiple payers reimbursing for care
 - Include all sources, e.g., MC, MA, private insurance, self-pay
- If one or more payment sources
 - Include known, NOT uncertain ones



M0150 Current Payment Sources

- Do not consider any equipment, medications, or supplies being paid for by the patient, in part or in full
- Response 2 - MC HMO, another MC Advantage Plan, or MC Part C.
- Response 3 - MA waiver or home and community-based waiver (HCBS) program.



M0150 Current Payment Sources

- Response 6 – Title programs
 - Title III – State Agency on Agency grants
 - Title V – State programs for maternal and child health
 - Title XX – State program for homemaking, chore service, home mgmt, or aide services



M0150 Current Payment Sources

- Response 7 – Tri-Care program
 - Replaced CHAMPUS
- Response 10 – Patient is paying for all or part of the care
 - E.g., copayments



Items to be Used at Specific Time Points¹

<p><u>Start of Care</u></p> <p>Start of care—further visits planned</p>	<p>M0010-M0030, M0040- M0150, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250</p>
<p><u>Resumption of Care</u></p> <p>Resumption of care (after inpatient stay)</p>	<p>M0032, M0080-M0110, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250</p>
<p><u>Follow-Up</u></p> <p>Recertification (follow-up) assessment</p> <p>Other follow-up assessment</p>	<p>M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1324, M1330-M1350, M1400, M1610, M1620, M1630, M1810-M1860, M2030, M2200</p>



Items to be Used at Specific Time Points₂

<p><u>Transfer to an Inpatient Facility</u></p> <p>Transferred to an inpatient facility patient not discharged from an agency</p> <p>Transferred to an inpatient facility — patient discharged from agency</p>	<p>M0080-M0100, M1040-M1055, M1500, M1510, M2004, M2015, M2300-M2410, M2430-M2440, M0903, M0906</p>
<p><u>Discharge from Agency -- Not to an Inpatient Facility</u></p> <p>Death at home</p> <p>Discharge from agency</p>	<p>M0080-M0100, M0903, M0906 M0080-M0100, M1040-M1055, M1230, M1242, M1306-M1350, M1400-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2100-M2110, M2300-M2420, M0903, M0906</p>



OASIS - C

Patient History & Diagnoses



M1000

- **(M1000)** From which of the following **Inpatient Facilities** was the patient discharged during 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 (IPP S)
- 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 M1016**]



M1000-Inpatient Facility DC

- Identifies whether the patient has been discharged from an inpatient facility within the 14 days immediately preceding SOC/ROC
- Mark all that apply
- An inpatient facility DC that occurs on the day of the assessment **does** fall within the 14-day period



M1000-Inpatient Facility DC

- “Past fourteen days” is the two-week period immediately preceding SOC/ROC
- SOC is day 0 and the day immediately prior to the date of admission is day 1
- Facility type is determined by the facility’s state license



M1000-Inpatient Facility DC

- **Response 1, Long-term Nursing facility (NF) means:**
- Patient was discharged from a MC-certified skilled nursing facility,
- but **did not** receive care under the Medicare Part A benefit in the 14 days prior to home health care



M1000-Inpatient Facility DC

- **Response 2 - Skilled nursing facility (SNF/TCU)** means patient was discharge within the last 14 days from:
 - a) a **MC certified** nursing facility where the patient received a **skilled level of care** under the **Medicare Part A** benefit **or**
 - b) a transitional care unit (TCU) within a Medicare-certified nursing facility



M1000-Inpatient Facility DC

- **Response 3, Short-stay acute hospital** applies to most hospitalizations
- **Response 4, Long-term Care Hospital, (LTCH)** applies to a hospital which has an average inpatient length of stay of greater than 25 days



M1000-Inpatient Facility DC

- **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 the mentally retarded (ICF/MR) = **Response 7 – Other**



M1000-Inpatient Facility DC

- If discharged from a **swing-bed hospital**, 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)



M1005

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

___ / ___ / _____

month / day / year

UK- Unknown



M1005 Inpatient DC Date

- Identifies the date of the **most recent** discharge from an inpatient facility (within last 14 days)
- 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



M1010

- **(M1010)** List each **Inpatient Diagnosis** and ICD-9-C M code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E-codes, or V-codes):

	<u>Inpatient Facility Diagnosis</u>	<u>ICD-9-C M Code</u>
a.	_____	_____. ____
b.	_____	_____. ____
c.	_____	_____. ____
d.	_____	_____. ____
e.	_____	_____. ____
f.	_____	_____. ____



M1010 Inpatient Diagnosis

- List each **Inpatient Diagnosis** and ICD-9-CM code at the level of highest specificity **for only** those conditions **treated** during an inpatient stay within the last 14 days
- No E-codes, or V-codes
 - List underlying diagnosis
- No surgical codes
 - List underlying dx that was surgically treated. If a joint replacement for osteoarthritis, list the disease, not the procedure



M1010 Inpatient Diagnosis

- If diagnosis **not treated** during an inpatient admission, **don't list it**
- E.g., 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



M1012

- **(M1012)** List each **Inpatient Procedure** and the associated ICD-9-C M procedure code relevant to the plan of care.

<u>Inpatient Procedure</u>	<u>Procedure Code</u>
a. _____	_____ . _____
b. _____	_____ . _____
c. _____	_____ . _____
d. <input type="checkbox"/> NA - Not applicable _____	_____ . _____
<input type="checkbox"/> UK - Unknown	



M1012 Inpatient Procedure

- **Medical procedures** that the patient received **during an inpatient facility stay within the past 14 days** that are **relevant** to the home health plan of care
- Based on the info available at SOC/ROC
 - Example: a joint replacement surgery that requires home rehabilitation services



M1016

- (M1016) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days:**
 List the patient's Medical Diagnoses and ICD-9-C M codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no surgical, E-codes, or V-codes):

<u>Inpatient Facility Diagnosis</u>	<u>ICD-9-C M Code</u>
a. _____	_____ . _____
b. _____	_____ . _____
c. _____	_____ . _____
d. _____	_____ . _____
e. _____	_____ . _____
f. <input type="checkbox"/> NA - Not applicable (no medical or treatment regimen changes within the past 14 days)	_____ . _____



M1016 - Dx Req. Med. Tx Reg Chg Within Past 14 Days

- Identifies if any change occurred to the patient's tx regimen, health care services, or medications within the past 14 days
- Helps identify patients at higher risk of becoming unstable
- Mark NA if changes due to improvement



M1016 - Dx Req. Med. Tx Reg Chg Within Past 14 Days

- No surgical codes
 - list the underlying diagnosis
- No V-codes or E-codes
 - list the appropriate diagnosis.
- May include the same dx as M01010 if the condition was treated during an inpt stay AND caused changes in the tx regimen



M1018

- **(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 which 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



M1018

- Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days
- Identifies existence of condition(s) **prior to** medical regimen change or inpatient stay within past 14 days



M1018

- Mark **“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



M1018

- Mark “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.”



M1018

- Mark “**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

M1020/1022/1024



(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
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-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete <u>only if</u> the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M/ Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis	(V-codes are allowed)	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
a. _____	a. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	a. _____ (_____ . _____)	a. _____ (_____ . _____)
(M1022) Other Diagnoses	(V- or E-codes are allowed)	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
b. _____	b. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	b. _____ (_____ . _____)	b. _____ (_____ . _____)
c. _____	c. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	c. _____ (_____ . _____)	c. _____ (_____ . _____)
d. _____	d. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	d. _____ (_____ . _____)	d. _____ (_____ . _____)
e. _____	e. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	e. _____ (_____ . _____)	e. _____ (_____ . _____)
f. _____	f. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	f. _____ (_____ . _____)	f. _____ (_____ . _____)

M1020/1022/1024



(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
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-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is	Complete <u>only</u> if the V-code in Column 2 is reported in
Description	ICD-9-C M / Symptom Control Rating		of a case mix that is a multiple situation (e.g., a respite code).
(M1020) Primary Diagnosis	(V-codes are allowed)		description/ ICD-9-C M
a. _____	a. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1		codes NOT allowed)
(M1022) Other Diagnoses	(V- or F-codes are NOT allowed)		
b. _____	b. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1		codes NOT allowed)
c. _____	c. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3		
d. _____	d. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
e. _____	e. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
f. _____	f. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	f. _____	f. _____

Column 1
List each diagnosis for which the patient is receiving home care

M1020/1022/1024



(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)
Column 1	Column 2	Column 3
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code assigned under certain circumstances to Code in place of a case diagnosis.
Description	ICD-9-C M / Symptom Control Rating	Description / ICD-9-C M
<u>(M1020) Primary Diagnosis</u> a. _____	<u>(V-codes are allowed)</u> a. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<u>(V- or E-codes are allowed)</u> a. _____
<u>(M1022) Other Diagnoses</u> b. _____	<u>(V- or E-codes are allowed)</u> b. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<u>(V- or E-codes are allowed)</u> b. _____
c. _____	c. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	c. _____
d. _____	d. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	d. _____
e. _____	e. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	e. _____
f. _____	f. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	f. _____

Column 2
Enter its ICD-9-CM code at the level of highest specificity (no surgical, procedure codes)

M1020/1022/1024



(M1020) Primary Diagnosis & (M1022) Other Diagnoses Column 1	Column 2	(M1024) Payment Column 3
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code assigned under circumstances to be in place of a case diagnosis.
Description	ICD-9-C M/ Symptom Control Rating	Description ICD-9-C M
(M1020) Primary Diagnosis	(V-codes are allowed)	(V- or E-codes NOT)
a. _____	a. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	a. _____
(M1022) Other Diagnoses	(V- or E-codes are allowed)	
b. _____	b. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	
c. _____	c. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	
d. _____	d. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	
	e. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	
	f. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	

Column 2
Rate the degree of symptom control for each condition
Choose one value that represents the degree of symptom control appropriate for each diagnosis

Do not assign symptom control ratings for V- or E-codes.



Symptom Control Rating

Symptom Control Ratings Defined:

- 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



Symptom Control Rating

- The symptom control rating should not be used to determine the sequencing of the diagnoses
- Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided

M1020/1022/1024



Columns 3 and 4

If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses may be completed. Refer to Appendix D for guidance.

Other Diagnoses	(M1024) Payment Diagnoses (OPTIONAL)	
Column 2	Column 3	Column 4
ICD-9-CM and symptom control rating for each condition. Note that the sequencing of ratings may not match sequencing of the diagnoses.	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete <u>only</u> if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
ICD-9-CM/ Symptom Control Rating	Description/ ICD-9-CM	Description/ ICD-9-CM
Diagnoses are a	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
	a. _____ (. . . .)	a. _____ (. . . .)
	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
	b. _____ (. . . .)	b. _____ (. . . .)
	c. _____ (. . . .)	c. _____ (. . . .)
	d. _____	d. _____
	e. _____	e. _____
	f. _____	f. _____

A case mix diagnosis gives a score toward the Medicare PPS group assignment.



Payment Diagnoses

- **Column 4: (OPTIONAL)**
- If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines:
 - Enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4

M1020/1022/1024



(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
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-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete <u>only</u> if the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M/ Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis	(V-codes are allowed)	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
a. _____	a. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	a. (_____)	a. (_____)
(M1022) Other Diagnoses	(V- or E-codes are allowed)	(V- or E-codes NOT allowed)	(V- or E-codes NOT allowed)
b. _____	b. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
c. _____	c. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
d. _____	d. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
e. _____	e. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	e. _____	e. _____
f. _____	f. (_____) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		

Column 3
Etiology
Underlying
Condition

Column 4
Manifestation

Complete Column 4 ONLY
If the case mix dx
is a manifestation code



Coding Accurately

- To code diagnoses accurately and compliantly
 - CMS expects HHAs to understand each patient's specific clinical status before selecting and assigning each diagnosis



Coding Accurately

- Each patient's overall medical condition and care needs must be comprehensively assessed
- **BEFORE** the HHA identifies and assigns each diagnosis for which the patient is receiving home care.



Coding Accurately

- Each **diagnosis** (other than an E code) **must comply** with the “Criteria for OASIS Diagnosis Reporting.”
- See Appendix D - if a patient has a **resolved condition** which has **no impact** on the patient’s **current plan of care**, then the **condition does not meet the criteria** for a **home health diagnosis** and **should not be coded**



M1020 Primary Diagnosis

- The **primary diagnosis** should be:
 - the **diagnosis most related** to the patient's **current plan of care**,
 - the **most acute diagnosis** and
 - therefore the **chief reason** for providing home care



M1022 Secondary Diagnosis

- All conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care
- Include not only conditions actively addressed in the POC but also any co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis
 - Even if the condition is not the focus of any home health treatment itself



M1022 Secondary Diagnosis

- Avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome
- List in the order to best reflect the seriousness of the patient's condition and justify the disciplines and services provided



M1022 Secondary Diagnosis

- List by the degree they impact the patient's health and need for home health care, rather than the degree of symptom control
- Example, if a patient is receiving home health care for Type 2 diabetes which 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"



M1022 Secondary Diagnosis

- The diagnosis may or may not be related to a patient's recent hospital stay but must relate to the services rendered by the HHA
- Skilled services (skilled nursing, physical, occupational and speech language pathology) are used in judging the relevancy of a diagnosis to the plan of care and to the OASIS



Case Mix or Payment Dx

- A case-mix diagnosis is a diagnosis that gives a patient a score for Medicare Home Health PPS case-mix group assignment
- A case mix diagnosis may be the primary diagnosis, “other” diagnosis, or a manifestation associated with a primary or other diagnosis



Case Mix or Payment Dx

- Each diagnosis listed in M1020 and M1022 should be supported by the patient's medical record documentation
- The list of case mix diagnosis codes is included in the HH PPS Grouper documentation available on the CMS web site



V Codes

- V codes may be primary or secondary codes
- CMS expects HHAs to avoid assigning excessive V-codes to the OASIS
- V-codes are less specific to the clinical condition of the patient than are numeric diagnosis codes



V Codes

- In the home health setting, V-codes are appropriately assigned to M1020 and M1022 when:
 - a patient with a resolving disease or injury requires specific aftercare of that disease or injury
 - Example: surgical aftercare or aftercare for rehabilitation



V Codes

- V codes and E codes **may not** be entered in optional Columns 3 or 4 as these columns pertain to the Medicare PPS case mix diagnosis only
 - See Appendix D for further guidance
- No surgical codes – list underlying diagnosis



M1030

- **(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



M1030 Therapies at Home

- 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



M1030 Therapies at Home

- Mark the applicable therapy
 - If the patient will receive such therapy as a result of this SOC/ROC or follow-up assessment
 - Example: the IV will be started at this visit or a specific subsequent visit; the physician will be contacted for an enteral nutrition order; etc.



M1030 Therapies at Home

- Select “1” if a patient receives intermittent medications or fluids via an IV line (e.g., heparin or saline flush)
- Do **not** mark “1” if IV catheter is present but not active (e.g., site is observed only or dressing changes are provided)



M1030 Therapies at Home

- Select “1” if ongoing infusion therapy is being administered at home via
 - central line,
 - subcutaneous infusion,
 - epidural infusion,
 - intrathecal infusion,
 - insulin pump
 - hemodialysis or peritoneal dialysis IN THE HOME



M1030 Therapies at Home

- Do NOT select “1”
 - if there are orders for an IV infusion to be given when specific parameters are present (e.g., weight gain),
 - but those parameters are not met on the day of the assessment



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



M1032

- **(M1032) Risk for Hospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization?

(Mark all that apply.)

- 1 - Recent decline in mental, emotional, or behavioral status
- 2 - Multiple hospitalizations (2 or more) in the past 12 months
- 3 - History of falls (2 or more falls - or any fall with an injury - in the past year)
- 4 - Taking five or more medications
- 5 - Frailty indicators, e.g., weight loss, self-reported exhaustion
- 6 - Other
- 7 - None of the above



M1032 Risk for Hospitalization

- Patient characteristics that may indicate patient is at risk for hospitalization in the **care provider's professional judgment**
- Response 3, History of falls, includes witnessed and unwitnessed falls
- In Response 4, Taking five or more medications, includes OTC meds



M1032 Risk for Hospitalization

- **Recent decline in mental, emotional, or behavioral status** refers to significant changes occurring over the past year that may impact the patient's ability to remain safely in the home and increase the likelihood of hospitalization
- **Frailty** includes weight loss in the last year, self-reported exhaustion, and slower movements (sit to stand and while walking)



M1034

- **(M1034) Overall Status:** Which description best fits the patient's overall status?
(Check one)
 - 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.



M1034 Overall Status

- The general potential for health status stabilization, decline, or death
- Use information from other providers and clinical judgment
- Consider current health status, medical dx, and information from the physician and patient/family on expectations for recovery or life expectancy
- DNR order not needed for 2 or 3



M1036

- **(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



M1036 Risk Factors

- 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**



M1036 Risk Factors

- CMS does not provide a specific definition for each of these factors
 - Amount and length of exposure (e.g., smoking one cigarette a month may not be considered a risk factor) should be considered when responding.
- Use judgment in evaluating risks to current health conditions from behaviors that were stopped in the past



M1040

- **(M1040) Influenza Vaccine:** Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?
 - 0 - No
 - 1 - Yes [**Go to M1050**]
 - NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season.
[**Go to M1050**]



M1040 Influenza Vaccine

- Did the patient receive an influenza vaccine for the current influenza season from the HHA during this episode of care?
- Episode of care = SOC/ROC to TRN or DC
 - For each influenza season, the Centers for Disease Control (CDC) recommends the timeframes for administration of the influenza vaccines



M1040 Influenza Vaccine

- Only mark responses 0 or 1 if **any** portion of the home health episode
(from SOC/ROC to transfer or discharge) occurs during the influenza season as identified by the CDC
- Only select 1 if the patient received the flu vaccine from **your agency** during this episode (SOC/ROC to Transfer/Discharge)



M1040 Influenza Vaccine

- **Does not assess** influenza vaccines given by **another health care provider** or provision of the flu vaccine by your agency **earlier in the flu season** prior to the most recent SOC/ROC
- **Mark NA** if the entire home health episode (from most recent SOC/ROC to transfer or discharge) occurs outside the influenza season



M1045

- **(M1045) Reason Influenza Vaccine not received:** If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:
 - 1 - Received from another health care provider (e.g., physician)
 - 2 - Received from your agency previously during this year's flu season
 - 3 - Offered and declined
 - 4 - Assessed and determined to have medical contraindication(s)
 - 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine
 - 6 - Inability to obtain vaccine due to declared shortage
 - 7 - None of the above



M1045 Reason Flu Vaccine Not Received

- The reason patient did not receive an influenza vaccine from your agency during this home health care episode of care
- Select “1” if there is documentation in the medical record that:
 - the patient received the influenza vaccine for the current flu season from another provider
 - The provider can be the pt’s MD, a clinic or health fair providing influenza vaccines, etc.



M1045 Reason Flu Vaccine Not Received

- Select “2” if your agency provided the flu vaccine for this year’s flu season prior to this home health episode
 - E.g. 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



M1045 Reason Flu Vaccine Not Received

- Select “3” if the patient and/or healthcare proxy (e.g., someone with power of attorney refused the vaccine



M1045 Reason Flu Vaccine Not Received

- Select “4” if the influenza vaccine is contraindicated for medical reasons.
 - Medical contraindications include:
 - anaphylactic hypersensitivity to eggs or other component(s) of the vaccine,
 - hx of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, or
 - bone marrow transplant within 6 months



M1045 Reason Flu Vaccine Not Received

- Select “5” if age/condition guidelines indicate that influenza vaccine is not indicated for this patient
- Select “7” only if the home health agency did not provide the vaccine due to a reason other than responses 1-6



M1050

- **(M1050) Pneumococcal Vaccine:** Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC Transfer/Discharge)?
 - 0 - No
 - 1 - Yes [*Go to M1500 at TRN; Go to M1230 at DC*]



M1050 PPV

- Did the patient receive a PPV from the HHA during this episode of care?
 - This item does not assess PPVs given by another care provider
- Select “1” only if the patient received the pneumococcal (PPV) vaccine from your agency during this episode
 - Most recent SOC/ROC to Transfer/Discharge



M1055

- **(M1055) Reason PPV not received:** If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:
 - 1 - Patient has received PPV in the past
 - 2 - Offered and declined
 - 3 - Assessed and determined to have medical contraindication(s)
 - 4 - Not indicated; patient does not meet age/condition guidelines for PPV
 - 5 - None of the above



M1055 Reason PPV Not Rcvd

- Why didn't the patient receive a PPV from the HHA during this episode of care? (from SOC/ROC to transfer or DC)
- Select “1” if the patient received the PPV from your HHA or from another provider
 - Including the patient's physician, a clinic or health fair, etc.) **at any time in the past**
- PPV does not need to be up-to-date



M1055 Reason PPV Not Rcvd

- Select “2” if the patient and/or healthcare proxy (e.g., power of attorney) refused the vaccine
- Select “3” if PPV is medically contraindicated
 - Anaphylactic hypersensitivity to vaccine
 - Acute febrile illness bone marrow transplant within past 12 months, or
 - Receiving course of chemotherapy or radiation therapy within past 2 weeks



M1055 Reason PPV Not Rcvd

- Select “4” if CDC age/condition guidelines indicate that PPV is not indicated for this patient
- Only select “5” if the home health agency did not provide the vaccine due to a reason other than responses 1- 4



OASIS - C

Clinical Record Items



M0080

- **(M0080) Discipline of Person Completing Assessment:**

- 1-RN 2-PT 3-SLP/ST 4-OT



M0080 Discipline of Person Completing Assessment

- Only one individual completes the comprehensive assessment
 - If more than one discipline involved in case
 - Care coordination & consultation is needed
 - But only ONE actually completes & records assessment



M0080 Discipline of Person Completing Assessment

- RN & PT/SLP ordered at initial referral, the RN **must** perform SOC comprehensive assessment
- RN, PT, SLP or OT may perform subsequent assessments
- LPNs, PTAs, COTAs, MSWs, & HH aides not authorized to complete comprehensive assessments
- The last qualified clinician to see patient at DC completes the DC assessment



M0090

- **(M0090) Date Assessment Completed:**

___ / ___ / _____
month / day / year



M0090 Date Assessment Completed

- The actual date the assessment is completed
- M0090 cannot be before the SOC date
- If agency policy allows assessments to be completed over more than one visit date
 - M0090 = the last date – when the final assessment data is collected



M0090 Date Assessment Completed

- Record date data collection completed after learning of event:
 - Transfer to Inpatient Facility; no agency DC
 - Transfer to Inpatient Facility; patient discharged from agency
 - Death at Home
- A visit is not necessarily associated with these events



M0100₁

- **(M0100) This Assessment is Currently Being Completed for the Following Reason:**

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 M1040*]
- 7 – Transferred to an inpatient facility—patient discharged from agency [*Go to M1040*]

Discharge from Agency — Not to an Inpatient Facility

- 8 – Death at home [*Go to M0903*]
- 9 – Discharge from agency [*Go to M1040*]



M0100₂

- (M0100) This Assessment is Currently Being Completed for the Following Reason:

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**]



M0100₃

Transfer to Inpatient Facility

- 6 – Transferred to an inpatient facility—patient not discharged from agency [**Go to M1040**]
- 7 – Transferred to an inpatient facility—patient discharged from agency [**Go to M1040**]

Discharge from Agency – Not to an Inpatient Facility

- 8 – Death at home [**Go to M0903**]
- 9 – Discharge from agency [**Go to M1040**]



M0100

- Assessment/data collection time points
- Reason why the assessment data are being collected and reported
 - Reason for assessment (RFA)
- Data reporting software accepts or rejects certain data based on the M0100 response
 - Accuracy critical



RFA 1- Start of Care

- Comprehensive assessment completed when the POC established
 - Whether or not further visit will be provided after the SOC visit
 - Appropriate response anytime a HHRG is required



RFA 3 - ROC

- Resumption of Care (ROC) comprehensive assessment
- Performed when resuming care of patient
 - Following inpatient stay of 24 hrs. or longer
 - For reasons other than diagnostic testing



RFA 3 - ROC

- If resuming care during last 5 days of the episode following inpatient discharge
 - Perform ROC not a Recertification (RFA 4)
 - Answer payment questions as if Recert
 - This assessment establishes payment code for next 60 day episode



RFA 4 - Recertification

- Comprehensive assessment during last five days of the 60-day cert period
 - Need to continue services for additional 60 day episode of care



RFA 5 – Other Follow-up

- Comprehensive assessment due to a major decline or improvement in health status
 - At time other than during the last 5 days
- Reevaluation of patient's condition
 - Allowing revision of POC, as appropriate



RFA 6 – Transfer; No DC

- Data collection completed when:
 - Admitted to inpatient facility bed for 24 hrs or more
 - For reasons other than diagnostic test
- Expectation that home care will be resumed following discharge from facility



RFA 6 – Transfer; No DC

- Short stay observation periods in a hospital do not count as a Transfer
 - Regardless of duration
- Not a comprehensive assessment – does not require a home visit
 - May gather information via telephone



RFA 7 – Transfer & DC

- Data collection completed when:
 - Admitted to inpatient facility bed for 24 hrs or more
 - For reasons other than diagnostic test
- No plan to resume care of patient
- No additional OASIS DC data required
- Short stay observation periods in a hospital do not count as a Transfer
 - Regardless of duration



RFA 7 – Transfer & DC

- Also completed when patient dies:
 - In ER
 - In Inpatient bed before stay of 24 hours

(M0906 guidance)



RFA 8 – Death at Home

- Data collection – not assessment
- Patient dies before being treated in an ER or before being admitted to an inpatient facility



RFA 9 - Discharge

- Comprehensive assessment when patient discharged from agency
 - For reasons other than death or transfer to inpatient facility
 - An actual patient interaction, a visit, is required
- Complete when you transfer and discharge to another HHA or an in-home hospice



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.

___ / ___ / _____

(Go to M0110, if date entered)

month / day / year

- NA – No specific SOC date ordered by physician



M0102

- Date of physician-ordered SOC/ROC
 - **If** MD indicated a specific date on referral
 - If date entered, skip M0104-Date of referral and go to M0110, Episode Timing
 - Mark NA - If initial orders do not specify a SOC date
- If the originally ordered SOC is delayed for any reason
 - Report the date on the updated or revised order



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.

___ / ___ / _____
month / day / year



M0104 - Date of Referral

- Most recent date verbal, written or electronic authorization to begin care was **received** by HHA
- If SOC is delayed for any reason, driven by patient's condition or MD request
 - Report the date HHA received updated/revised referral information
- Does not refer to calls from ALF or family preparing HHA for possible admission



M0110

- **(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?
 - 1 - Early
 - 2 - Later
 - UK - Unknown
 - NA - Not Applicable: No Medicare case mix group to be defined by this assessment.



M0110 – Episode Timing

- PPS payment item
 - Also used by non-PPS payers using a PPS-like payment model
- Identifies **placement** of the current MC payment episode in the patient's current **sequence** of **adjacent** MC PPS payment episodes



M0110 – Episode Timing

- **Sequence** of adjacent MC PPS payment episodes = a continuous series of MC PPS payment episodes
 - Regardless of whether the same HHA provided care for the entire series
 - Low utilization payment adjustment (LUPA) episodes (less than 5 total visits) and Partial Episode Payments (PEP) included
 - Denied episodes are not included



M0110 – Episode Timing

- Adjacent means there was no gap between MC-covered episodes of more than 60 days
 - Care under HMO, MA or private payer = gap days when counting the sequence of MC episodes



M0110 – Episode Timing

- “1-Early” selected if this is:
 - the only PPS episode in a single episode case
- OR
- the first or second PPS episode in a sequence of adjacent MC home health PPS payment episodes



M0110 – Episode Timing

- “2-Later” selected if this is:
 - the third or later PPS episode in a current sequence of adjacent Medicare home health PPS payment episodes
- “UK - Unknown” selected if:
 - the placement of this PPS payment episode in the sequence of adjacent episodes is unknown.
 - For payment, this will have the same effect as selecting the “Early” response



M0110 – Episode Timing

- Enter “NA” if no Medicare case mix group is to be defined for this episode.
- If you select “NA” you cannot generate the PPS payment code (HIPPS/HHRG).
- Some non-MC payers will use this information in setting an episode payment rate



Counting Days Manually

- A MC payment episode ordinarily comprises 60 days **beginning** with **SOC date**, or 60 days **beginning** with **recertification date**
- There can be a **gap of up to 60 days** between episodes in the same sequence
- **To determine if adjacent count** from the **last day of one payment episode** (Day 0) until the **first day of the next**
- If you count 60 or less = adjacent episode



Counting Days Manually

- A sequence of adjacent MC payment episodes continues **as long as there is no 60-day gap**, even if Medicare episodes are provided by different home health agencies.
- Episodes with HMOs, Medicaid, or private payers do NOT count as part of a sequence – they are part of the gap between PPS episodes
- If the period of service with those payers is 60 days or more, the next MC home health payment episode would begin a new sequence.



OASIS - C

Living Arrangements



M1100 Patient Living Situation

Living Arrangement	Availability of Assistance				
	Around the clock	Regular Daytime	Regular Nighttime	Occasional/short-term assistance	No assistance available
a. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05
b. Patient lives with other person's) in the home	<input type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
c. Patient lives in congregate situation (e.g. assisted living)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15



M1100 Patient Living Situation

- **Determine** in the care provider's **professional judgment**
 - a) whether the patient is living alone or with other's) and
 - b) the availability of the people who live with the patient to provide **physical** assistance
- **To answer this question:**
 - First, determine where the patient lives
 - Second, determine who lives with the patient
 - Third, determine how much assistance home-mates can/will give



M1100 Patient Living Situation

- Identify the frequency with which in-person **physical assistance** is provided
- Physical assistance includes assistance with:
 - ADLs and IADLs,
 - including meal preparation and medication management
- Does **not** include assistance from someone by phone or emergency assistance (Lifeline or 911)



M1100 Patient Living Situation

- Select **Box 10** if a **person** living in the patient's home may not provide any **ADL/IADL** assistance
- Select a response from **Row a** if the patient lives **alone** in an independent (**non-assisted**) setting
 - 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**.



M1100 Patient Living Situation

- Select a response from **Row b** if the patient lives with others in an independent (non-assisted) setting
 - Example: the patient lives with a spouse, family member or another significant other in an independent (non-assisted) setting
- 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
 - 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



M1100 Patient Living Situation

- Use your **professional judgment** to determine if the people the patient lives with can/will provide physical assistance to the patient if needed
 - Consider home-mates' cognitive, physical and emotional ability to provide needed physical assistance with ADLs and IADLs
- Consider when they are in the home and the relationship the patient has with home-mates



M1100 Patient Living Situation

- If the **patient living situation varies**:
 - A caregiver temporarily staying with the patient to provide care
 - A family member living with the patient who occasionally travels out of town
- Select the response that best reflects the **usual living arrangements**



OASIS-C

Sensory Status



M1200

- **(M1200) Vision** (with corrective lenses if the patient usually wears them):
 - 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.



M1200 Vision

- Identifies ability to see and visually manage (function) safely within his/her environment
 - wearing corrective lenses usually worn
 - 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.
- “Nonresponsive” - the patient is not **able** to respond
- Be sensitive to requests to read, as patient may not be able to read though vision is adequate



M1210

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



M1210 Hearing

- Identifies ability to hear spoken language and other sounds (e.g., alarms, etc.)
 - Assess with hearing aids or devices if he/she usually uses them
- Select the “UK” if the patient is not **able** to respond or if it is otherwise impossible to assess hearing
 - E.g. severe dementia, schizophrenia, unconscious



M1220

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



M1220 Understanding Verbal Content

- Identifies 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
- “**UK**” should be selected if the patient is not **able** to respond or if it is otherwise impossible to assess understanding of spoken words and instructions



M1220 Understanding Verbal Content

- If 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



M1230

- **(M1230) Speech and Oral (Verbal) Expression of Language** (in patient's own language):
 - 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 (e.g., speech is nonsensical or unintelligible).
 - 5 - Patient nonresponsive or unable to speak.



M1230 Speech & Oral (Verbal) Expression of Language

- Identifies the patient's physical and cognitive ability to communicate in the patient's primary language
 - Does not address communicating in sign language, in writing, or by any nonverbal means
- Augmented speech (e.g., a trained esophageal speaker, use of an electrolarynx) **is** considered verbal expression of language



M1230 Speech

- 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?
- Select “5” for a patient who communicates entirely nonverbally (e.g., by sign language or writing) **or** is unable to speak
- “Nonresponsive” means that the patient is not **able** to respond



M1240

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



M1240 Pain Assessment

- Was a standardized pain assessment conducted?
- Was a clinically significant level of pain is present?
 - as determined by the assessment tool used
- Process measure item – Does the HHA utilize best practices?
 - Best practices are not necessarily required in the Conditions of Participation



M1240 Pain Assessment

- A standardized tool includes a standard response scale (e.g., a scale where patients rate pain from 0-10)
 - It 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 system for the standardized tool being used
- CMS does not endorse a specific tool



M1240 Pain Assessment

- Select “0” if such a tool was not used to assess pain
- In order to respond “1” or “2”, the pain assessment must be **conducted by agency staff** during the **allowed data collection time frame**
 - SOC within 5 days
 - ROC within 48 hours following inpatient discharge



M1242

- **(M1242) Frequency of Pain Interfering** with patient's activity or movement:
 - 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



M1242 Freq Pain Interferes

- Identifies frequency with which pain interferes with patient's activities or movement
 - with treatments if prescribed
- 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
 - causes the activity to take longer to complete



M1242 Freq Pain Interferes

- 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



M1242 Freq Pain Interferes

- Don't overlook seemingly unimportant activities
 - e.g., 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 ability to perform ADLs and IADLs can provide additional information about such pain



M1242 Freq Pain Interferes

- Assessing pain in a nonverbal patient involves:
 - observation of facial expression (e.g., frowning, gritting teeth),
 - monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or
 - use of visual pain scales (e.g., FACES)



M1242 Freq Pain Interferes

- Pain treatment (whether pharmacologic or nonpharmacologic) must be considered when evaluating whether pain interferes with activity or movement
- Well controlled pain may not interfere with activity or movement at all



OASIS - C

Integumentary Status



M1300

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



M1302

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



M1306

- **(M1306)** Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as "unstageable"?
 - 0 - No [**Go to M1322**]
 - 1 - Yes



M1307

- **(M1307) The Oldest Non-epithelialized Stage II Pressure Ulcer** that is present at discharge
 - 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 non-epithelialized Stage II pressure ulcers are present at discharge



M1308₁

- **(M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:** (Enter “0” if none; excludes Stage I pressure ulcers)

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	—	—
b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	—	—
c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	—	—
d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	—	—
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	—	—
d.3 Unstageable: Suspected deep tissue injury in evolution.	—	—



M1308₂

- **(M1308) Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:**
(Enter “0” if none; excludes Stage I pressure ulcers)



M1308₃

	Column 1 Complete at SOC/ROC/FU & D/C	Column 2 Complete at FU & D/C
Stage description – unhealed pressure ulcers	<u>Number Currently Present</u>	<u>Number of those listed in Column 1 that were present on admission (most recent SOC / ROC)</u>
a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	—	—



M1308₄

<p>b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.</p>	<p>—</p>	<p>—</p>
<p>c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.</p>	<p>—</p>	<p>—</p>



M1308₅

d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device	—	—
d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	—	—
d.3 Unstageable: Suspected deep tissue injury in evolution.	—	—



Directions for M1310, M1312, and M1314

- If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.



M1310

- **(M1310) Pressure Ulcer Length:** Longest length
“head-to-toe”

___ | ___ | . | ___ | (cm)



M1312

- **(M1312) Pressure Ulcer Width:** Width of the same pressure ulcer; greatest width perpendicular to the length

| ___ | ___ | . | ___ | (cm)



M1314

- **Pressure Ulcer Depth:** Depth of the same pressure ulcer; from visible surface to the deepest area

| ___ | ___ | . | ___ | (cm)



M1320

- **(M1320) Status of Most Problematic (Observable) Pressure Ulcer:**

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



M1322

- **(M1322) Current Number of Stage I 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.

0 1 2 3 4 or more



M1324

- **(M1324) Stage of Most Problematic Unhealed (Observable) Pressure Ulcer:**

- 1 - Stage I
- 2 - Stage II
- 3 - Stage III
- 4 - Stage IV
- NA - No observable pressure ulcer or unhealed pressure ulcer



M1330

- **(M1330)** Does this patient have a **Stasis Ulcer**?
 - 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 [**Go to M1340**])



M1332

- **(M1332) Current Number of (Observable) Stasis Ulcer(s):**

- 1 - One
- 2 - Two
- 3 - Three
- 4 - Four or more



M1334

- **(M1334) Status of Most Problematic (Observable) Stasis Ulcer:**

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing



M1340

- **(M1340)** Does this patient have a **Surgical Wound**?
 - 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 [**Go to M1350**]



M1342

- **(M1342) Status of Most Problematic (Observable) Surgical Wound:**

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing



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?
 - 0 - No
 - 1 - Yes



OASIS - C

Respiratory Status



M1400

- **(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 (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
 - 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
 - 4 - At rest (during day or night)



M1400 Dyspnea

- Identifies the level of exertion/activity that results in dyspnea or shortness of breath
- Critical assessment rule
 - If oxygen used continuously, mark response based on assessment of the patient's SOB while using oxygen
 - If oxygen used intermittently, mark response based on the patient's SOB WITHOUT the use of oxygen



M1400 Dyspnea

- For a chairfast or bedbound patient, evaluate the level of exertion required to produce shortness of breath while performing ADLs or at rest
 - “0” if not SOB during the day of assessment
 - “1” if demanding bed-mobility activities produce dyspnea in the bedbound patient (or physically demanding transfer activities produce dyspnea in the chairfast patient)



M1410

- **(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



M1410 Respiratory Treatments

- Identifies any of the listed respiratory treatments being used by this patient in the home
 - Excludes any respiratory treatments that are not listed in the item (e.g., does not include nebulizers, inhalers, etc.)
- “3” reflects both CPAP and BiPAP



OASIS - C

Cardiac Status



M1500

- **(M1500) Symptoms in Heart Failure Patients:** If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?
 - 0 - No [**Go to M2004 at TRN; Go to M1600 at DC**]
 - 1 - Yes
 - 2 - Not assessed [**Go to M2004 at TRN; Go to M1600 at DC**]
 - NA - Patient does not have diagnosis of heart failure [**Go to M2004 at TRN; Go to M1600 at DC**]

Collected at Transfer & Discharge



M1500 Symptoms in HF Patients

- Identifies whether a patient with a **diagnosis of heart failure** experienced one or more **symptoms of heart failure since the most recent OASIS assessment**
- A complete list of symptoms of heart failure can be found in clinical heart failure guidelines
 - Examples of standard clinical guidelines can be found in Chapter 5, Resources



M1500 Symptoms in HF Patients

- **Process measure** item - Captures 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 (CoPs)



M1500 Symptoms in HF Patients

- **Only select 0, 1, or 2 if the patient has a diagnosis of heart failure in any one of:**
 - M1010: Inpatient Diagnoses
 - M1016: Diagnoses Causing Change in Treatment, or
 - M01020/1022/1024: Primary/Secondary diagnoses for home care
- **Select NA if no diagnosis of heart failure**



M1500 Symptoms in HF Patients

- Consider any **new or ongoing** heart failure symptoms that occurred **since the previous OASIS assessment**
- **Data collection sources** - Review of clinical record including physical assessment data, weight trends, clinical notes using HHA systems designed for this purpose
 - (e.g., flow sheets, electronic health record data reports, etc.)



M1510

- **(M1510) Heart Failure Follow-up:** If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**
 - 0 - No action taken
 - 1 - Patient's physician (or other primary care practitioner) contacted the same day
 - 2 - Patient advised to get emergency treatment (e.g., 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 (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)

Collected at Transfer & Discharge



M1510 Heart Failure Follow-up

- Identifies **actions** the HHA providers took **in response to symptoms of HF** that occurred **since the most recent OASIS assessment**
- **Process measure** item – Best Practices
- The best practices/assessments stated in the item are not necessarily required in the Conditions of Participation



M1510 Heart Failure Follow-up

- Include **any actions** that were taken **at least one time** since completion of the **last OASIS assessment**
- If the **interventions are not completed** as outlined in this item, select **“0 – No action taken”**
 - **Document rationale** in the clinical record
 - If “0” selected, no other responses should be selected



M1510 Heart Failure Follow-up

- “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
- “1” **only** if a physician **responds** with **acknowledgment** of receipt of information and/or **further advice or instructions**



M1510 Heart Failure Follow-up

- In many situations, other responses will also be marked that indicate the action taken as a result of the contact (i.e., any of responses 2-5) – **Mark all that apply**
- Response 3 best when the clinician either:
 - reminds the patient to implement an intervention or
 - is aware patient is following physician-established parameters for treatment



M1510 Heart Failure Follow-up

- **Data collection sources** - Review of clinical record including physical assessment data, weight trends, clinical notes since the previous OASIS assessment
 - (e.g., flow sheets, electronic health record data reports, etc.)
- Physician-ordered home health plan of care
- Examples of standard clinical guidelines can be found in Chapter 5, Resources



OASIS - C

Elimination Status



M1600

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



M1600 UTI Treatment

- Identifies treatment of urinary tract infection during the past 14 days
- “Past fourteen days” is the two-week period immediately preceding the SOC/ROC/DC
 - When counting the 14-day period
 - The date of admission is day 0 and
 - The day immediately prior to the date of admission is day 1
- “UK” is not an option at discharge from agency



M1600 UTI Treatment

- Select “**0-No**”
 - if patient has **not** been **treated** for a UTI within the past two weeks
 - 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**



M1600 UTI Treatment

- Select “**1-Yes**”
 - When the patient has been prescribed an **antibiotic** within the past 14 days specifically for a confirmed or suspected UTI
 - If the patient is on prophylactic treatment **and** develops a UTI
- Select “**NA**” if the patient is on **prophylactic treatment** to prevent UTIs



M1610

- **(M1610) Urinary Incontinence or Urinary Catheter Presence:**

- 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 (i.e., external, indwelling, intermittent, suprapubic) [**Go to M1620**]



M1610 Urinary Incontinence or Urinary Catheter Presence

- Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type
 - including intermittent or indwelling
- A leaking urinary drainage appliance is **not** incontinence.



M1610 Urinary Incontinence or Urinary Catheter Presence

- Select “0” if the patient has anuria or an ostomy for urinary drainage (e.g., an ileal conduit)
- Select “0” If the patient has a urinary diversion **that is pouched** (ileal conduit, urostomy, ureterostomy, nephrostomy), with or without a stoma



M1610 Urinary Incontinence or Urinary Catheter Presence

- Select “1” incontinent AT ALL, i.e., “occasionally”, “only when I sneeze”, “sometimes I leak a little bit”, etc.
- Select “1” if dependent on a timed-voiding
- Timed voiding is scheduled toileting assistance or prompted voiding to manage incontinence based on identified patterns
 - Time voiding is a compensatory strategy; it does not cure incontinence



M1610 Urinary Incontinence or Urinary Catheter Presence

- Select “2” if a catheter or tube is utilized for drainage (even if intermittent)
- Select “2” if patient requires use of a urinary catheter for any reason (e.g., retention, post-surgery, incontinence, etc.)
- Select “2” and follow skip pattern if patient is **both** incontinent and requires a urinary catheter



M1615

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



M1615 When Urinary Incontinence Occurs

- Select “0” **only** if timed-voiding defers incontinence
- Select “1” – Occasional stress incontinence
 - 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



M1615 When Urinary Incontinence Occurs

- 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 select response 2, 3, or 4 as appropriate
- Select “2” when incontinence only occurs while the patient is sleeping at night



M1615 When Urinary Incontinence Occurs

- Select “3” when incontinence only occurs while the patient is up/awake during the day
 - Includes incontinence during daytime naps
- Select “4” if incontinent when sleeping at night and up/awake during the day
- Assessment strategies included in Chapter 3



M1620

- **(M1620) Bowel Incontinence Frequency:**

- 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**]



M1620 Bowel Incontinence Freq.

- 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 (e.g., a bowel program)



M1620 Bowel Incontinence Freq.

- “4 - On a daily basis” indicates that the patient experiences bowel incontinence once per day
- “NA” is used if patient has an ostomy for bowel elimination
- “UK” is not an option at follow-up or DC
- Assessment strategies included in Ch. 3



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?
 - 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.



M1630 Ostomy for Bowel Elim.

- Identifies whether the patient has an ostomy for bowel elimination

and, if so,

- Whether it was related to a recent inpatient stay or caused a change in medical treatment plan



M1630 Ostomy for Bowel Elim.

- Applies to any type of ostomy for bowel elimination
 - Examples: colostomy, ileostomy, etc.
- This item only addresses bowel ostomies, not other types of ostomies
 - Examples: urinary ostomies, tracheostomies, etc.



M1630 Ostomy for Bowel Elim.

- If an ostomy has been reversed, the patient does **not** have an ostomy at the time of assessment
- 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**



OASIS-C

Neuro/ Emotional/ Behavioral Status



M1700 Cognitive Functioning₁

- **(M1700) Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
 - 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 (e.g., 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.



M1700 Cognitive Functioning₂

- Identifies **current level** of cognitive functioning.
 - Including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
- Consider the patient's signs/symptoms of cognitive dysfunction at the time of the assessment **AND** that have occurred over the past 24 hours.
- Consider amount of supervision and care required due to cognitive deficits.



M1700 Cognitive Functioning₃

- Patients with dementia, delirium, development delay disorders, mental retardation etc. **will** have various degrees of cognitive dysfunction.
 - Consider the degree of impairment.
- Patients with neurological deficits related to stroke, mood/anxiety disorders or who receive opioid therapy **may** have cognitive deficits.



M1710 When Confused₁

- **(M1710) When Confused (Reported or Observed Within the Last 14 Days):**

- 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



M1710 When Confused₂

- Identifies the time of day or situations when the patient experienced confusion, **if at all**.
- Assess specifically for confusion in the past 14 days.
- May not relate directly to M1700, Cognitive Functioning, as it reports what's true on the day of assessment.



M1710 When Confused₃

- If “occasionally” confused, identify the situation(s) in which confusion has occurred within the last 14 days, **if at all**
- “Nonresponsive” means patient is unable to respond or responds in a way that you can’t make a clinical judgment about the patient’s level of orientation



M1720 When Anxious₁

- **(M1720) When Anxious (Reported or Observed Within the Last 14 Days):**

- 0 - None of the time
- 1 - Less often than daily
- 2 - Daily, but not constantly
- 3 - All of the time
- NA - Patient nonresponsive



M1720 When Anxious₂

- Identifies frequency the patient has felt anxious within the past 14 days.
- Anxiety includes:
 - Worry that interferes with learning and normal activities OR
 - Feelings of being overwhelmed and having difficulty coping OR
 - Symptoms of anxiety disorders



M1730 Depression Screening₁

- **(M1730) Depression Screening:** Has the patient been screened for depression, using a standardized depression screening tool?
 - 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 [®] Pfizer	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	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

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

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M1730 Depression Screening₂

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[®] Pfizer	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	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na



M1730 Depression Screening₃

- Has the HHA screened patient for depression using a standardized depression screening tool?
- CMS **does not mandate** that clinicians conduct depression screening for all patients, nor the use of the PHQ-2 or any other particular standardized tool.
- Item used for Process Measure – Best practices.
- The best practices in this item are not necessarily required in the CoPs.



M1730 Depression Screening₄

- Depressive feelings, symptoms and/or behaviors may be **observed** by the clinician or **reported** by the patient, family, or others.
- If a standardized 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.
- Select “0” if a **standardized** depression screening was not conducted.



M1730 Depression Screening₅

- Select “1” if the PHQ-2 Pfizer is completed when responding to the question:
“Over the last two weeks, how often have you been bothered by any of the following problems”
 - The results for row a & b are for agency use only and will not be encoded and transmitted with OASIS data.
 - If pt/cg scores at “3” or higher on the PHQ-2, further depression screening is indicated.



M1730 Depression Screening₆

- Select “2” if the patient is screened with a different standardized assessment
AND the tool indicated the need for further evaluation
- Select “3” if the patient is screened with a different standardized assessment
BUT the tool indicates no need for further evaluation



M1740 Cognitive, Behavioral, & Psychiatric Symptoms₁

- **(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, in-ability 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 (e.g., 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



M1740 Cognitive, Behavioral, & Psychiatric Symptoms₂

- **(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, in-ability to appropriately stop activities, jeopardizes safety through actions



M1740 Cognitive, Behavioral, & Psychiatric Symptoms₃

- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4 - Physical aggression: aggressive or combative to self and others (e.g., 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



M1740 Cognitive, Behavioral, & Psychiatric Symptoms₄

- Identifies specific behaviors associated with **significant** neurological, developmental, behavioral or psychiatric disorders.
 - Demonstrated once a week.
- Behaviors may be **observed** by the clinician or **reported** by the patient, family, or others.



M1740 Cognitive, Behavioral, & Psychiatric Symptoms₅

- Include behaviors severe enough to:
 - Make the patient unsafe to self or others OR
 - Cause considerable stress to caregivers OR
 - Require supervision or intervention
- If “7” is selected, none of the other responses should be selected.



M1745 Frequency of Disruptive Behavior Symptoms₁

- **(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.
 - 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



M1745 Frequency of Disruptive Behavior Symptoms₂

- Identifies frequency of any behaviors that are disruptive or dangerous to pt. or caregivers
- Are there any problematic behaviors which jeopardize or could jeopardize the safety and well-being of the patient or caregiver?
 - Not just the behaviors listed in M1740 – Cognitive, behavioral, and psychiatric symptoms
- How frequently do these behaviors occur?



M1745 Frequency of Disruptive Behavior Symptoms₃

- Include behaviors considered symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders.
- Use clinical judgment to determine if 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.



M1745 Frequency of Disruptive Behavior Symptoms₄

- Examples of disruptive/ dangerous behaviors include:
 - Sleeplessness, “sun-downing,”
 - Agitation, wandering,
 - Aggression, combativeness,
 - Getting lost in familiar places, etc.



M1750 Psychiatric Nursing₁

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



M1750 Psychiatric Nursing₂

- Identifies whether 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.



OASIS-C

ADLs/ IADLs



ADL General Conventions₁

- Identifies ABILITY, not necessarily actual performance.
- "Willingness" and "compliance" are not the focus.
- These items address patient's ability to **safely** perform included tasks, given:
 - current physical status
 - mental/emotional/cognitive status
 - activities permitted, and environment



ADL General Conventions₂

- 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 (e.g., limited range of motion, impaired balance)
 - Emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
 - Sensory impairments, (e.g., impaired vision or pain)
 - Environmental barriers (e.g., accessing grooming aids, mirror and sink, narrow doorways, stairs, location of bathroom, etc)



ADL General Conventions₃

- Ability may change as:
 - The patient's condition improves or declines,
 - As medical restrictions are imposed or lifted, or
 - As the environment is modified
- **Consider what the patient is able to do on the day of the assessment.**
- If ability varies over time, report the patient's ability more than 50% of the time period.



ADL General Conventions₄

- Scales present the most independent or optimal level first, then proceed to the most dependent or less optimal level.
- Read each response carefully to determine which one best describes what the patient is currently able to do.



ADL Assessment Strategies₁

- A combined observation/interview approach with pt. or caregiver is required to determine the most accurate response for these items.
- Ask the patient if he/she has difficulty with the functional tasks.
- Observe the patient's general appearance and clothing.
- Evaluate ROM, strength, balance, coordination, spinal flexion, and manual dexterity.



ADL Assessment Strategies₂

- Ask patient to demonstrate the body motions involved in performing tasks.
- Observe patient ambulating, during the bed to chair and toilet transfer, and actually stepping into shower or tub.
- Determine how much assistance the patient needs to perform the activity **safely**.



M1800 Grooming₁

- **(M1800) Grooming:** Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).
 - 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.



M1800 Grooming₂

- Ability to tend to personal hygiene needs.
 - **Includes** washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care.
 - **Excludes** bathing, shampooing hair, and toileting hygiene.
- The frequency with which grooming activities are necessary must be considered.
 - Patients able to do more frequently performed activities (e.g. washing hands and face) but unable to do less frequently performed activities (trimming fingernails).
 - Should be considered to have more ability in grooming.



M1800 Grooming₃

- In cases where patient's ability is different for various grooming tasks:
 - Select the response that best describes ability to perform the majority of grooming tasks.
- Response 2 “Someone must assist the patient to groom self” includes standby assistance or verbal cueing.



M1810 Upper Body Dressing₁

- **(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:
 - 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.



M1810 Upper Body Dressing₂

- Ability to dress upper body, including ability to obtain, put on and remove upper body clothing.
- Assess to put on whatever clothing is routinely worn.
 - Specifically includes ability to manage zippers, buttons, and snaps, if these are routinely worn.
- Prosthetic, orthotic, or other support devices applied to the upper body should be considered as upper body dressing items.
 - E.g., upper extremity prosthesis, cervical collar, or arm sling.



M1810 Upper Body Dressing₃

- If ability is different for various dressing upper body tasks, pick response that best describes ability to perform the majority of upper body dressing tasks.
- Select Response 2 – “Someone must help the patient put on upper body clothing”.
- If patient requires standby assistance (a "spotter") to dress **safely**.

or

- Requires verbal cueing/reminders.



M1820 Lower Body Dressing₁

- **(M1820) Current Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
 - 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 under-garments, slacks, socks or nylons, and shoes.
 - 3 - Patient depends entirely upon another person to dress lower body.



M1820 Lower Body Dressing₂

- Upper Body Dressing principles and concepts apply to lower body dressing.
- Prosthetic, orthotic, or other support devices applied to the lower body (e.g., lower extremity prosthesis, ankle-foot orthosis [AFO], or TED hose) should be considered as lower body dressing items.



M1830 Bathing₁

- **(M1830) Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**
 - 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 throughout the bath.
 - 6 - Unable to participate effectively in bathing and is bathed totally by another person.



M1830 Bathing₂

- **(M1830) Bathing:** Current ability to wash entire body safely.
Excludes grooming (washing face, washing hands, and shampooing hair).
 - 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.



M1830 Bathing₃

- 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 throughout the bath.
- 6 - Unable to participate effectively in bathing and is bathed totally by another person.



M1830 Bathing₄

- Ability to bathe entire body and the assistance that may be required to **safely** bathe, including transferring in/out of the tub/shower.
 - Specifically excludes washing face and hands, and shampooing hair.
- If standby assistance or verbal cueing/reminders required to bathe **safely** in the tub/shower.
 - Select “2” if assistance needed is intermittent.
 - Select “3” if assistance needed is continuous.



M1830 Bathing₅

- Select “2” - If transfer into/out of tub or shower is the **only** bathing task requiring human assistance.
- Select “2” if one, two, or all three types of assistance is required.
 - Intermittent supervision, encouragement or reminders
 - Help getting in and out of the shower/tub
 - Help washing difficult to reach areas



M1830 Bathing₆

- Medically restricted from stair climbing and the only tub/shower requires climbing stairs.
 - Patient is temporarily unable to bathe in 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.



M1830 Bathing₇

- Sink Bathers -
- For Response 4, patient must be able to safely and **independently** bathe outside tub/shower.
 - Including independently accessing water at the sink, or setting up basin at the bedside, etc.
- For Response 5, patient must be unable to bathe in tub/shower, **can participate** in bathing self but **needs assistance**.



M1830 Bathing₈

- Unable to bathe in tub or shower if:
 - No tub or shower in home.
 - Tub/shower nonfunctioning or not safe.
 - Select “4” or “5”, based on ability to bathe outside the tub/shower.
- Don’t make an assumption about patient’s ability to perform a task with equipment they do not currently have.



M1830 Bathing₉

- If patient is **totally unable to participate** in bathing and is totally bathed by another person.
 - Select Response 6.
 - Regardless of where bathing occurs or if patient has a functioning tub or shower.



M1840 Toilet Transferring₁

- **(M1840) Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely **and** transfer on and off toilet/commode.
 - 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.



M1840 Toilet Transferring₂

- Ability to **safely** get to and from **and** transfer on and off toilet or bedside commode.
 - Excludes personal hygiene and management of clothing when toileting.
- Select “0” if patient can get to and from toilet during the day independently, but uses commode at night for convenience.



M1840 Toilet Transferring₃

- Select “1” if patient:
 - Requires standby assistance to get to and from toilet **safely** or requires verbal cueing/reminders.
 - Can independently get to the toilet, but requires assistance to get on and off the toilet.
 - Needs assistance getting to/from toilet **OR** with toileting transfer **OR both**.



M1840 Toilet Transferring₄

- Select “3” if patient is:
 - **Unable** to get to/from the toilet or bedside commode, but **able** to place and remove bedpan/urinal independently.
 - Whether or not patient requires assistance to empty the bedpan/urinal.



M1845 Toileting Hygiene₁

- **(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.
 - 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.



M1845 Toileting Hygiene₂

- Ability to manage personal hygiene and clothing when toileting (with or without assistive devices).
- Includes pulling clothes up or down and adequately cleaning (wiping) the perineal area.
 - Includes cleaning area around stoma, but not managing equipment.
- “Assistance” refers to assistance from another person by:
 - Verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.



M1845 Toileting Hygiene₃

- If ability differs for:
 - Various toileting hygiene tasks
 - e.g., accessing toilet paper, wiping the perineal area
 - Various clothing management tasks
 - e.g., unzipping pants, removing pants, removing underclothing
- Select “2” able to participate in hygiene and/or clothing management but needs some assistance with either or both activities



M1850 Transferring₃

- For Response 1, “minimal human assistance” could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance.
- Select Response 1 if patient:
 - Transfers self from bed to chair, but requires standby assistance to transfer **safely**, or requires verbal cueing/reminders.
 - Transfers **either** with minimal human assistance (no device), **or** with device (but no human assistance).



M1850 Transferring₄

- Select Response 2 if patient:
 - Requires **both** minimal human assistance **and** an assistive device to transfer safely or
 - Can bear weight and pivot, but requires more than minimal human assist.
- The patient must be able to **both** bear weight and pivot for Response 2 to apply.
 - If patient is unable to do one or the other **and** is not bedfast, select Response 3.



M1850 Transferring₅

- 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.**
- E.g., 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.



M1850 Transferring₆

- Bedfast refers to being confined to the bed, either per physician restriction or due to patient's inability to tolerate being out of the bed.
- Taking extra time or pushing up with both arms can help ensure the patient's stability and safety during the transfer process, but they do not mean that the patient is not independent.



M1860 Ambulation/ Locomotion₁

- **(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.
 - 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
 - 1 - With the use of a one-handed device (e.g. 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 (e.g., 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.



M1860 Ambulation/ Locomotion₂

- **(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.
 - 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
 - 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.



M1860 Ambulation/ Locomotion₃

- 2 - Requires use of a two-handed device (e.g., 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.



M1860 Ambulation/ Locomotion₄

- 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.



M1860 Ambulation/ Locomotion₅

- Ability and the type of assistance required to **safely** ambulate or propel self in a wheelchair over a variety of surfaces.
- 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.



M1860 Ambulation/ Locomotion₆

- 1 With the use of a **one-handed device** (e.g. 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** (e.g., 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.

New breakout in response options



M1860 Ambulation/ Locomotion₇

- Select “1” if able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
 - Using a **one-handed device**.
 - E.g. cane, single crutch, hemi-walker
 - Requiring **no human assistance**.



M1860 Ambulation/ Locomotion₈

- Regardless of need for an assistive device, if patient requires human assistance (hands on, supervision and/or verbal cueing) to **safely** ambulate.
- Select:
 - “2” for intermittent human assistance.
 - “3” for continuous human assistance.



M1860 Ambulation/ Locomotion₉

- Select “2” if patient is able to safely ambulate without a device on a level surface, but requires minimal assistance on stairs, steps and uneven surfaces.
 - Why? The patient **requires human supervision or assistance** to negotiate stairs or steps or uneven surfaces.
 - “0” & “1” means no human supervision or assistance is required ambulate safely.



M1860 Ambulation/ Locomotion₁₀

- **No human assistance** required, but **requires a walker** in **some areas** of home, and a **cane** in **other areas** to ambulate safely (due to space limitations, distances, etc.).
 - Select response that reflects the **device** that **best supports safe ambulation on all surfaces** patient **routinely encounters**.
 - E.g., “2” appropriate if walker required for safe ambulation in hallway and living room, even if there are some situations in the home where a cane provides adequate support.



M1860 Ambulation/ Locomotion₁₁

- If a patient does not have a walking device but is clearly not safe walking alone,
 - Select Response 3, able to walk only with the supervision or assistance, unless the patient is chairfast.
- “4” & “5” - Unable to ambulate even with use of assistive devices and/or continuous assistance.
- A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate = chairfast Score “4” or “5”, based on ability to wheel self.
- If chairfast, assess ability to safely propel wheelchair independently, whether the wheelchair is a powered or manual version.



M1870 Feeding or Eating₁

- **(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.
 - 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 through-out 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.



M1870 Feeding or Eating₂

- **(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.
 - 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.



M1870 Feeding or Eating₃

- 2 - **Unable** to feed self and must be assisted or supervised through-out 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.



M1870 Feeding or Eating₄

- Ability to feed self, including the process of eating, chewing, and swallowing food.
 - **Excludes** preparation of food items, and transport to the table.
- Score based on assistance needed to feed self once food placed in front of them.
- Assistance means human assistance by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.



M1870 Feeding or Eating₅

- Meal "set-up" 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.
- If a patient is being weaned from tube feeding, "3" or "4" will continue to apply until the patient no longer uses the tube for nutrition.
 - This is true, even if the tube remains in place, unused for a period of time.



M1880 Plan & Prepare Light Meals₁

- **(M1880) Current Ability to Plan and Prepare Light Meals** (e.g., cereal, sandwich) or reheat delivered meals safely:
 - 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 (i.e., 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.



M1880 Plan & Prepare Light Meals₂

- Identifies the patient's physical, cognitive, and mental ability to plan and prepare meals, even if the patient does not routinely perform this task.
- “0” = patient has **consistent** physical and cognitive ability to plan and prepare meals.
- “1” = patient has **inconsistent** ability to prepare light meals.
 - E.g., can't prepare breakfast due to morning arthritic stiffness, but can prepare other meals throughout day.



M1880 Plan & Prepare Light Meals₃

- “2” = patient **does not** have the ability to prepare light meals at any point during the day of assessment.
- 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 selecting a response.



M1880 Plan & Prepare Light Meals₄

- If **prescribed** diet consists either partially or completely of **enteral nutrition**:
 - Assess ability to plan and prepare prescribed diet.
 - Including knowledge of feeding amount and ability to prepare enteral feeding, based on product used.
 - Note that ability to set up, monitor and change feeding equipment is **excluded** from M1880.
 - Assessed in M2100, Types & Sources of Assistance.



M1890 Telephone Use₁

- **(M1890) Ability to Use Telephone:** Current ability to answer the phone safely, including dialing numbers, and **effectively** using the telephone to communicate.
 - 0 - Able to dial numbers and answer calls appropriately and as desired.
 - 1 - Able to use a specially adapted telephone (i.e., 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.



M1890 Telephone Use₂

- **(M1890) Ability to Use Telephone:** Current ability to answer the phone safely, including dialing numbers, and **effectively** using the telephone to communicate.
 - 0 - Able to dial numbers and answer calls appropriately and as desired.
 - 1 - Able to use a specially adapted telephone (i.e., 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.



M1890 Telephone Use₃

- 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.



M1890 Telephone Use₄

- Ability to answer the phone, dial number, and effectively use the telephone to communicate.
- Select “1” if a speech impaired patient can only communicate using a phone equipped with texting functionality.



M1900 Prior ADL/ IADL Functioning₁

- **(M1900) Prior Functioning ADL/IADL:** Indicate the patient’s usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (e.g., grooming, dressing, and bathing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Ambulation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Transfer	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Household tasks (e.g., light meal preparation, laundry, shopping)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2



M1900 Prior ADL/ IADL Functioning₂

- Identifies changes that have occurred in the patient's ability to perform ADL and IADL activities **since the onset of the current illness, exacerbation of a chronic condition, or injury** (whichever is most recent) that initiated this episode of care.
- This item is used for risk adjustment and can be helpful for setting realistic goals for the patient.



M1900 Prior ADL/ IADL Functioning₃

- For each functional area, select one response.
- **“Independent”** means patient had ability to complete the activity by self (with or without assistive devices) without physical or verbal assistance from a helper.
- **“Needed some help”** means patient contributed effort but required help from another person to accomplish the task/activity safely.
- **“Dependent”** means patient was physically and/or cognitively **unable to contribute** effort toward completion of task, and the helper had to contribute all the effort.



M1900 Prior ADL/ IADL Functioning₄

- **“Self-care”** refers specifically to grooming, dressing, bathing, and toileting hygiene.
 - Medication management is not included in the definition of self-care for M1900.
 - It is addressed in a separate question (M2040).
- **“Ambulation”** refers to walking (with or without assistive device).
 - Wheelchair mobility is not directly addressed.
 - A patient who is unable to ambulate safely (even with devices and/or assistance), but is able to use a wheelchair (with or without assistance) would be reported as “Dependent”.



M1900 Prior ADL/ IADL Functioning₅

- **“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 prior functional ability varied, pick response that best describes ability to perform the majority of included tasks



M1910 Fall Risk Assessment₁

- **(M1910)** Has the patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?
 - 0 - No multi-factor falls risk assessment conducted.
 - 1 - Yes, and it does not indicate a risk for falls.
 - 2 - Yes, and it indicates a risk for falls.

Collected at SOC/ROC



M1910 Fall Risk Assessment₂

- Did the HHA assess the patient and home environment for characteristics that place the patient at risk for falls?
- Process measure item.
 - Identifying HHA use of best practices.
 - Patients under the age of 65 will be excluded from the denominator of the publicly reported measure.
- Not necessarily required in the CoPs.
- CMS does not mandate clinicians conduct falls risk screening for all patients, nor is there a mandate for the use of standardized tools.



M1910 Fall Risk Assessment₃

- If a standardized falls risk screening tool is used, use the scoring parameters specified for the tool to identify if a patient is at risk for falls.
 - Falls assessment tool used must be appropriately validated for home care geriatric patients.
- If a multi-factor risk assessment is conducted **without** use of a **standardized falls risk tool**.
 - i.e., agency-specific falls risk tool.
- Clinician must use **professional judgment** in interpreting the findings to identify if the patient is at risk for falls.



M1910 Fall Risk Assessment₄

- For “1” and “2”, a multi-factor falls risk assessment may incorporate several tools, e.g.
 - A physical performance component,
 - e.g., Timed Up and Go
 - A medication review,
 - Review of patient history of falls,
 - Assessment of lower limb function and
 - Selected OASIS items, e.g., cognitive status, vision, incontinence, ambulation, transferring



M1910 Fall Risk Assessment₅

- For “1” and “2”, the assessment **must** have been completed **by the HHA during the CMS-specified time frames** for completion of the comprehensive assessment.
 - 5 days for SOC;
 - 48 hours following inpatient facility discharge, or knowledge of patient’s return home for ROC)
- For “1” and “2”, the fall risk assessment **must** have been completed by the clinician completing the SOC or ROC Comprehensive Assessment.



M1910 Fall Risk Assessment₆

- Select Response 0 if:
 - A multi-factor falls risk screening was **not conducted** by the home health agency.
 - A multi-factor falls risk screening was conducted by the home health agency but **NOT** during the required assessment time frame.
 - A multi-factor falls risk screening was conducted during the assessment time frame, **but by someone other than the assessing clinician.**



OASIS-C

Medications



M2000 Drug Regimen Review₁

- **(M2000) Drug Regimen Review:** Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?
 - 0 - Not assessed/reviewed [**Go to M2010**]
 - 1 - No problems found during review [**Go to M2010**]
 - 2 - Problems found during review
 - NA - Patient is not taking any medications [**Go to M2040**]

Collected at SOC/ROC



M2000 Drug Regimen Review₂

- Does a complete **drug regimen review** (DRR) indicate **potential clinically significant medication issues**, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?
- Process measure item.
 - Identifies if best practices are utilized by the agency.
- The drug regimen review **is** required by CoP.



M2000 Drug Regimen Review₂

- Includes all medications
- Prescribed and over the counter
- Administered by any route
 - e.g. oral, topical, inhalant, pump, injection



M2000 Drug Regimen Review₃

- If portions of the DRR are completed by agency staff other than the clinician responsible for completing the SOC/ROC OASIS.
 - E.g., identification of potential drug-drug interactions or potential dosage errors
- Information on DRR findings **must** be communicated to the clinician responsible for the SOC/ROC OASIS assessment.



M2000 Drug Regimen Review₄

- Collaboration does not violate the one clinician rule for completion of the assessment.
 - E.g. the assessing clinician evaluates patient status (e.g., presence of potential ineffective drug therapy or patient noncompliance), and another clinician (in the office) assists with review of the medication list (e.g. for possible duplicate drug therapy or omissions).



M2000 Drug Regimen Review₅

- Agency policy and practice will determine the collaborative process and how it is documented
- M0090 is the date the two clinicians collaborated and the assessment was completed
- Ch. 3 includes guidance related to drug interactions and adverse drug reactions



M2000 Drug Regimen Review₆

- Problem(s) defined as:
 - Potential clinically significant medication issues which include adverse reactions to medications (e.g., rash),
 - Ineffective drug therapy (e.g., analgesic that does not reduce pain),
 - Side effects (e.g. potential bleeding from an anticoagulant),
 - Drug interactions (e.g., serious drug-drug, drug-food and drug-disease interactions),



M2000 Drug Regimen Review₇

- Problem(s) defined as:
 - Duplicate therapy (e.g. generic name and brand name drugs that are equivalent both prescribed),
 - Omissions (missing drugs from an ordered regimen),
 - Dosage errors (e.g., either too high or too low),
 - Noncompliance (e.g., regardless of whether the noncompliance is purposeful or accidental) or
 - Impairment or decline in an individual's mental or physical condition or functional or psychosocial status



M2000 Drug Regimen Review₈

- Select Response “1 – No problems found” – when (as applicable) :
 - 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 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 meds safely at the right time.
 - Patient is not showing signs/symptoms that could be adverse reactions caused by medications.



M2000 Drug Regimen Review₉

- Select Response “2 – Problems found during review” – when (as applicable):
 - 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 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.



M2000 Drug Regimen Review₁₀

- Select Response “2 – problems found during review” – when (as applicable):
 - 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 meds.
 - Patient has a complex medication plan with meds prescribed by multiple physicians and/or obtained from multiple pharmacies so that the risk of med interactions is high.



M2002 Medication Follow-up₁

- **(M2002) Medication Follow-up:** Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

- 0 - No
- 1 - Yes

Collected at SOC/ROC



M2002 Medication Follow-up₂

- Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?
- Process measure item
 - Identifies use of best practices.
- Best practices not necessarily required by CoP.



M2002 Medication Follow-up₃

- Complete M2002 Med Follow-up if M2000 DRR = Response 2 “Problems found during review”.
- **Clinically significant medication issues** are those that pose an **actual or potential threat to patient health and safety**, in the **clinician’s judgment**, such as:
 - Drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, medication omissions, dosage errors, or nonadherence to prescribed medication regimen.



M2002 Medication Follow-up₄

- Contact with physician is defined as:
 - Communication to the physician made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status.
- Select “1 – Yes”, **only** if a physician **responds** to HHA communication with acknowledgment of receipt of information and/or further advice or instructions.



M2002 Medication Follow-up₅

- If interventions not completed as outlined in this item, select “0 – No” and document **why not**.
- If staff other than clinician responsible for completing the SOC/ROC OASIS contacted the physician, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment.
- This does not violate the one clinician rule for assessment completion.



M2004 Medication Intervention₁

- **(M2004) Medication Intervention:** If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?
 - 0 - No
 - 1 - Yes
 - NA - No clinically significant medication issues identified since the previous OASIS assessment

Collected at Transfer & Discharge



M2004 Medication Intervention₂

- If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?
- Process measure item
 - Identifies use of best practices.
- Best practices not necessarily required by CoP.



M2004 Medication Intervention₃

- Identifies **if** potential clinically significant **problems** such as adverse effects or drug reactions **identified** at the time of the most recent OASIS assessment or after that time **were addressed with the physician.**
- If the interventions were not completed as outlined in this item, select “0-No” and explain why not.



M2004 Medication Intervention₄

- The guidance at M2002, Medication Follow-up, is repeated here. Note that M2004, Medication Intervention is:
 - Completed with every OASIS collected at Transfer & Discharge.
 - M2004 timeframe is at the time of the most recent OASIS assessment or after.
 - M2002 timeframe is SOC/ROC assessment.



M2010 Patient/Caregiver High Risk Drug Education₁

- **(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?
 - 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

Collected at SOC/ROC



M2010 Patient/Caregiver High Risk Drug Education₂

- Identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes.
- Process measure item
 - Identifies use of best practices.
- Best practices not necessarily required by CoP.



M2010 Patient/Caregiver High Risk Drug Education₃

- High-risk medications are those identified by quality organizations (Institute for Safe Medication Practices, JCAHO, etc.) as having considerable potential for causing significant patient harm when they are used erroneously.
- Targeted to high-risk medications.
 - Unrealistic to expect that patient education on all medications occur on admission.
 - Failure to educate on high-risk medications at SOC/ROC could have severe negative impacts on patient safety and health.



M2010 Patient/Caregiver High Risk Drug Education₄

- High-risk medications should be identified based on one or more authoritative sources.
- Select “0 – No”, if the interventions are not completed as outlined in this item. Document **why not**, unless patient is not taking any drugs.
- Select “NA” if patient/caregiver fully knowledgeable about special precautions associated with high-risk medications.



M2010 Patient/Caregiver High Risk Drug Education₅

- If staff other than 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.
- This does not violate the one clinician rule for completing the comprehensive assessment.



M2015 Patient/Caregiver Drug Education Intervention₁

- **(M2015) Patient/Caregiver Drug Education Intervention:** Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects and how and when to report problems that may occur?
 - 0 - No
 - 1 - Yes
 - NA - Patient not taking any drugs

Collected at Transfer & Discharge



M2015 Patient/Caregiver Drug Education Intervention₂

- Identifies if clinicians instructed the patient/caregiver about how to manage medications effectively and safely.
- Process measure item
 - Identifies use of best practices.
- Best practices not necessarily required by CoP.



M2015 Patient/Caregiver Drug Education Intervention₃

- Effective, safe management of medications includes:
 - Knowledge of effectiveness,
 - Potential side effects and drug reactions, and
 - When to contact the appropriate care provider



M2015 Patient/Caregiver Drug Education Intervention₄

- Select “0 – No”:
 - If the last time pt/cg instruction regarding med monitoring and reporting was provided was at the last OASIS assessment visit, and no additional instruction at a subsequent visit has been provided.
 - Unless patient not taking any medications.
 - If interventions not completed as outlined in this item. Document **why not.**



M2020 Management of Oral Medications₁

- **(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.)**
 - 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.



M2020 Management of Oral Medications₂

- **(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.)**
 - 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.



M2020 Management of Oral Medications₃

- 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.



M2020 Management of Oral Medications₄

- Ability to take **all** oral (p.o.) medications reliably and safely at **all** times.
- Includes all prescribed and OTC (over-the-counter) meds the patient is currently taking and are included on the plan of care.
- Exclude topical, injectable, and IV medications.
- Only p.o. meds included.
 - Meds given per gastrostomy (or other) tube are **not** administered p.o., but are administered "per tube".



M2020 Management of Oral Medications₅

- Select “0” if 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.
- Select “1” if another person must prepare individual doses (e.g., set up a “planner device”) **and/or** if another person must develop a drug diary/chart which the patient relies on to take meds appropriately.
- Select “2” if daily reminders necessary.
 - Regardless of whether patient is independent or needs assistance in preparing individual doses (e.g., set up a “planner device”) and/or developing a drug diary or chart.



M2020 Management of Oral Medications₆

- Reminders provided by a device that the patient can independently manage are not considered “assistance” or “reminders.”
- If the patient’s **ability** to manage oral meds **varies from med to med**, consider the medication for which **the most assistance is needed** when selecting a response.



M2030 Management of Injectable Medications₁

- **(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.**
 - 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.



M2030 Management of Injectable Medications₂

- **(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.**
 - 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.



M2030 Management of Injectable Medications₃

- 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.



M2030 Management of Injectable Medications₄

- Ability to take **all** injectable medications reliably and safely at **all** times.
- **Excludes:**
 - IV medications,
 - Infusions (i.e., medications given via a pump),
 - Meds given in the physician's office or other settings outside the home



M2030 Management of Injectable Medications₅

- Select “1” if another person must prepare individual doses **and/or** if another person must develop a drug diary or chart.
- Select “2” if reminders are necessary.
 - Regardless of whether 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.”



M2030 Management of Injectable Medications₆

- If the patient's ability to manage injectable meds varies from med to med, consider the med for which the most assistance is needed when selecting a response.
- Cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.



M2040 Prior Medication Management₁

- **(M2040) Prior Medication Management:** Indicate the patient's usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> na
b. Injectable medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> na



M2040 Prior Medication Management₂

- Identifies **changes** that have occurred in the patient's ability to manage all prescribed oral and injectable medications since the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care
- Select only one response for each functional area (oral medications and injectable medications)



M2040 Prior Medication Management₃

- If **prior ability** to manage oral or injectable medications **varied from med to med**, consider the med for which **the most assistance was needed** when selecting a response.
- **“Independent”** means patient completed 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”.



M2040 Prior Medication Management₄

- **“Needed some help”** means patient required some help from another person to accomplish the task/activity.
- **“Dependent”** means patient was incapable of performing any of the task/activity.
 - For oral meds, this means patient was only capable of swallowing meds given to her/him.
 - For injectable meds, this means someone else must have prepared and administered the medication.



M2040 Prior Medication Management₅

- Select Response “NA” if there were no oral medications (row a) or no injectable medications (row b) used.

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> na
b. Injectable medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> na



OASIS-C

Care Management



M2100 Types & Sources of Assistance₁

(M2100) Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only one box in each row.)

Type of Assistance	No assistance needed in this area	Caregiver(s) currently provide assistance	Caregiver(s) need training/ supportive services to provide assistance	Caregiver(s) <u>not likely</u> to provide assistance	Unclear if Caregiver(s) will provide assistance	Assistance needed, but no Caregiver(s) available
a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Medication administration (e.g., oral, inhaled or injectable)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. Medical procedures/ treatments (e.g., changing wound dressing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
f. Supervision and safety (e.g., due to cognitive impairment)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5



M2100 Types & Sources of Assistance₂

- **(M2100) Types and Sources of Assistance:**
Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only **one** box in each row.)



M2100 Types & Sources of Assistance₃

- Identifies availability and ability of the caregiver(s) to provide categories of assistance needed by the patient.
- Concerned broadly with types of assistance, not just the ones specified in other OASIS items.
- For each row a-g, select one description of caregiver assistance.



M2100 Types & Sources of Assistance₄

- If patient needs assistance with **any** aspect of a category of assistance,
 - E.g., needs assistance with some IADLs but not others
- Consider the aspect that represents the **most need** and the availability and ability of the caregiver(s) to meet that need.



M2100 Types & Sources of Assistance₅

- If more than one response in a row applies,
 - E.g., the caregiver(s) provides the assistance but also needs training or assistance
- Select the response that represents the greatest need.
 - “caregiver(s)needs training/supporting services to provide assistance”



M2100 Types & Sources of Assistance₆

- **“Caregiver(s) not likely to provide”** means:
 - CG(s) indicated unwillingness to provide assistance, or
 - CG(s) physically and/or cognitively unable to provide needed care.
- **“Unclear if caregiver(s) will provide”** means:
 - CG(s) express willingness to, but their ability in question, or
 - there is reluctance that raises questions as to whether the cg will provide the needed assistance.



M2100 Types & Sources of Assistance₇

Type of Assistance	No assistance needed in this area	Care-giver(s) currently provide assistance	Care-giver(s) need training/ supportive services to provide assistance	Care-giver(s) <u>not likely</u> to provide assistance	Unclear if Care-giver(s) will provide assistance	Assistance needed, but no Care-giver(s) available
a. ADL assistance (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Row a – ADLs include basic self-care activities such as the examples listed.



M2100 Types & Sources of Assistance₈

Type of Assistance	No assistance needed in this area	Care-giver(s) currently provide assistance	Care-giver(s) need training/ supportive services to provide assistance	Care-giver(s) <u>not likely</u> to provide assistance	Unclear if Care-giver(s) will provide assistance	Assistance needed, but no Care-giver(s) available
b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Row b – IADLs include activities associated with independent living necessary to support the ADLs such as the examples listed.



M2100 Types & Sources of Assistance₉

Type of Assistance	No assistance needed in this area	Care-giver(s) currently provide assistance	Care-giver(s) need training/ supportive services to provide assistance	Care-giver(s) <u>not likely</u> to provide assistance	Unclear if Care-giver(s) will provide assistance	Assistance needed, but no Care-giver(s) available
c. Medication administration (e.g., oral, inhaled or injectable)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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 or j-tube, etc.



M2100 Types & Sources of Assistance₁₀

Type of Assistance	No assistance needed in this area	Care-giver(s) currently provide assistance	Care-giver(s) need training/ supportive services to provide assistance	Care-giver(s) <u>not likely</u> to provide assistance	Unclear if Care-giver(s) will provide assistance	Assistance needed, but no Care-giver(s) available
d. Medical procedures/ treatments (e.g., changing wound dressing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Row d – Medical procedures/treatments include those ordered for purpose of improving health status.



M2100 Types & Sources of Assistance₁₁

- Examples:
 - Wound care and dressing changes
 - Range of motion exercises
 - Intermittent urinary catheterization
 - Postural drainage
 - Electromodalities, etc.



M2100 Types & Sources of Assistance₁₂

Type of Assistance	No assistance needed in this area	Care-giver(s) currently provide assistance	Care-giver(s) need training/ supportive services to provide assistance	Care-giver(s) <u>not likely</u> to provide assistance	Unclear if Care-giver(s) will provide assistance	Assistance needed, but no Care-giver(s) available
e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Row e – Management of equipment refers to the ability to safely use medical equipment as ordered.



M2100 Types & Sources of Assistance₁₃

- Examples:
 - Oxygen
 - IV/infusion equipment
 - Enteral/parenteral nutrition
 - Ventilator therapy equipment or supplies
 - Continuous passive motion machine
 - Wheelchair
 - Hoyer lift, etc.



M2100 Types & Sources of Assistance₁₄

Type of Assistance	No assistance needed in this area	Care-giver(s) currently provide assistance	Care-giver(s) need training/ supportive services to provide assistance	Care-giver(s) <u>not likely</u> to provide assistance	Unclear if Care-giver(s) will provide assistance	Assistance needed, but no Care-giver(s) available
f. Supervision and safety (e.g., due to cognitive impairment)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Row f – Supervision and safety includes needs related to ability of patient to safely remain in the home.



M2100 Types & Sources of Assistance₁₅

- Includes a wide range of activities that may be necessary due to cognitive, functional, or other health deficits.
 - Calls to remind the patient to take medications.
 - In-person visits to ensure that the home environment is safely maintained.
 - 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 (i.e., leaving the stove burner on).



M2100 Types & Sources of Assistance₁₆

Type of Assistance	No assistance needed in this area	Care-giver(s) currently provide assistance	Care-giver(s) need training/ supportive services to provide assistance	Care-giver(s) <u>not likely</u> to provide assistance	Unclear if Care-giver(s) will provide assistance	Assistance needed, but no Care-giver(s) available
g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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.



M2110 ADL/ IADL Assistance₁

- **(M2110) How Often** does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?

- 1 - At least daily
- 2 - Three or more times per week
- 3 - One to two times per week
- 4 - Received, but less than weekly
- 5 - No assistance received
- UK - Unknown **[Omit “UK” option on DC]**



M2110 ADL/ IADL Assistance₂

- Identifies the frequency of the assistance provided by any non-agency caregivers with ADLs.
 - Examples: bathing, dressing, toileting, transferring, ambulating, feeding, etc.
- IADLs
 - Examples: medication management, meal preparation, housekeeping, laundry, shopping, financial management
- Concerned broadly with ADLs and IADLs, not just the ones specified in other OASIS items.
- Select the response that reports how often the patient receives assistance with **any** ADL or IADL.



OASIS-C

Therapy Need and Plan of Care



M2200 Therapy Need₁

- **(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.



M2200 Therapy Need₂

- Identifies the total number of therapy visits (PT, OT, SLP combined).
- Planned for the Medicare payment episode for which this assessment will determine the case mix group.
- Only applies to payers utilizing a payment model based on case mix group assignment.
- Report a number that is “zero filled and right justified.”
 - For example, 11 visits should be reported as “011.”



M2200 Therapy Need₃

- Answer "000" if no therapy services are needed.
- If the number of visits that will be needed is uncertain, provide your best estimate.
- 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



M2200 Therapy Need₄

- When the ROC will act as the Recert because the patient was discharged from the inpatient setting between days 56-60.
 - The total number of therapy visits planned for the upcoming 60-day episode should be reported in M2200.
- Select “NA” when this assessment will **not** be used to determine a case mix group for Medicare, or other payers.



M2250 Plan of Care Synopsis₁

- **(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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Patient is not diabetic or is bilateral amputee
c. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	No pain identified
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Patient is not assessed to be at risk for 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Patient has no pressure ulcers with need for moist wound healing

Collected at SOC/ROC



M2250 Plan of Care Synopsis₂

- Identifies if the physician-ordered home health POC incorporates specific best practices.
- The “physician ordered plan of care” means that the patient condition has been **discussed** and there is **agreement** as to the POC between HHA staff and the physician.
- Process measure item.
- Best practices included are not necessarily required in the CoPs.



M2250 Plan of Care Synopsis₃

- Can answer “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 POC.
 - Assuming all other OASIS information is completed.
 - The M0090 date becomes the date of the communication with the physician to establish the POC.
 - Select “No” if the best practice interventions specified in this item are **not** included in the POC.



M2250 Plan of Care Synopsis₄

- Select "No" when orders for interventions have been **requested but not authorized by the end of the comprehensive assessment time period**, unless otherwise indicated in row g.
 - In this case, the care provider should document rationale in the clinical record.
 - Reminder: These POC orders must be in place within the 5-day SOC window and the 2-day ROC window in order to meet the measure definition.



M2250 Plan of Care Synopsis₅

- Assessing clinician may choose to wait until after other disciplines have completed their assessments and developed their care plans.
- This does not violate the requirement that the comprehensive assessment be completed by one clinician.
 - Must complete within required time frames.
 - Five days for SOC, two days for ROC.



M2250 Plan of Care Synopsis₆

- Example: If the RN identifies fall 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 POC includes interventions to prevent fall risk.
- The M0090 date should reflect the last date that information was gathered that was necessary for completion of the assessment.



M2250 Plan of Care Synopsis₇

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 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



M2250 Plan of Care Synopsis₈

- **Row a:** Select “Yes” if the physician-ordered POC contains specific clinical parameters relevant to patient's condition that, when exceeded, would indicate that the physician should be contacted.
- The parameters may be ranges and may include temp, pulse, respirations, BP, weight, wound measurements, pain intensity ratings, intake and output measurements, blood sugar levels, or other relevant clinical assessment findings.



M2250 Plan of Care Synopsis₉

- **Row a:** 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.



M2250 Plan of Care Synopsis₁₀

Plan / Intervention	No	Yes	Not Applicable	
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Patient is not diabetic or is bilateral amputee



M2250 Plan of Care Synopsis₁₁

- **Row b:** Select “Yes” if the physician-ordered POC 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 “No” if the physician-ordered POC contains orders for only one (or none) of the interventions.
- Select “NA” if the patient does not have a diagnosis of diabetes or is a bilateral amputee.



M2250 Plan of Care Synopsis₁₂

Plan / Intervention	No	Yes	Not Applicable	
c. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Patient is not assessed to be at risk for falls



M2250 Plan of Care Synopsis₁₃

- **Row c:** Select “Yes” if the physician-ordered POC contains specific interventions to reduce the risk of falls.
 - Environmental changes and strengthening exercises are examples of possible fall prevention interventions.
- If POC does not include interventions for fall prevention, mark “No” for the applicable line, whether or not an assessment for falls risk was conducted.
- Select “NA” if not at risk for falls, per assessment.



M2250 Plan of Care Synopsis₁₄

Plan / Intervention	No	Yes	Not Applicable	
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Patient has no diagnosis or symptoms of depression



M2250 Plan of Care Synopsis₁₅

- **Row d:** Select “Yes” if the physician-ordered POC contains orders for treating depression.
- Interventions for depression may include:
 - New medications,
 - Adjustments to already-prescribed medications, or
 - Referrals to agency resources (e.g., social worker)



M2250 Plan of Care Synopsis₁₆

- **Row d:** 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.
- Select “NA” if the patient has no diagnosis or symptoms of depression.



M2250 Plan of Care Synopsis₁₇

Plan / Intervention	No	Yes	Not Applicable	
e. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	No pain identified



M2250 Plan of Care Synopsis₁₈

- **Row e:** Select “Yes” if the physician-ordered POC contains interventions to monitor **AND** mitigate pain.
 - Medication, massage, visualization, biofeedback, and other intervention approaches have successfully been used to monitor or mitigate pain severity.
- Select “No” if the physician-ordered POC contains orders for **only one** of the interventions.
 - E.g., pain medications but no monitoring plan.
- Select “NA” if no pain was identified after conducting the comprehensive assessment.



M2250 Plan of Care Synopsis₁₉

Plan / Intervention	No	Yes	Not Applicable	
f. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Patient is not assessed to be at risk for pressure ulcers



M2250 Plan of Care Synopsis₂₀

- **Row f:** Select “Yes” if the physician-ordered POC includes planned clinical interventions to reduce pressure on bony prominences or other areas of skin at risk for breakdown.
- 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.
- Select “NA” if the patient was not identified as at risk for pressure ulcers.



M2250 Plan of Care Synopsis₂₁

Plan / Intervention	No	Yes	Not Applicable	
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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Patient has no pressure ulcers with need for moist wound healing



M2250 Plan of Care Synopsis₂₂

- **Row g:** Select “Yes” if the physician-ordered POC contains orders for pressure ulcer treatments based on principles of moist wound healing (e.g., moisture retentive dressings).

OR

- Such orders have been requested from the physician.
- Select “NA” if the patient has no pressure ulcers needing moist wound healing treatments.



OASIS-C

Emergent Care



M2300 Emergent Care₁

- **(M2300) Emergent Care:** Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?
 - 0 - No [**Go to M2400**]
 - 1 - Yes, used hospital emergency department WITHOUT hospital admission
 - 2 - Yes, used hospital emergency department WITH hospital admission
 - UK - Unknown [**Go to M2400**]



M2300 Emergent Care₂

- Identifies whether the patient was seen in a **hospital emergency** department **since the previous OASIS assessment**.
- Responses to this item include the **entire** period since the last time OASIS data were collected, **including current events**.
- **Includes** holding and observation in the emergency department setting only.



M2300 Emergent Care₃

- **Excludes:**

- Urgent care services not provided in a hospital emergency department.
- Doctor's office visits scheduled less than 24 hours in advance.
- Care provided by an ambulance crew without transport.
- Care received in urgent care facilities.
 - Urgent care facilities defined as freestanding walk-in clinics (not a department of a hospital) for pts in need of immediate medical care.



M2300 Emergent Care₄

- Select “1” or “2” if a patient went to a hospital emergency department regardless of who directed them to go or if it was pt/cg decision.
 - “Hospital admission” is defined as admission to a hospital where the stay is for 24 hours or longer, for reasons other than diagnostic testing.



M2300 Emergent Care₅

- If patient went to a hospital ED, was “held” for observation, then released, the patient **did** receive emergent care.
 - The time period that a patient can be "held" without admission can vary.
- OASIS Transfer is not required if the patient was never actually admitted to an inpatient facility.



M2300 Emergent Care₆

- Select “2” if patient went to hospital ED and was subsequently admitted to the hospital.
 - An OASIS transfer assessment is required (assuming the patient stay was for 24 hours or more for reasons other than diagnostic testing).
- Select “0-No” if a patient was directly admitted to the hospital and was **not** treated or evaluated in the ER.

And

- Had no other emergency department visits since the last OASIS assessment.



M2300 Emergent Care₇

- Select “1 - Yes, used hospital emergency department WITHOUT hospital admission” - not “2” for a patient who:
- Since the last time OASIS was collected, experienced both a direct admission to the hospital without treatment or evaluation in ER.

AND

- Accessed a hospital ER that did not result in an inpatient admission.



M2300 Emergent Care₈

- Select “2 - Yes, used hospital emergency department WITH hospital admission”
 - If a patient utilized a hospital emergency department more than once since the last OASIS assessment .

AND

- Any ER visit since the last OASIS assessment resulted in hospital admission.
- Otherwise, select Response 1.



M2300 Emergent Care₉

- Select “1 - Yes, used hospital emergency department WITHOUT hospital admission” when:
 - A patient dies in a hospital emergency department
 - Note a Transfer OASIS is completed
 - Not "Death at Home”



M2310 Emergent Care Reason₁

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

- 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- 2 - Injury caused by fall
- 3 - Respiratory infection (e.g., pneumonia, bronchitis)
- 4 - Other respiratory problem
- 5 - Heart failure (e.g., 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



M2310 Emergent Care Reason₂

- **(M2310) Reason for Emergent Care:** For what reason(s) did the patient receive emergent care (with or without hospitalization)?
(Mark all that apply.)
 - 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
 - 2 - Injury caused by fall
 - 3 - Respiratory infection (e.g., pneumonia, bronchitis)
 - 4 - Other respiratory problem
 - 5 - Heart failure (e.g., fluid overload)
 - 6 - Cardiac dysrhythmia (irregular heartbeat)
 - 7 - Myocardial infarction or chest pain
 - 8 - Other heart disease



M2310 Emergent Care Reason₃

- 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



M2310 Emergent Care Reason₄

- Identifies the reasons for which the patient received care in a **hospital emergency department**.
- 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.



M2310 Emergent Care Reason₅

- If the reason is not included in the choices, mark Response 19 - Other than above reasons.
- If the patient has received emergent care in a hospital emergency department multiple times since the last time OASIS data were collected, include the reasons for all visits.



OASIS-C

Data Items Collected at Inpatient Facility Admission or Agency Discharge Only



M2400 Intervention Synopsis₁

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

Plan / Intervention	No	Yes	Not Applicable
a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Patient is not diabetic or is bilateral amputee
b. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Formal assessment did not indicate pain since the last OASIS assessment
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers OR patient has no pressure ulcers with need for moist wound healing



M2400 Intervention Synopsis₂

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

Collected at Transfer and Discharge



M2400 Intervention Synopsis₃

- 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 the previous OASIS assessment **or** since that time.



M2400 Intervention Synopsis₄

- The physician-ordered POC means that the patient condition was **discussed** and there was **agreement** as to the POC **between** the home health agency staff **and** the patient's physician.
- Process Measure item.
- Problem-specific interventions referenced in the item may or may not directly correlate to stated requirements in the Conditions of Participation.



M2400 Intervention Synopsis₅

- 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.
 - Formal multi-factor Fall Risk Assessment
 - Formal assessments for depression, pain, pressure ulcer risk



M2400 Intervention Synopsis₆

- Select “**Yes**” if the clinical intervention was included in the POC.

AND

- Implemented at the time of the previous OASIS assessment or since that time.
- Select “**No**” if the intervention was on the POC but not implemented.

OR

- If the intervention was implemented but not on the POC.



M2400 Intervention Synopsis₇

- Select “0 – No” if the interventions are not on the plan of care.

OR

- If the interventions were not implemented by the time the assessment was completed.
- Document **why not**.



M2400 Intervention Synopsis₈

- Interventions provided by HHA staff, including the assessing clinician, may be reported by the assessing clinician.
- Example, if the RN finds a patient to be at risk for falls, and the physical therapist implements fall prevention interventions included on the POC prior to the end of the allowed assessment time frame, the RN may select “Yes” for row b.
 - M0090 reports the date the last information was gathered.



M2400 Intervention Synopsis₉

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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Patient is not diabetic or is bilateral amputee



M2400 Intervention Synopsis₁₀

- **Row a:** Select “Yes” if the physician-ordered POC contains **both** orders for:
 - a) Monitoring the skin of the patient's lower extremities for evidence of skin lesions.

AND

- a) Patient education on proper foot care.

AND

- There is clinical documentation that these interventions were performed at the time of the previous OASIS assessment or since that time.



M2400 Intervention Synopsis₁₁

- **Row a:** Select “No” if the physician-ordered POC 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 “NA” if no diagnosis of diabetes **or** is a bilateral amputee.



M2400 Intervention Synopsis₁₂

Plan / Intervention	No	Yes	Not Applicable	
b. Falls prevention interventions	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment



M2400 Intervention Synopsis₁₃

- **Row b:** Select “Yes” if the physician-ordered POC contains:
- Specific interventions to reduce the risk of falls **and** the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time.
 - Environmental changes, strengthening exercises, and consultation with the physician regarding med concerns are examples of possible falls prevention interventions.



M2400 Intervention Synopsis₁₄

- **Row b:** Select “No” if the POC does not include interventions for fall prevention.

And/or

- No documentation in the clinical record that these interventions were performed at the time of the previous OASIS assessment or since that time.
 - Mark “No” whether or not an assessment for falls risk was conducted.
- Select “NA” if a formal multi-factor Fall Risk Assessment indicates patient was not at risk for falls since the last OASIS assessment.



M2400 Intervention Synopsis₁₅

Plan / Intervention	No	Yes	Not Applicable	
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment



M2400 Intervention Synopsis₁₆

- **Row c:** Select “**Yes**” if the physician-ordered POC contains interventions for treating depression.

And

- The clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time.



M2400 Intervention Synopsis₁₇

- **Row c:** Interventions for depression may include:
 - New meds, adjustments to already-prescribed meds, or referrals to agency resources (e.g., social worker).
- If the patient is already under MD care for a diagnosis of depression, interventions may include:
 - Monitoring med effectiveness, teaching regarding the need to take prescribed meds, etc.



M2400 Intervention Synopsis₁₈

- **Row c:** Select “No” if the POC 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 the previous OASIS assessment or since that time.
 - Whether or not a formal assessment for depression was conducted.



M2400 Intervention Synopsis₁₉

- **Row c:** Select “NA” if:
- Formal assessment indicates patient did not meet criteria for depression.

AND

- Patient did not have diagnosis of depression.



M2400 Intervention Synopsis₂₀

Plan / Intervention	No	Yes	Not Applicable		
d. Intervention(s) to monitor and mitigate pain	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Formal assessment did not indicate pain since the last OASIS assessment	



M2400 Intervention Synopsis₂₁

- **Row d:** Select “Yes” if the physician-ordered POC contains interventions to monitor **AND** mitigate pain.

AND

- The clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time.
 - Intervention examples: Medication, massage, visualization, biofeedback.



M2400 Intervention Synopsis₂₂

- **Row d:** Select “No” if the physician-ordered POC contains orders for **only one** of the interventions (e.g., pain medications but no monitoring plan)

And/or

- Only one type of intervention (i.e., administering pain medications but no pain monitoring)

Or

- No interventions were documented at the time of the previous OASIS assessment or since that time, whether or not a formal pain assessment was conducted.
- Select “NA” if formal assessment did not indicate pain.



M2400 Intervention Synopsis₂₃

Plan / Intervention	No	Yes	Not Applicable	
e. Intervention(s) to prevent pressure ulcers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment



M2400 Intervention Synopsis₂₄

- **Row e:** Select “Yes” if the physician-ordered POC 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 the previous OASIS assessment or since that time.



M2400 Intervention Synopsis₂₅

- **Row e:** 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.



M2400 Intervention Synopsis₂₆

- **Row e:** Select “No” if the POC does not include interventions to prevent pressure ulcers.

And/or

- No interventions were documented in the clinical record at the time of the previous OASIS assessment or since that time.
 - Whether or not a formal pressure ulcer risk assessment was conducted.
- Select “NA “ if formal assessment indicates the patient was not at risk of pressure ulcers.



M2400 Intervention Synopsis₂₇

Plan / Intervention	No	Yes	Not Applicable	
f. Pressure ulcer treatment based on principles of moist wound healing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> na	Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers OR patient has no pressure ulcers with need for moist wound healing



M2400 Intervention Synopsis₂₈

- **Row f:** Select “Yes” if the physician-ordered POC contains orders for pressure ulcer treatments based on principles of moist wound healing (e.g., moisture retentive dressings).

And

- The clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time.



M2400 Intervention Synopsis₂₉

- **Row f:** Select “No” if the POC 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 in the at the time of the previous OASIS assessment or since that time.
 - Whether or not an assessment identified a pressure ulcer that needed moist wound healing treatment.



M2400 Intervention Synopsis₃₀

- **Row f:** Select “NA” if dressings that support the principles of moist wound healing were not indicated for this patient’s pressure ulcers.

OR

- Patient has no pressure ulcers with need for moist wound healing.



M2410 Inpatient Facility Admission₁

- **(M2410)** To which **Inpatient Facility** has the patient been admitted?
 - 1 - Hospital [**Go to M2430**]
 - 2 - Rehabilitation facility [**Go to M0903**]
 - 3 - Nursing home [**Go to M2440**]
 - 4 - Hospice [**Go to M0903**]
 - NA - No inpatient facility admission [Omit “NA” option on TRN]



M2410 Inpatient Facility Admission₂

- Identifies the type of inpatient facility to which the patient was admitted.
- If the patient was admitted to more than one facility.
 - Indicate the facility to which the patient was admitted first.
 - E.g. the facility type that they were transferred to from their home.



M2410 Inpatient Facility Admission₃

- When a patient dies in a hospital emergency department, the Transfer to an Inpatient Facility OASIS is completed.
- In this unique situation, clinicians are directed to select Response 1 – Hospital for M2410.
 - Even though the patient was not admitted to the inpatient facility.



M2410 Inpatient Facility Admission₄

- A rehabilitation facility admission means:
 - Admission to a freestanding rehabilitation hospital
 - a certified distinct rehabilitation unit of a nursing home
 - a distinct rehabilitation unit that is part of a short-stay acute hospital
- Nursing home admission means:
 - Skilled nursing facility (SNF)
 - Intermediate care facility for the mentally retarded (ICF/MR)
 - Nursing facility (NF)



M2410 Inpatient Facility Admission₅

- At Transfer, select Response 1, 2, 3, or 4.
- NA should be omitted from this item for transfer.
- At Discharge from agency – not to an inpatient facility, select Response “NA.”



M2420 Discharge Disposition₁

- **(M2420) Discharge Disposition:** Where is the patient after discharge from your agency? **(Choose only one answer.)**
 - 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**]



M2420 Discharge Disposition₂

- Identifies where the patient resides after discharge from the home health agency.
- Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not in an inpatient hospice facility.



M2420 Discharge Disposition₃

- 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 include:
 - Community-based services like homemaking services under Medicaid waiver programs.
 - Home-delivered meals.
 - Home care or private duty care from another agency.
 - Other types of community-based services.



M2430 Reason for Hospitalization₁

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

<input type="checkbox"/>	1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
<input type="checkbox"/>	2 - Injury caused by fall
<input type="checkbox"/>	3 - Respiratory infection (e.g., pneumonia, bronchitis)
<input type="checkbox"/>	4 - Other respiratory problem
<input type="checkbox"/>	5 - Heart failure (e.g., fluid overload)
<input type="checkbox"/>	6 - Cardiac dysrhythmia (irregular heartbeat)
<input type="checkbox"/>	7 - Myocardial infarction or chest pain
<input type="checkbox"/>	8 - Other heart disease
<input type="checkbox"/>	9 - Stroke (CVA) or TIA
<input type="checkbox"/>	10 - Hypo/Hyperglycemia, diabetes out of control
<input type="checkbox"/>	11 - GI bleeding, obstruction, constipation, impaction
<input type="checkbox"/>	12 - Dehydration, malnutrition
<input type="checkbox"/>	13 - Urinary tract infection
<input type="checkbox"/>	14 - IV catheter-related infection or complication
<input type="checkbox"/>	15 - Wound infection or deterioration
<input type="checkbox"/>	16 - Uncontrolled pain
<input type="checkbox"/>	17 - Acute mental/behavioral health problem
<input type="checkbox"/>	18 - Deep vein thrombosis, pulmonary embolus
<input type="checkbox"/>	19 - Scheduled treatment or procedure
<input type="checkbox"/>	20 - Other than above reasons
<input type="checkbox"/>	UK - Reason unknown
[Go to M0903]	



M2430 Reason for Hospitalization₂

- **(M2430) Reason for Hospitalization:** For what reason(s) did the patient require hospitalization? **(Mark all that apply.)**
 - 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
 - 2 - Injury caused by fall
 - 3 - Respiratory infection (e.g., pneumonia, bronchitis)
 - 4 - Other respiratory problem
 - 5 - Heart failure (e.g., 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



M2430 Reason for Hospitalization₃

- 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 [**Go to M0903**]



M2430 Reason for Hospitalization₄

- Mark all that apply
- Example, if a psychotic episode results from an untoward medication side effect, both “1” and “17” would be marked
- Example, if patient requires hospitalization for both heart failure and pneumonia, both “3” and “5” would be marked



M2440 Reason for Nursing Home Admission₁

- **(M2440) For what Reason(s) was the patient Admitted to a Nursing Home? (Mark all that apply.)**

- 0 - Therapy services
- 1 - Respite care
- 2 - Hospice care
- 3 - Permanent placement
- 4 - Unsafe for care at home
- 5 - Other
- UK - Unknown [**Go to M0903**]



M2440 Reason for Nursing Home Admission₂

- **Excludes** acute care facility and rehabilitation facility admissions.
- Defined as admissions to:
 - A freestanding rehabilitation hospital
 - A certified distinct rehabilitation unit of a nursing home, or
 - Part of a general acute care hospital



M2440 Reason for Nursing Home Admission₃

- Mark all that apply.
 - Example, if a patient has dementia and is unsafe for care at home.
- And**
- There is no plan for the patient to leave the facility.
 - Both Response 4 and Response 5 would be marked.



M0903 Date of Last (Most Recent Home Visit)₁

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

___ / ___ / _____
month / day / year



M0903 Date of Last (Most Recent Home Visit)₂

- Identifies the last or most recent home visit by any agency provider that is included on the Plan of Care.
- 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.



M0906 DC/TRF/Death Date₁

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

___ ___ / ___ ___ / ___ ___ ___ ___
month / day / year



M0906 DC/TRF/Death Date₂

- Identifies the actual date of discharge, transfer, or death (at home), depending on the reason for assessment.
- 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.



M0906 DC/TRF/Death Date₃

- **Death date** is the actual date of the patient's death at home.
 - **Include** death during transport to an ER or transport to an inpatient facility (before being seen in the emergency department or admitted to the inpatient facility).
 - **Exclude** death occurring in an inpatient facility or in an ER, as both situations would result in Transfer OASIS and would report the date of transfer.