OASIS-E: Comprehensive Clinical Training

Comprehensive review of OASIS concepts, updated and new OASIS-E items and structure, current OASIS-E guidance, and all OASIS-E items in preparation for the HCS-O Exam

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1

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Presented By

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2

2

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Learning Objectives

- *At the completion of this educational activity, the learner will be able to:*
  - Understand OASIS conventions and guidelines in preparation for the HCS-O exam
  - Understand the purpose of changes to OASIS-E and identify these changes including item changes, structural changes and guideline changes
  - Understand and identify the role of OASIS in payment and outcomes (including value-based purchasing [VBP])
  - Identify the purpose of individual OASIS items, individual item guidance and apply guidance to specific case scenarios.
  - Understand current OASIS guidance and Q&A relevant to OASIS E and its implementation

3

3

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OASIS-E: Purpose & Background

Understanding the Intent of the dataset and reasons for updates

4

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OASIS Background

- OASIS dataset originally developed in early 1990s
  - Set of quality & outcome measures to be applied across all home health agencies
  - Used as the basis for Outcome Based Quality Improvement (OBQI) for home health
  - Selected items eventually identified for use in payment (PPS, now PDGM)
- CMS has revised since from original format to multiple revisions (OASIS B, B1, C1, C2, D, etc.)
  - Periodically revised based on CMS's addition or removal of quality measures from the Home Health Quality Reporting Program (HHQRP) or for other program requirements.
- **Current revision to OASIS-E**
  - Currently the main reason for revising OASIS is to increase standardization across post-acute care (PAC) settings to uniformly collect social determinants of health data and to enable calculation of standardized quality measures pursuant to the provisions of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act.

5

5

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OASIS E Revision and Intent

- 27 NEW items
- Patient specific focused
- Increase in cognitive focused assessment
- Items and guidance intended to align across PAC settings
  - Standardization of assessment and expansion of standardized, validated tools such as PHQ-2 to PHQ-9
  - Reorganization of sections and guidance
  - Format for item guidance changed/updated

6

6

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OASIS E Revised Sections

OASIS E Includes the following sections:

- A – Administrative Information/Patient tracking
- B – Hearing, Speech, and Vision
- C – Cognitive Patterns
- D – Mood
- E – Behavior
- F – Preferences for Customary Routine Activity
- G – Functional Status
- GG – Functional Status: Functional Activities and Goals
- H – Bowel and Bladder
- I – Active Diagnosis

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OASIS E Revised Sections

OASIS E Includes the following sections:

- J – Health Conditions
- K- Swallowing/Nutritional Status
- M – Skin Conditions
- N- Medications
- O- Special treatments, procedures, and programs
- Q- Participation in Assessment and Goal Setting

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OASIS-E Review of Updated Conventions & Guidelines

Understanding Guidelines, Intent, and Use for Payment & Outcomes

9

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OASIS-E RELATED COPs, GUIDELINES, & CONVENTIONS

Guidance manual updated for OASIS E in May 2022

- Specific areas of guidance updated to match up with updated OASIS Q&As
- OASIS Categories 1-4 Q&A guidance updated (multiple q&a retired/removed and new/more recent q&a archived to the categorical Q&A)
  - Available at: https://qtso.cms.gov/reference-and-manuals/oasis-quarterly-q
  - **Category 1 Applicability:** These Q&A review how OASIS apply and when to perform OASIS under specific circumstances (e.g. – for which payers, which patients, which services)
  - **Category 2:** Comprehensive Assessment: These Q&A review which specific OASIS timepoints apply when the OASIS should be performed, who may perform OASIS and when under specific circumstances, how to handle special OASIS timepoint circumstances such as transfers, discharges and death at home, as well as discipline specific OASIS issues
  - **Category 3:** Follow up Assessments: These Q&A review specific issues related to recertification and other follow up OASIS
  - **Category 4:** OASIS Data Set- Forms and Items: These Q&A review OASIS E Item specific questions and how to handle specific scenarios related to these.

Q&As including CATEGORIES 1-4 are allowed for reference during HCS-O exam

10

10

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OASIS-E RELATED COPs, GUIDELINES, & CONVENTIONS

Specific Areas of OASIS Chapter 3 Guidance Updated for OASIS E

GG0130/GG0170

- Coding an item when only a portion of the activity has been completed:
  - *If the patient only completes a portion of the activity (e.g., performs a partial bath or transfers into but not out of a vehicle) and does not complete the entire activity during the assessment time frame, use clinical judgment to determine if the situation allows the clinician to adequately assess the patient's ability to complete the activity. If the clinician determines that this observation is adequate, code based on the type and amount of assistance the patient requires to complete the ENTIRE activity. If the clinician determines the partial activity does not provide adequate information to support determination of a performance code, select an appropriate "activity not attempted" code.*

11

11

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OASIS-E RELATED COPs, GUIDELINES, & CONVENTIONS

Specific Areas of OASIS Chapter 3 Guidance Updated for OASIS E

GG0170C – Lying to sitting on side of bed

- Additional guidance added:
  - It is not required that the patient's feet be flat on the floor to consider the activity as being completed.
  - *NOTE: Reference to patient having feet on the floor has been removed from the item.*

GG0170G – Car transfer

- Additional guidance added:
  - If the patient remains in a wheelchair and does not transfer in and out of a car or van seat, the activity is not considered completed and the appropriate "activity not attempted" code would be used.

12

12

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OASIS-E RELATED COPs, GUIDELINES, & CONVENTIONS

Specific Areas of OASIS Chapter 3 Guidance Updated for OASIS E

GG0170I-Q (Ambulation, Wheelchair activities)

- Additional verbiage added to guidance
  - The walking activities cannot be completed without some level of patient participation that allows patient ambulation to occur for the entire stated distance. A helper cannot complete a walking activity for a patient.
  - A helper can assist a patient to complete the wheelchair distance or make turns if required. When a patient is unable to wheel the entire distance themselves the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required from the helper to complete the entire activity.

13

13

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OASIS-E RELATED COPs, GUIDELINES, & CONVENTIONS

Specific Areas of OASIS Chapter 3 Guidance Updated for OASIS E

M2420 – Discharge disposition

- Updated guidance to support Transfer of Health Quality Measure
  - *Code 1, Patient remained in the community (without formal assistive services), should be coded for this item if the patient remained in the community (in a non-institutional setting – this includes assisted living and group homes) and did not continue to receive either SKILLED HOME HEALTH CARE SERVICES or HOSPICE.*
  - *Code 3, Patient transferred to non institutional hospice should be coded for this item, if after discharge, the patient remained in the community under the care of hospice services (NON INPATIENT).* ***A discharge OASIS is completed in this circumstance. **If the patient is admitted to inpatient hospice, complete a TRANSFER oasis.***
  - Example 1: Patient admitted to agency, requests DC and will be admitted to another skilled home health agency per patient's request. M2420 should be answered 2 on DC OASIS E.
  - Example 2: Patient admitted to agency, changed from traditional Medicare to UHC Medicare on May 1. Agency completed DC on 4/31, New SOC on 5/1. M2420 on 4/31 OASIS E DC OASIS should be answered 2.

14

14

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OASIS-E RELATED COPs, GUIDELINES, & CONVENTIONS

Specific Areas of OASIS Chapter 3 Guidance Updated for OASIS E

M2420 – Discharge disposition

- Updated guidance to support Transfer of Health Quality Measure
  - *Code 2, Patient remained in the community (with formal assistive services), now applies if, after discharge from your agency the patient remained a non-inpatient setting, receiving skilled services from another Medicare certified home health agency, (with or without other assistive services), or when an agency completes a discharge and new SOC OASIS due to a pay source change for a patient.*
  - What this means is that "remained in community (with formal assistive services) is now LIMITED to meaning skilled services of the SAME or ANOTHER Medicare certified home health agency (which may or may not include additional non skilled services such as aide or MSW services, dietician, etc.), but MUST include SKILLED home health.
    - **EXCLUDES non-skilled HH such as homemaker and personal care, other community health resources and services such as MOW, visiting physicians, and any other assistive services (healthcare related or otherwise)**

15

15

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Importance of OASIS-E in HHVBP Expanded Model

2023 Implementation of OASIS and the role of data collection

16

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Expanded Home Health Value Based Purchasing (HHVBP) Model

- **2022 has been the pre-implementation** year. This is the year for allowing education and preparation leading up to the first performance year which will impact actual payment (maximum bonus or penalty in payment of 5%)
- **2023 is the first PERFORMANCE** year, aligning with the implementation of OASIS E.
  - Multiple measures, including outcome-based OASIS measures, claims-based measures, and CAHPS based measures will determine payment bonus or reduction upon ***first payment year in 2025.*** Again, the DATA that determines payment in 2025 begins JANUARY 1, 2023.
  - Performance is in part measured against baseline data for the agency's unique improvement threshold
    - Agencies certified prior to 1/1/19 = baseline year 2019
    - Certified on or after 1/1/19 = first full year of services after date of certification
    - Certified 1/1/19-12/31/19 = baseline year is 2021, performance year is first full year following beginning with 2023
- HHVBP model claims payments will begin starting in 2025 based on claims data from 2023

17

17

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Expanded Home Health Value Based Purchasing (HHVBP) Model

- Benchmarking for VBP achievement is between large and small agency cohorts and is calculated separately by CMS
- Different measures hold different weights
  - OASIS measures vs. claims based vs. CAHPS based
  - Claims based measures
    - Acute care hospitalization during first 60 days of home health episode
    - Emergency Department Use Without Hospitalization During the First 60 Days of Home Health measure
  - Total Performance Score is awarded to each measure
- Under the expanded HHVBP Model, CMS will apply a reduction or increase of up to 5% to an HHA's Medicare payments starting in 2025, based on their performance for the specified measures relative to peer performance in the same cohort starting in 2023. Performance on these quality measures in a specified year (performance year) impacts payment adjustments in a later year (payment year).
  - **Performance year 1= 2023 Payment year 1= 2025**

18

18

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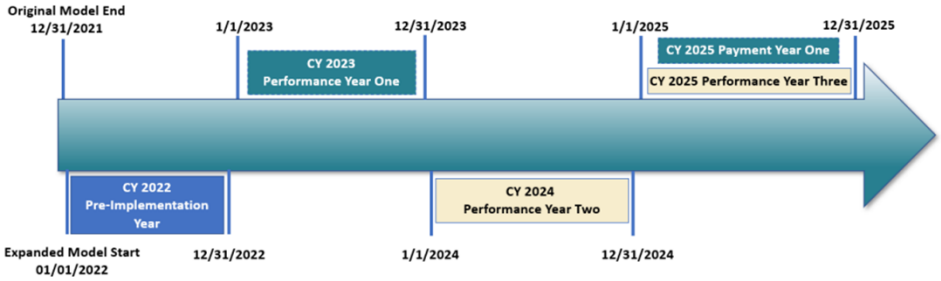
Expanded Home Health Value Based Purchasing (HHVBP) Model



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Expanded Home Health Value Based Purchasing (HHVBP) Model

- Agencies are measured against similarly sized peer agencies for performance in outcomes
  - **Smaller volume cohort =** the group of competing HHAs that had fewer than sixty (60) unique beneficiaries in the calendar year prior to the performance year.
  - **Larger volume cohort =** the group of competing HHAs that had sixty (60) or more unique beneficiaries in the calendar year prior to the performance year

- **12 total quality measures used**
  - 5 OASIS based
  - 2 claims based
  - 5 HHCAHPS based (*Patient satisfaction survey)
    - ***This becomes of even greater importance to encourage patients to follow up with surveys and assure that patients understand that you, as the clinician, are working with them in certain areas!***

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Expanded Home Health Value Based Purchasing (HHVBP) Model

- OASIS Items impacting VBP
  - ***M1400***
  - ***M1800***
  - ***M1810***
  - ***M1820***
  - ***M1830***
  - ***M1840***
  - ***M1845***
  - ***M1850***
  - ***M1860***
  - ***M1870***
  - ***M2020***
  - ***M2420***

21

21

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Expanded Home Health Value Based Purchasing (HHVBP) Model

- **HHCAHPS Based (Patient Survey Based) measure – 5 component questions that represent one NQF measure (NQF0517) –** each is weighted the same
  - Care of Patients
  - Communication Between Providers and Patients
  - Specific Care Issues
  - Overall Rating of Home Health Care
  - Willingness to Recommend the Agency

HHVBP Resources

- ***https://innovation.cms.gov/media/document/hhvbp-exp-faqs***
- ***https://innovation.cms.gov/innovation-models/expanded-home-health-value-based-purchasing-model***
- ***https://www.federalregister.gov/documents/2022/11/04/2022-23722/medicare-program-calendar-year-cy-2023-home-health-prospective-payment-system-rate-update-home***

22

22

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OASIS E Guidelines and Conventions

Understanding the role when, the where, and the how of OASIS

23

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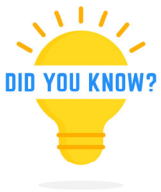
General OASIS Guidelines & Conventions



OASIS Patient Requirements - OASIS data are collected for skilled Medicare and Medicaid patients, 18 years and older, except for patients receiving maternity (pre/post-natal) services. ***Those receiving only personal care, homemaker, or chore services are excluded from OASIS data collection and submission requirements.***

Comprehensive Assessment - OASIS is not intended to represent a comprehensive assessment in and of itself. HHAs are expected to incorporate OASIS items into their comprehensive assessment documentation and follow their own assessment policies and procedures.

- **Comprehensive assessment & OASIS MAY be completed by one clinician OR utilize collaboration as applicable**
  - Collaboration requires proper policies in place and documentation to support

24

24

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General OASIS Guidelines & Conventions

OASIS Time Points

All OASIS assessments, except transfer to inpatient facility and death at home, require the clinician to have an in-person encounter with the patient during a home visit. The transfer to an inpatient facility and death at home time points require collection of limited OASIS data (most of which may be obtained through a telephone call). OASIS data should be collected at each time point based on a unique patient assessment, not simply carried over from a previous assessment.

- **Reason for Assessment (RFA)**
  - **Start of Care (SOC) – Assessment time frame = w/in 5 calendar days after SOC date (day 0)**
  - **Resumption of Care (ROC) = w/in 2** calendar days of the facility discharge date or knowledge of patient's return home
  - **Recertification follow up =** days 56-60 of the current 60-day certification period
  - **Other follow up ("SCIC") =** days 56-60 of the current 60-day period
  - **Transfer (TRF) =** Within 2 calendar days of disch/trans/death date or knowledge of a qualifying transfer to inpatient facility
  - **Discharge (DC) =** Within 2 calendar days of disch/trans/death date or knowledge of a qualifying transfer to inpatient facility
  - **Death at Home (DAH) =** Within 2 calendar days of death at home date

25

25

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Choosing the correct OASIS RFA

Scenario #1 – SOC for RN/PT, patient refuses nursing

An RN goes to see a patient for a SOC on 1/15/23 where SN and PT services are ordered following a right hip replacement due to hip fracture. The patient also has new medication and some continued pain issues. The patient lives with his wife and says she helps with his meds and he does not want nursing, only therapy. Therapy is not scheduled to see the patient until 1/17/23 for the evaluation. Can the SOC OASIS completed by the RN be used even though nursing will not continue or must the SOC date be updated and the PT complete the SOC including OASIS and comprehensive assessment.

- **Per CMS Q&A, Category 2, Q&A 9.1:** *"If it is determined during the initial assessment visit, that the patient either did not have a need for nursing services and/or the patient declined all nursing services, the SOC will not be established by that visit. The RN can notify the physician that nursing will not be involved in the patient's care, and either continue on to complete the SOC comprehensive assessment (if the PT will be establishing the SOC that day), OR have the PT complete the SOC comprehensive assessment on or within 5 days after the PT establishes the start of care."*
  - ***SN SOC OASIS cannot be used for SOC as there is no SOC established by that visit and the RN cannot do a non billable OASIS for PT for that date as the PT is going after (first billable skill must be established – PT – before the 5 day window clock begins (i.e. the SOC date and associated OASIS are invalid.) The physician should be notified and the PT can complete the SOC OASIS and comprehensive assessment as of 1/17/23.***

26

26

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Content of the OASIS & Comprehensive Assessment

- **Comprehensive Assessment MUST include, at a minimum:**
  - The patient's primary caregiver(s), if any, and other available supports, including their:
    - (i) Willingness and ability to provide care, and
    - (ii) Availability and schedules;
  - (7) The patient's representative (if any);
  - (8) Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary. The OASIS data items determined by the Secretary must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.

27

27

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Updating the Comprehensive Assessment

- The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than:
  - The last 5 days of every 60 days beginning with the start-of-care date, unless there is a -
    - (i) Beneficiary elected transfer;
    - (ii) Significant change in condition; or
    - (iii) Discharge and return to the same HHA during the 60-day episode.
  - Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician or allowed practitioner-ordered resumption date;
  - At discharge.

28

28

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OASIS Conventions

Conventions- General rules to follow when completing OASIS. Per CMS, the assessing clinician should consider available guidance and allows use of professional judgment and interdisciplinary collaboration for assessment.

General vs. Specific Conventions – Specific conventions are available and developed applicable to certain sections of OASIS (such as M1800 ADL/IADL items) while general conventions are a group of over arching rules that apply to all items. If a more specific rule is available that applies to a specific item or group of items, that more specific rule would be followed

29

29

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OASIS GENERAL Conventions

- **Look Back -** each item has a specific look back period that should be referenced. Report what is true on the day of assessment **unless a different time period has been indicated in the item or related guidance**.
  - DAY OF ASSESSMENT – defined as 24 hours immediately preceding the home visit and the time spent by the clinician in the home.
- **Variability of ability or status or patient -** report the patient's "usual status" or what is true greater than 50% of the time period under consideration, **unless the item specifies differently.**
- **Unknown and NA responses** should be minimized whenever possible

30

30

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OASIS GENERAL Conventions

- **DASH responses** are allowed in some items. This means no info is available and should be avoided when possible. These should be RARELY USED.
- **CURRENT STATUS** – When an item refers to a patient's current status this should be based on observation and report of the patient's condition and ability at the time of assessment WITHOUT referring back to prior assessments or documentation of status from any prior care setting.
  - Several process items require review of documentation of care that occurred at the time of or at any time since the most recent SOC or ROC OASIS assessment. Specific item guidance should be followed for these items.
- **ASSISTANCE –** item guidance that refers to assistance means assistance from another person and is NOT limited to physical contact. This may include verbal cues and supervision

31

31

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OASIS GENERAL Conventions

- **DEFINITIONS** are available throughout Chapter 3 of the OASIS guidance manual. These definitions are considered integral guidance to each item and should be reviewed and followed when considering how to respond to items.
- **"Specifically" vs. "For Example" -** The use of the term "specifically," means scoring of the item should be limited to only the circumstances listed. The use of "for example," means the clinician may consider other relevant circumstances or attributes when scoring the item

32

32

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OASIS GENERAL Conventions

- **Current knowledge-** CMS expects that all assessing clinicians and those using OASIS documents within the home health agency remain current with evolving CMS OASIS guidance via updates to the guidance manual and posted Q&A documents.
- **Chapter 3 –** Item specific guidance is contained in **Chapter 3** of the OASIS E Guidance manual. CMS expects that that all assessing clinicians and those using OASIS documents within the home health agency refer to this first for item- by-item guidance
- **Accuracy –** Clinicians should complete all OASIS E items accurately, comprehensively and adhere to all skip patterns to avoid error

33

33

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OASIS GENERAL Conventions

- **COLLABORATION –**
  - Assessing clinician is responsible for accurately completing and signing the OASIS and comprehensive assessment
  - May collaborate with others if agency policy allows
  - May consider information from others such as the patient, caregivers, and other health care personnel, including the physician, pharmacist, and/or other agency staff who have had direct contact with the patient or had some other means of gathering information to contribute to the OASIS data collection.
  - M0090 - Date Assessment Completed, is the last date that information used to complete the comprehensive assessment and determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed.
  - Must occur within the assessment timeframe and be consistent with data collection guidance.
  - **REFER TO ITEM SPECIFIC GUIDELINES FOR EXCEPTIONS TO ALLOWED COLLABORATION**

34

34

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SPECIFIC CONVENTIONS – M1800 ADL/IADL ITEMS

- **Ability –** When responding to M1800 items, report the patient's ability to safely perform a task, rather than preference or willingness
- **Level of Ability –** refers to assist needed to safely perform task. Assistance includes verbal cues, reminders, supervision and/or stand-by or hands-on assistance
- **Presence of caregiver-** does not impact the assessing clinician's ability to assess and determine/report level of assistance the patient requires to safely complete a task.
- **Included/Excluded tasks –** understand guidelines for each item and select responses only based upon included tasks
- **Majority of included tasks-** 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.
- **Medical restrictions-** consider medical restrictions, such as physician restrictions for weight bearing and activity when selecting the best response for functional items.

35

35

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COLLABORATION EXCEPTION SCENARIO

- **A patient is admitted to home health with a SOC on 2/2/23 by the RN for cellulitis of the bilateral lower legs. She is morbidly obese, diabetic, has chronic pain and is limited in mobility to a chair and is unable to ambulate, although she can wheel short distances of 5-10 feet in her living room. The RN provided wound care to the bilateral legs and performed a skin assessment at the SOC to all visible areas. However, no caregiver was present with the patient during the RN's SOC to assist with a transfer and the patient requires at least the assist of 2 people. The RN was unable to visualize the patient's buttocks, groin, upper/inner thighs or genital region skin. On 2/4/23, the PT saw the patient for an evaluation on the same day that the next SN visit was completed by an LPN and was able to assist with visualization of the buttocks, groin, thighs and genital skin. An ulceration on the sacrum is identified that is confirmed with the physician to be a stage 3 pressure ulcer. The LPN and PT inform the RN who completed the OASIS SOC on 2/2/23. Since this occurred in the 5 day window, can the RN collaborate with the LPN and PT and include the pressure ulcer in M1306, M1311, M1324?**

36

36

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COLLABORATION EXCEPTION SCENARIO

- **In this case the pressure ulcer identified on 2/4/23 by the LPN and PT CANNOT BE included on the SOC OASIS**
- Collaboration IS allowed, but would not relate to pressure ulcer in this case
- The wound WAS identified within the 5-day window
- Pressure ulcers/injuries must be reported as of the first skin assessment
  - RN completed first skin assessment on 2/2/23. This excluded the pressure ulcer which could not be observed.

37

37

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Types of Episodes

- Certification Episode = 60 days, defined by the provider/physician ordered certification period.
  - OASIS timepoints required to initiate SOC & Recertification 60-day episodes
- Payment Episode = Billing period. 30 days maximum for traditional Medicare. Defined by generated HIPPS for the 30-day period.
  - OASIS items from most recent SOC or recert (or inpatient acute care hospitalization w/in past 14 days if applicable) will impact payment generation.
- Quality Episode = Outcomes generated. Does NOT include Recertification
  - SOC to DC, ROC to DC, SOC to TRF, ROC to TRF
  - Periods over 12 months are excluded from Outcomes

38

38

OASIS GENERAL Conventions

- **Quality Episodes**
  - For OASIS purposes, a quality episode must have a beginning and a conclusion to be considered a complete quality episode.
  - Quality Episodes are different than payment episodes/billing periods in that they contribute to OUTCOMES
    - Impact Star Ratings, Value Based Purchasing, Home Health Compare, etc.
  - Types of Quality Episodes:
    - SOC – DC
    - SOC – TRF
    - SOC – DAH
    - ROC – DC
    - ROC- TRF
    - ROC- DAH

***ANY QUALITY EPISODE OVER 12 MONTHS IS EXCLUDED FROM CALCULATION IN AGENCY OUTCOMES/HHQI REPORTING**

39

39

Outcomes

- Outcomes and quality measures are determined on a patient level with each individual quality episode
- Includes ALL OASIS data (MCR, MCD, MCR HMO, MCD HMO)
- Improvement
  - Data must improve from one level to a higher performance level on a measured item (*Recerts not considered)
- Decline
  - Data shows decline in performance from SOC to DC, ROC to DC, SOC to TRF, ROC to TRF. (*Recerts not considered)
- Null Data (no contribution to outcomes)
  - Patient's level of performance does not change for an included item
  - Data measurement baseline is 0/highest performance – will not be included
  - Data for any quality episode over 12 months excluded

40

40

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OASIS Item Applicability

- Risk Adjustment
  - The general intent of risk adjustment is to compensate or adjust for differences in case mix or risk factors (between agency and a comparison sample) that should be taken into consideration if outcomes are to be compared validly. **Risk adjustment compensates or controls for the potential influence of case mix variables (i.e., risk factors) that can affect outcomes.**
    - Includes factors such as age, gender, recent inpatient stay, therapies received at home, hospitalization risk factors, height/weight, caregiver support, presence of wounds, cognitive factors, baseline mobility function, falls history

41

41

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OASIS Item Applicability

- Quality Measures – Includes both Process and Outcome Measures
- Outcome Measures:
  - **End-Result Outcomes** include changes in patient health status, such as physiologic, functional, cognitive, emotional, or behavioral health, between two or more time points. Examples of end-result outcomes are: Improvement in Ambulation/Locomotion and Stabilization in Bathing.
  - **Utilization Outcomes** are a type of health care utilization (or non-utilization) that reflects (typically a substantial) change in patient health status over time. Examples of utilization outcomes include quality measures that address hospital admission, use of hospital emergency department services, and discharge to the community.
    - Measured using both OASIS and Claims based data

42

42

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OASIS Item Applicability

- Process Measures:
  - Process quality measures evaluate the rate of home health agency use of ***specific evidence-based processes of care***. The standardized home health quality process measures focus on high-risk, high-volume, problem-prone areas for home health care. These include measures pertaining to all or most home care patients, such as ***timeliness of home care admission/resumption of care and immunizations.***
  - EXAMPLE: percentage of home health quality episodes during which patients received the influenza immunization for the current flu season. An agency rate of 72% for that measure means that the agency's process of caring for patients included the recommended practice in 72% of the included quality episodes

43

43

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OASIS Item Applicability

- PDGM Payment is primarily determined by primary diagnosis assigned to the ***CLAIM***
  - While M1021, M1023 appear on the OASIS, these are technically optional items and coding is considered claim coding under PDGM (not required to match. Ex: may change at 30-day billing period point).
- Specific OASIS items result in variability of final HIPPS code to claim, determining final payment amount
  - Early/Late now determined by CLAIM, not M0110 (but item should still be answered accurately)

44

44

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PDGM Payment & OASIS Item Applicability

- HIPPS Structure
  - Position 1 = Source & Timing (Claim)
  - Position 2 = Clinical Grouping (Primary Dx)
  - Position 3 = Functional Level (OASIS)
  - Position 4 = Comorbidity Adjustment (Claim secondary dx)
  - Position 5 = Placeholder (*Always will be 1 until further updates to PDGM to give this position further meaning)
- Using this structure, a second billing period for a patient with a hospital inpatient stay before the period, in the Wounds group, with high functional severity and no co-morbidity would be coded 4CC11. Under this coding structure there is a 1:1 DIRECT relationship between HHRGs and HIPPS codes, resulting in 432 valid codes.

45

45

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PDGM Payment & OASIS Item Applicability

- OASIS Items impacting payment:
  - M1033, Risk for hospitalization
  - M1800, Grooming
  - M1810, Dressing upper body
  - M1820, Dressing lower body
  - M1830, Bathing
  - M1840, Toilet transferring
  - M1850, Transferring
  - M1860, Ambulation/Transferring

46

46

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PDGM Payment & OASIS Item Applicability

- Based upon OASIS item responses:
  - Functional Level for 3rd character of HIPPS is determined as:
    - A= LOW
    - B = MED
    - C = HIGH

47

47

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OASIS-E Item by Item Review

Guidance, Intent, and how to apply each OASIS E item

48

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M0030 Start of Care Date

M0030. Start of Care Date	
	☐☐ - ☐☐ - ☐☐☐☐ Month Day Year

- For PT or SLP to perform SOC visit for Medicare patient:
  - Must have orders for PT or ST PRIOR to SOC visit
  - NO ORDERS FOR NURSING ARE PRESENT
  - A reimbursable skilled service must be provided and the need for this service establishes eligibility
- For OT to perform SOC visit on Medicare patient:
  - NO ORDERS FOR NURSING ARE PRESENT
  - Orders are present for OT AND PT or ST
- When the agency's policy/practice is for an RN to perform the SOC assessment in a therapy-only case, the nursing assessment visit must be made the same day or within five days after the therapist's first visit.

49

49

decisionhealth

M0032 Resumption of Care Date

M0032. Resumption of Care Date	
	☐☐ - ☐☐ - ☐☐☐☐ Month Day Year ☐ NA – Not Applicable

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

50

50

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M0040 Patient Name

- Data sources that may be used include: patient's Medicare card, private insurance card, HMO identification card, etc.
- MUST be correctly spelled
- If no suffix, leave blank. If middle initial is not known, leave blank.
- The name entered should be exactly as it appears on the patient's Medicare or other insurance card.
- The name entered should be the patient's legal name, even if the patient consistently uses a nickname

Failure to enter patient's name as it appears in patient's Medicare records can result in rejection of the OASIS upon submission to iQIES

51

51

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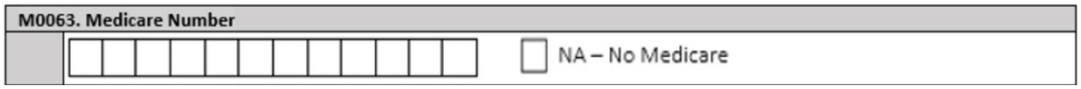
M0063 Medicare Number



- Review the patient's Medicare card to verify the Medicare number against referral information as well as the patient's Medicare Common Working File
- MBI should be used since 12/31/19
- If the patient does not have Medicare, NA should be marked
- Do not enter insurance ID or Medicare HMO ID. If the patient is a member of Medicare HMO plan, the Medicare MBI may be entered here or enter NA if not available
- DASH IS NOT A VALID RESPONSE

52

52

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M0065 Medicaid Number

M0065. Medicaid Number	
	☐ NA – No Medicaid

- Review the patient's Medicaid card and verify state records
- Medicaid expiration dates should be verified (monthly)
- Regardless of payer source, it should be indicated if the patient has Medicaid
- DASH IS NOT A VALID RESPONSE

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A1005 Ethnicity

A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?	
↓ Check all that apply	
☐	A. No, not of Hispanic, Latino/a, or Spanish origin
☐	B. Yes, Mexican, Mexican American, Chicano/a
☐	C. Yes, Puerto Rican
☐	D. Yes, Cuban
☐	E. Yes, another Hispanic, Latino, or Spanish origin
☐	X. Patient unable to respond
☐	Y. Patient declines to respond

- The ethnicity and race data elements use a two-question format. Collection of A1005, Ethnicity and A1010, Race provide data granularity important for documenting and tracking health disparities and conform to the 2011 Health and Human Services Data Standards.
- Identifies patient self-reported ethnicity data
- Item intent to improve understanding of and address racial and ethnic disparities in health care outcomes requires the availability of better data related to social determinants of health, including ethnicity.

decisionhealth

A1005 Ethnicity

- Multiple responses are allowed
- If a patient declines to respond, do not code based on proxy response or medical record documentation
  - Respond Y, patient declines to respond

decisionhealth

A1010 Race

A1010. Race What is your race? ↓ Check all that apply		
☐	A.	White
☐	B.	Black or African American
☐	C.	American Indian or Alaska Native
☐	D.	Asian Indian
☐	E.	Chinese
☐	F.	Filipino
☐	G.	Japanese
☐	H.	Korean
☐	I.	Vietnamese
☐	J.	Other Asian
☐	K.	Native Hawaiian
☐	L.	Guamanian or Chamorro
☐	M.	Samoan
☐	N.	Other Pacific Islander
☐	X.	Patient unable to respond
☐	Y.	Patient declines to respond
☐	Z.	None of the above

- Identifies patient's self reported race data
- These categories are NOT used to determine eligibility for participation in any Federal program.
- More than one response is acceptable for this item
- If the patient declines to respond, mark response Y

M0150 Current Payment Sources for Home Care

M0150. Current Payment Sources for Home Care	
↓	Check all that apply
☐	0. **None;** no charge for current services
☐	1. **Medicare** (traditional fee-for-service)
☐	2. **Medicare** (HMO/managed care/Advantage plan)
☐	3. **Medicaid** (traditional fee-for-service)
☐	4. **Medicaid** (HMO/managed care)
☐	5. **Workers' compensation**
☐	6. **Title programs** (for example, Title III, V, or XX)
☐	7. **Other government** (for example, TriCare, VA)
☐	8. **Private insurance**
☐	9. **Private HMO/managed care**
☐	10. **Self-pay**
☐	11. **Other** (specify)
☐	UK. **Unknown**

- Identifies payers who will be billed by your agency for services during the episode.
- Pending payers should be excluded
- Only payers that will be billed for home health services should be included (exclude payers that will be reimbursing only other services or supplies

57

57

A1110 Language

A1110. Language	
Enter Code	A. **What is your preferred language?**
☐	B. **Do you need or want an interpreter to communicate with a doctor or health care staff?** 0. **No** 1. **Yes** 9. **Unable to determine**

- Reports patient's preferred language
- Identifies need for interpreter
- If the patient or proxy cannot provide a response, medical record documentation can be used
- An organized system of signing, such as American Sign Language (ASL), can be reported as the preferred language if the patient needs or wants to communicate in this manner.

58

58

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M0090 Date Assessment Completed

M0090. Date Assessment Completed	
	☐☐ · ☐☐ · ☐☐☐☐ Month Day Year

- Completion date cannot be prior to SOC date/date of initial assessment
- last date that information used to complete the comprehensive assessment and determine OASIS coding was gathered by the assessing clinician and documentation of the specific information/responses was completed.
- If an error is identified at any time, it should be corrected following the agency's correction policy and M0090 would not necessarily be changed (i.e. do not update M0090 date when reopening an OASIS for correction)
- When completing a Transfer or Death at Home, record the date the agency completed the data collection after learning of the event. (i.e. the M0090 date on a Transfer should NOT reflect the date of TRANSFER (M0906) but rather the date of data collection).

59

59

decisionhealth

M0906 Discharge/Transfer/Death date

M0906. Discharge/Transfer/Death Date Enter the date of the discharge, transfer, or death (at home) of the patient.	
	☐☐ · ☐☐ · ☐☐☐☐ Month Day Year

- Identifies the actual date of discharge, transfer, or death (at home), depending on the reason for assessment.
- Transfer date = date patient was ADMITTED to an inpatient facility not transported
- Death date for DAH home OASIS –
  - Reports actual death date either in the home,
  - While in transport to the ER,
  - In the ER, but prior to being seen or admitted to the inpatient facility
  - When the patient expires in the ER
  - Date of death during outpatient surgery
  - Date of death occurring less than 24 hours after being admitted to an inpatient facility
- Death occurring after the patient has been admitted to an inpatient facility for a qualifying inpatient stay (after 24 hr.) = Transfer OASIS

60

60

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M0102 Date of Physician-ordered Start of Care

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.	
	☐☐ - ☐☐ - ☐☐☐☐ → *Skip to M0110, Episode Timing, if date entered* Month Day Year ☐ NA – No specific SOC/ROC date ordered by physician

- Date of specifically ordered SOC date or ROC date if provided
- If the originally ordered Start of Care (SOC)/Resumption of Care (ROC) is delayed due to the patient's condition or physician/allowed practitioner request (for example, extended hospitalization), then the date specified on the revised order to start/resume home care services would be considered the date of physician-ordered SOC/ROC.
- A revised physician's ordered SOC/ROC date must be received on or before the date of the previous physician's ordered SOC/ROC.
- If the order to extend the physician's ordered SOC/ROC date is received after the previous physician's ordered SOC/ROC date has passed, report NA for M0102 and report the original referral date in M0104.

61

61

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M0102 Date of Physician-ordered Start of Care

- In order to be considered a physician-ordered SOC/ROC date, the physician/allowed practitioner must give a specific date to initiate or resume care, not a range of dates.
  - If a single date to initiate or resume services is not provided, the initial contact (via the initial assessment visit or ROC visit) must be conducted within 48 hours of the referral or within 48 hours of the patient's return home from the inpatient facility
- "Order" includes orders from a nurse practitioner, physician assistant

62

62

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M0104 Date of Referral

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

- Specifies the most recent date that verbal, written, or electronic authorization to begin or resume home care was received by the home health agency.
- A valid referral is considered received when the agency has received adequate information about a patient (such as name, address/contact info, and diagnosis and/or general home care needs) to initiate patient assessment and confirmed that the referring physician/allowed practitioner or another physician/allowed practitioner, will provide the plan of care and ongoing orders.
  - In cases where home care is requested by a hospitalist who will not be providing an ongoing plan of care for the patient, the agency must contact an alternate or attending physician/allowed practitioner. The agency will note the date the alternate or attending physician/allowed practitioner agreed to follow the patient as the referral date (M0104) unless referral details are later updated or revised.

63

63

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M0104 Date of Referral

- If Start of Care or Resumption of Care is delayed due to the patient's condition or physician/allowed practitioner request (for example, extended hospitalization), the date the agency received the updated/revised referral for home care services would be considered the date of referral.
  - This does not include calls or documentation from others, such as assisted living facility staff or family, who contact the agency to prepare the agency for possible admission.
- The date authorization was received from the patient's payer is NOT the date of the referral (for example, the date the Medicare Advantage case manager authorized service is not considered a referral date).

64

64

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M0110 Episode Timing

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

- Some other payers that are not Medicare FFS payers will use this information to calculate HIPPS for payment rate
- M0110 is not used in the calculation of HIPPS for PDGM. Episode timing for HIPPS position 1 is calculated based upon claims data.

decisionhealth

A1250 Transportation

A1250. Transportation *(NACHC ©)* Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	
↓ Check all that apply	
☐	A. Yes, it has kept me from medical appointments or from getting my medications
☐	B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	C. No
☐	X. Patient unable to respond
☐	Y. Patient declines to respond

- Patient self report item – proxy may respond if patient is unable and proxy is available and response is relevant ****MULTIPLE RESPONSES ARE ACCEPTABLE****
- Intent – to improve care planning around accessing effective health care/reducing barriers to meeting health care needs and accessing needs limited by transportation barriers, facilitating community resources
- Patient should be offered the option of selecting more than one yes designation, if applicable
- **If the patient declines to respond**, do not code on proxy input or medical record documentation
- Time frame: Complete as close to the time of SOC/ROC as possible and within three days of discharge.

decisionhealth

A1250 Transportation

SCENARIO EXAMPLE 1 – A patient with early onset Alzheimer's dementia is admitted for therapy. She is verbal, but frequently confused to events over 24 hours prior and unable provide any relevant information regarding transportation barriers and cannot provide a relevant response regarding a lack of transportation preventing access to medical, food, or other resources. No proxy is available, but her medical record consistently indicates that her neighbor has transported her to her medical appointments, picks up her medications, and does her grocery shopping. The patient appears to have all of her medications and ample groceries.

A1250 would be coded response C- No AND response X- patient unable to respond

- If neither the patient nor a proxy is able to provide a response, but the medical record documentation can provide the necessary information, code both the information in the medical record, and Code X, Patient unable to respond.

67

67

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A1250 Transportation SOC vs. DC

SCENARIO EXAMPLE 2 – A 65 yr. old patient with a fractured left femur is admitted for therapy. Outpatient therapy was ordered but the patient missed several appointments due to no one available to drive him and he also missed his surgical follow up appointment. Due to medical restrictions the patient is unable to drive at the SOC and has no assistance to get to physician appointments or obtain medications. The patient's daughter will be coming from out of town to assist but will not arrive for a week, so the patient states he has no current assist. At discharge, the patient has full ROM, no restrictions, and is able to drive and no longer requires any assist. He reports he is able to drive himself to appointments and obtain medication and all other needs

SOC – A1250 would be coded response A- Yes, it has kept me from medical appointments or from getting my medications

DC - A1250 would be coded response C- No

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68

68

M1000 Inpatient Facilities

decisionhealth

M1000. From which of the following **Inpatient Facilities** was the patient discharged within the past 14 days?	
↓ Check all that apply	
☐	1. Long-term nursing facility (NF)
☐	2. Skilled nursing facility (SNF/TCU)
☐	3. Short-stay acute hospital (IPPS)
☐	4. Long-term care hospital (LTCH)
☐	5. Inpatient rehabilitation hospital or unit (IRF)
☐	6. Psychiatric hospital or unit
☐	7. Other (specify)
☐	NA **Patient was not discharged from an inpatient facility** → *Skip to B0200, Hearing at SOC, Skip to B1300, Health Literacy at ROC*

- If patient has been discharged from a swing-bed hospital, it is necessary to determine whether the patient was occupying a designated hospital bed (Response 3), a skilled nursing bed under Medicare Part A (Response 2), or a nursing bed at a lower level of care (Response 1). The referring hospital can answer this question regarding the bed status
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) are considered "Other" (Response 7) for the purpose of this item
- Long term care hospital (LTCH) – inpatient hospital where the average length of stay exceeds 25 days, however facility type is determined by state licensure
- Past 14 days – SOC = day 0 and day prior = day 1
- Multiple responses are acceptable

69

69

M2301 Emergent Care

decisionhealth

M2301. Emergent Care At the time of or at any time since the most recent SOC/ROC assessment has the patient utilized a hospital emergency department (includes holding/observation status)?	
Enter Code ☐	0. **No** → *Skip to M2410, Inpatient Facility* 1. **Yes, used hospital emergency department WITHOUT hospital admission** 2. **Yes, used hospital emergency department WITH hospital admission** UK **Unknown** → *Skip to M2410, Inpatient Facility*

- Identifies whether the patient was seen in a hospital emergency department at or since the most recent SOC/ROC assessment, **with or without a hospital admission.**
- Includes any ER visit resulting in admission from the current transfer when completing TRN OASIS
- This item is coded whether the patient independently decides to seek care at a hospital emergency department or was advised to go by the physician, the home health agency or other health care provider
- EXCLUDES care provided at an urgent care/walk in clinic facility
- EXCLUDES direct admission to inpatient facility without evaluation/treatment in the ER

70

70

M2310 Reason for Emergent Care

decisionhealth

M2310. Reason for Emergent Care For what reason(s) did the patient seek and/or receive emergent care (with or without hospitalization)?	
↓ Check all that apply	
☐	1. Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
☐	10. Hypo/Hyperglycemia, diabetes out of control
☐	19. Other than above reasons
☐	UK Reason unknown

- Excludes urgent care services
- If the patient has received emergent care in a hospital emergency department multiple times since the most recent SOC/ROC, include the reasons for all visits.
- If more than one reason contributed to the hospital emergency department visit, mark all appropriate responses.
- If a patient seeks care in a hospital emergency department for a specific suspected condition, report that condition, even if the suspected condition was ruled out.

71

71

M2410 Inpatient Facility

decisionhealth

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

- If the patient was admitted to more than one facility, **indicate the facility type to which the patient was admitted first** (for example, the facility type that they were transferred to from their home).
- May obtain information from family, providers, facility

72

72

M2420 Discharge Disposition

decisionhealth

VBP Discharged to Community ITEM

M2420. Discharge Disposition Where is the patient after discharge from your agency? (Choose only one answer.)	
Enter Code ☐	1. **Patient remained in the community (without formal assistive services)** → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge* 2. **Patient remained in the community (with formal assistive services)** → Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge 3. **Patient transferred to a non-institutional hospice** → Continue to A2121, Provision of Current Reconciled Medication List to Subsequent Provider at Discharge 4. **Unknown because patient moved to a geographic location not served by this agency** → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge* UK **Other unknown** → *Skip to A2123, Provision of Current Reconciled Medication List to Patient at Discharge*

- **FORMAL ASSISTIVE SERVICES =**
  - Skilled services from the same or another Medicare certified home health agency (includes readmission to the same agency), or;
  - Hospice care from a non-institutional (non inpatient) hospice provider

- Code 1 if the patient discharged to community without skilled services or home hospice services
  - Any other community assistive services are NOT considered FORMAL assistive services (MOW, visiting physicians, transportation assistance, nonskilled/home maker/personal care assistance)

73

73

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M2420 Discharge Disposition

- Follow skip pattern for Provision of Current Reconciled Medication list to patient at Discharge (A2123) or Provision of Current Reconciled Medication list to Subsequent Provider at Discharge (A2121)
  - Based upon response to M2420 Code 1, 2, or 3 response

- Response of 1, 4, or Unknown will require skip to A2123, Provision of Current Reconciled Medication list to patient at Discharge
  - CMS recommends that reconciled medication list that is provided to the patient, family, or caregiver use consumer-friendly terminology and plain language to ensure that the information provided to patients and caregivers is clear and understandable
  - Data gathered only when no skilled Medicare agency following after DC
- Response of 2 will require skip to A2121, Provision of Current Reconciled Medication list to Subsequent Provider at Discharge
  - CMS recommends the transfer of a current reconciled medication list at the time of discharge or transfer to improve care coordination, quality of care to help subsequent providers reconcile medications and may mitigate adverse outcomes related to medications.

74

74

A2120 and A2121: Provision of Current Reconciled Medication List to Subsequent Provider at Transfer and Discharge

A2120. Provision of Current Reconciled Medication List to Subsequent Provider at Transfer At the time of transfer to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?	
Enter Code ☐	*0.* **No – Current reconciled medication list not provided to the subsequent provider** ➔ *Skip to J1800, Any Falls Since SOC/ROC* 1. **Yes – Current reconciled medication list provided to the subsequent provider** ➔ Continue to A2122, Route of Current Reconciled Medication List Transmission to Subsequent Provider 2. **NA** – The agency was not made aware of this transfer timely ➔ *Skip to J1800, Any Falls Since SOC/ROC*

A2121. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge At the time of discharge to another provider, did your agency provide the patient's current reconciled medication list to the subsequent provider?	
Enter Code ☐	*0.* **No – Current reconciled medication list not provided to the subsequent provider** ➔ *Skip to B1300, Health Literacy* 1. **Yes – Current reconciled medication list provided to the subsequent provider** ➔ Continue to A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider

- The guidance for items A2120 and A2121 is the same, except that one item is used for home health transfers and the other one for discharges.
- DEFINITION OF "PROVIDING A CURRENT RECONCILED MEDICATION LIST": Same at transfer and discharge. This can be accomplished by any means, including active means (e.g., by mail, electronically, or verbally) and more passive means (e.g., a common electronic health record (EHR), giving providers access to a portal).

75

75

A2120 and A2121: Provision of Current Reconciled Medication List to Subsequent Provider at Transfer and Discharge

- A2120
  - only completed at TRN
  - Response 0 only answered if the agency did NOT provide current med list to the subsequent provider
  - Provision of list should be as close to the date of transfer as possible
  - Subsequent provider is the provider identified as provider facility to which patient was transferred
  - Assign response NA if agency was not made aware of the transfer timely and was, therefore, unable to provide the patient's current reconciled medication list
- A2121
  - completed at DC if RFA 9, Discharge from agency AND
    - M2420, Discharge disposition = response 2 (patient remained in community with formal assistive services) or 3 (patient transferred to non-institutional hospice)
  - Subsequent providers only include skilled Medicare home health agency or home hospice provider (non-inpatient)

76

76

A2120 and A2121: Provision of Current Reconciled Medication List to Subsequent Provider at Transfer and Discharge

- **DEFINITION- Current Reconciled Medication list -**This refers to a list of the patient's current medications at the time of discharge that was reconciled by the agency prior to the patient's discharge.
- Agency should be guided by current standards of care and any applicable regulations and guidelines (e.g., Conditions of Participation) in determining what information should be included in a current reconciled medication list.
- An example of items that could be on a reconciled medication list can be but are not limited to a list of the current prescribed and over-the-counter medications, nutritional supplements, vitamins, and/or homeopathic and herbal products administered by any route at the time of discharge or transfer.

77

77

A2120 and A2121: Provision of Current Reconciled Medication List to Subsequent Provider at Transfer and Discharge

SCENARIO EXAMPLE 1- The patient is being transferred from home health to an acute care hospital in the same healthcare system which uses the same electronic health record (EHR), also sometimes referred to as an electronic medical record (EMR) (see definition of EHR/EMR in Appendix A). The patient's current reconciled medication list at the time of transfer from the agency is accessible to the subsequent acute care hospital staff admitting them and this is how the medication list is shared.

A2120- Code 1- Yes

Access to the same electronic medical record system is one acceptable way to transfer the reconciled medication list. This is considered a passive means of providing the reconciled medication list for sending and receiving the list since the provider can access the same EMR.

78

78

A2120 and A2121: Provision of Current Reconciled Medication List to Subsequent Provider at Transfer and Discharge

SCENARIO EXAMPLE 2- A patient is seen monthly by the home agency for B12 injections due to pernicious anemia. During the monthly visit, the patient informs the RN that the patient was hospitalized last week for 3 days due to COVID 19 infection and provides the hospital discharge paperwork.

A2120- Code NA- the agency was not made aware of this transfer timely

When a home health agency is not made aware of a transfer to an inpatient setting timely, they are unable to provide the current reconciled medication list to the subsequent provider timely

79

79

A2123: Provision of Current Reconciled Medication List to Patient at Discharge

A2123. Provision of Current Reconciled Medication List to Patient at Discharge At the time of discharge, did your agency provide the patient's current reconciled medication list to the patient, family and/or caregiver?	
Enter Code ☐	0. **No– Current reconciled medication list not provided to the patient, family, and/or caregiver** ➔ *Skip to B1300, Health Literacy* 1. **Yes – Current reconciled medication list provided to the patient, family, and/or caregiver** ➔ Continue to A2124, Route of Current Reconciled Medication List Transmission to Patient.

- The item, collected at the time of discharge, can improve care coordination, quality of care, aids in medication reconciliation, and may mitigate adverse outcomes related to medications.
- Provided list should use easy to read and plain language to ensure that the information provided to patients and caregivers is clear and understandable
- A2123 is only answered when M0100 = 9, Discharge from agency AND
  - M2420 = 1, 4, or Unknown
- Medication list should be provided as close to the time of actual discharge as possible
- The recipient of the current reconciled medication list can be the patient and/or a family member and/or other caregiver in order to code 1, Yes, a current reconciled medication list was transferred. It is not necessary to provide the current reconciled medication list to all of these recipients in order to code 1, Yes.

80

80

A2120 and A2121: Provision of Current Reconciled Medication List to Subsequent Provider at Transfer and Discharge

SCENARIO EXAMPLE 1- A patient is discharged from the agency but the assessing clinician at discharge confirms that the patient is taking no medications. The clinician reviews this and communicates with the patient and caregivers that there are no medications present and assures that the patient has, in writing, the information on his pharmacy, including phone number and address, should he need to pick up any over the counter or other prescribed medication.

- **A2123 Code response 1- Yes, Medication list provided**
  - If the information regarding no active medication was not communicated to the patient, family and/or caregiver, code 0, No would be answered

Information confirming that the patient is not taking any medications at discharge is provided to the patient, family, and/or caregiver and meets the item intent of providing the patient's current reconciled medication list to patient, family, and/or caregiver.

81

81

A2122 and A2124: Route of Current Reconciled Medication List Transmission to Subsequent Provider and Patient

A2122. Route of Current Reconciled Medication List Transmission to Subsequent Provider
Indicate the route(s) of transmission of the current reconciled medication list to the subsequent provider.

Route of Transmission	↓ Check all that apply ↓
A. **Electronic Health Record**	☐
B. **Health Information Exchange**	☐
C. **Verbal** (e.g., in-person, telephone, video conferencing)	☐
D. **Paper-based** (e.g., fax, copies, printouts)	☐
E. **Other Methods** (e.g., texting, email, CDs)	☐

After completing A2122, Skip to B1300, Health Literacy at Discharge

A2124. Route of Current Reconciled Medication List Transmission to Patient
Indicate the route(s) of transmission of the current reconciled medication list to the patient, family, and/or caregiver.

Route of Transmission	↓ Check all that apply ↓
A. **Electronic Health Record**	☐
B. **Health Information Exchange**	☐
C. **Verbal** (e.g., in-person, telephone, video conferencing)	☐
D. **Paper-based** (e.g., fax, copies, printouts)	☐
E. **Other Methods** (e.g., texting, email, CDs)	☐

82

82

A2122 and A2124: Route of Current Reconciled Medication List Transmission to Subsequent Provider and Patient

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- The guidance for items A2122 and A2124 is the same, except that one item is used for the subsequent provider at transfer/discharge and the other one at discharge for the patient, family, and/or caregiver.
- Item assists in collection of data regarding how medication list data is transmitted at transfer/discharge
- **MULTIPLE RESPONSES ALLOWED FOR THIS ITEM**

- A2122/A2124A, Electronic Health Record Includes
  - Physician/Provider access to medical record system or receiving and discharging provider share same EMR access
  - Patient/caregiver EMR access (provider - patient portal)
  - Signature confirmations not required for the purpose of this item
  - "Passive" route of transmission

83

83

A2122 and A2124: Route of Current Reconciled Medication List Transmission to Subsequent Provider and Patient

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- A2122/A2124B, Health Information Exchange
  - IF agency is a participant in HIE this is an allowed method of providing medication list to providers/patients/family/caregivers
- Code A2122C/A2124C, Verbal
  - Medication list information was verbally communicated (e.g., in-person, telephone, video conferencing) to the subsequent provider, patient, family, and/or caregiver.
- Code A2122D/A2124D, Paper-Based
  - Medication list was transmitted to the subsequent provider, patient, family, and/or caregiver using a paper-based method such as a printout, **fax or efax.**
- Code A2122E/A2124E, Other Methods
  - Medication list was transmitted to the subsequent provider, patient, family, and/or caregiver using another method, not listed above (e.g., texting, email, CDs).

84

84

A2122 and A2124: Route of Current Reconciled Medication List Transmission to Subsequent Provider and Patient

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SCENARIO EXAMPLE 1- A patient receives a paper copy of their medication list, receives education about their medications by the home health nurse at discharge, and is notified that the home health patient portal is another means that the patient can obtain their discharge medication list.

- **DC A2124 Code responses Electronic Health Record (A), Verbal (C), and Paper-based (D)**

  Multiple responses are allowed. The copy of the medication list is paper-based (D). The information about the patient's medication list was also communicated verbally by the nurse at the time of discharge (C). The patient portal uses the agency's EHR to provide access to the medication list (A). **It is not necessary to confirm that the patient is a registered user of and accessed the patient portal in order to code EHR (A) as a route**

85

85

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B0200 Hearing

B0200. Hearing	
Enter Code ☐	**Ability to hear** (with hearing aid or hearing appliances if normally used) 0. **Adequate** – no difficulty in normal conversation, social interaction, listening to TV 1. **Minimal difficulty** – difficulty in some environments (e.g., when person speaks softly, or setting is noisy) 2. **Moderate difficulty** – speaker has to increase volume and speak distinctly 3. **Highly impaired** – absence of useful hearing

- Identifies hearing including WITH assistive hearing device if the patient usually wears a device for hearing
- Assists to identify gaps in communication related to hearing that could be mistaken for confusion or cognitive issues
- Assistive hearing devices are not limited to hearing aids and may include microphone, headphones, amplifiers or other devices meant to assist in hearing function. If patient NORMALLY USES, then assess with the device
- Assessment can include observation of patient's hearing during verbal interaction, review of the clinical record, consultation with the patient, family, and other caregivers
- Alternative assessment methods should be used for patients who are cognitively impaired or unable to respond. For example: Do they respond (e.g., turn their head) when a noise is made at a normal level? Does the patient seem to respond only to specific noise in a quiet environment? Assess whether the patient responds only to loud noise or do they not respond at all.

86

86

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B0200 Hearing

SCENARIO EXAMPLE 1- When asked about whether they can hear normal conversation without difficulty, patient responds, “When I’m at home, I usually keep the TV on a low volume and hear it just fine. When I have visitors, I can hear people from across the room.” Patient is able to hear and respond to clinician during visit without asking for any repetition and responds without hesitation.

- **B0200 – Code 0 – Adequate**
  - Patient is observed to have normal hearing and can clearly hear normal conversational speech with no difficulty

87

87

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B0200 Hearing

SCENARIO EXAMPLE 2- During the ROC, the patient reports, “I have trouble following normal conversations, especially when a lot of different people are talking at the same time. I can usually make out what someone is saying if they talk a little louder and make sure they speak clearly and I can see their face when they are talking to me.” The clinician notices that the patient is able to hear and respond to all verbal interaction during the assessment with no problem, but once her daughter arrives and begins speaking in the same room, the patient frequently mis-hears specific words or has to ask for repetition.

- **B0200 – Code 2- Moderate difficulty**
  - Patient has difficulty hearing people in conversation, but comprehension is improved when the speaker makes adjustments like speaking at high volume, speaking clearly, and sitting close by so that the speaker’s face is visible

88

88

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B1000 Vision

B1000. Vision	
Enter Code ☐	**Ability to see in adequate light** (with glasses or other visual appliances) 0. **Adequate** – sees fine detail, such as regular print in newspapers/books 1. **Impaired** – sees large print, but not regular print in newspapers/books 2. **Moderately impaired** – limited vision; not able to see newspaper headlines but can identify objects 3. **Highly impaired** – object identification in question, but eyes appear to follow objects 4. **Severely impaired** – no vision or sees only light, colors or shapes; eyes do not appear to follow objects

- Identifies the patient's ability to see objects nearby in their environment, in adequate light, and with glasses or other visual appliances.
- Adequate lighting should be used for assessment- lighting that is sufficient for a person with normal vision to see fine detail
- When the patient is unable to read out loud (e.g., due to aphasia, illiteracy), test this by another means such as, but not limited to:
  - Substituting numbers or pictures for words that are displayed in the appropriate print size (regular size print in a book or newspaper)
- For patients who have never learned to read/are unable to read in English, ask the patient to read numbers, dates, or identify pictures/name items in pictures. Display information in two sizes in case patient cannot view small sizes.
- If the patient is unable to communicate or follow your directions for testing vision, observe the patient's eye movements to see if their eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether or not the patient has any visual ability. For patients who appear to do this, code 3, highly impaired.

89

89

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B1000 Vision

SCENARIO EXAMPLE 1- During a SOC assessment, the patient is asked to read newspaper print with her glasses on and appears to have difficulty. After a moment, the patient states that she generally only reads the headlines and actually usually pulls the news up on her phone and has an app that reads it to her because she cannot read the smaller print, only large print. The clinician notices that all the notes left around her home by her caregiver are also in large 2 inch bold print as well. The patient is able to read these notes with no problem with her glasses on.

- **B1000 – Code 1- Impaired**
  - The patient is unable to read regular sized newsprint but is able to read large print without problem with her glasses on

90

90

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B1300 Health Literacy

B1300. Health Literacy *(From Creative Commons ©)* How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	
Enter Code ☐	0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Patient declines to respond 8. Patient unable to respond

- Patient self report health literacy. Response may not be based on any source other than patient response to questioning related to health literacy.
- Patient should be asked, "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"
- Health Literacy Definition: degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions
- Poor health literacy interferes with provider – patient communication, health related decision making
- Can affect ability of patient to understand and follow treatment plans, including medication management.

91

91

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B1300 Health Literacy

SCENARIO EXAMPLE 1- During SOC visit, a patient's daughter reports that she only occasionally needs help to read directions for her medications and will call her sometimes to come over and help with this or to read some other forms that the physician has provided. However, when the patient is asked, How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?, she states that she ALWAYS has the pharmacist read the pamphlet to her before she leaves the pharmacy for all of her medications and while this is sometimes time consuming, she is afraid of missing something that could be dangerous and will often call back and have some sections repeated. She also has her doctor's office read all directions that they give to her on medications, new diagnoses and other information when she has an appointment and if they call her regarding lab results she has them explain all of this information to her even if it is normal because she is afraid she will forget and sometimes doesn't understand "all that confusing writing." Her daughter says she was not aware that her mother did this.

B1300 – Code 4 - Always

- While the patient is literate and has no vision issues, she self-reports that she is overwhelmed by written health information and always needs help with reading this information. While her daughter reports not thinking the patient needed this assist, the item requires a response based on patient self-report alone.

92

92

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SECTION C: Cognitive Patterns

93

93

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BIMS (Brief Interview for Mental Status)

- Evaluates repetition, recall with and without prompting, and the critical skill of telling time.
- Not intended to indicate presence of dementia but may indicate cognitive difficulties warranting need for follow up

- **BIMS C0200 – C0400 (Summary score C0500)**
  - Word repetition
  - Temporal (Time) Orientation
  - Recall (based on earlier word repetition
  - Score total 00-15

94

94

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BIMS (Brief Interview for Mental Status)

- BIMS is not appropriate for patients who are rarely or never understood, are non-verbal, or for whom an interpreter is needed and is not available
- If an interpreter is needed and not currently available, consider completing within the 5-day window and M0090 date should reflect the completion date.
- Ok to perform if the individual is at least SOMETIMES understood verbally or in writing and/or if requires interpreter and one is available.
- Conduct in private setting if available
- Hearing impaired individuals should use any adapted equipment usually needed
- Individuals should be addressed face to face directly and spoken to clearly and directly
- Nonsensical responses should be coded as Zero/None (incomprehensible, incoherent, unrelated, non related). Refusal to answer is coded to zero.

95

95

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C0100 Should Brief Interview for Mental Status be Conducted?

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? Attempt to conduct interview with all patients.	
Enter Code ☐	0. **No** (patient is rarely/never understood) → *Skip to C1310, Signs and Symptoms of Delirium (from CAM ©)* 1. **Yes** → Continue to C0200, Repetition of Three Words

- A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.
  - Without an attempted structured cognitive interview, a patient might be mislabeled based on their appearance or assumed diagnosis.
  - Structured interviews will efficiently provide insight into the patient's current condition that will enhance good care
- Determine if patient is rarely/never understood verbally, in writing, or using other methods. IF RARELY/NEVER UNDERSTOOD, respond 0 and Skip C0200-C0500
- DASH is a valid response but should rarely be used. This response indicates no information, and the BIMS should be attempted with ALL patients unless it is determined that the patient is rarely/never understood

96

96

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BIMS (Brief Interview for Mental Status)

C0200. Repetition of Three Words	
Enter Code ☐	Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed****. Now tell me the three words."* **Number of words repeated after first attempt** 0. None 1. One 2. Two 3. Three After the patient's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

97

97

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BIMS (Brief Interview for Mental Status)

C0300. Temporal Orientation (Orientation to year, month, and day)	
Enter Code ☐	Ask patient: *"Please tell me what year it is right now."* A. **Able to report correct year** 0. **Missed by > 5 years** or no answer 1. **Missed by 2-5 years** 2. **Missed by 1 year** 3. **Correct**
Enter Code ☐	Ask patient: *"What month are we in right now?"* B. **Able to report correct month** 0. **Missed by > 1 month** or no answer 1. **Missed by 6 days to 1 month** 2. **Accurate within 5 days**
Enter Code ☐	Ask patient: *"What day of the week is today?"* C. **Able to report correct day of the week** 0. **Incorrect** or no answer 1. **Correct**

98

98

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BIMS (Brief Interview for Mental Status)

C0400. Recall	
Enter Code ☐	Ask patient: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. A. **Able to recall "sock"** 0. **No** – could not recall 1. **Yes, after cueing** ("something to wear") 2. **Yes, no cue required**
Enter Code ☐	B. **Able to recall "blue"** 0. **No** – could not recall 1. **Yes, after cueing** ("a color") 2. **Yes, no cue required**
Enter Code ☐	C. **Able to recall "bed"** 0. **No** – could not recall 1. **Yes, after cueing** ("a piece of furniture") 2. **Yes, no cue required**

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BIMS (Brief Interview for Mental Status)

C0500. BIMS Summary Score	
Enter Score ☐☐	**Add scores** for questions C0200-C0400 and fill in total score (00-15) **Enter 99 if the patient was unable to complete the interview**

- 99 is appropriate if the patient was able to begin the BIMS, but may have provided a nonsensical answer or refused to respond to an item.
- 99 should be assigned if the patient was appropriate for BIMS, but refused to participate OR 4 or more items were coded 0 due to refusal to answer or nonsensical response

SCORE INDICATIONS:

13-15: Cognitively intact

08-12: moderately impaired

00-07: severe impairment

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Conducting the BIMS other than verbally

- CMS allows for use of written cue cards when conducting the BIMS
  - ***This can assist with completion of the BIMS for patients who require additional cuing or are verbally or hearing impaired***

- Quarterly Q&A October 2022
  - Question: I know we can administer the BIMS either verbally or in writing and there are specific directions around this. When administering the BIMS in writing can we present the cue card questions *via laptop rather than an actual paper form for those patients who are hearing impaired etc., or does it need to be given in paper or card format?*
  - Answer: The agency may develop their own process for how to administer the BIMS in writing. Whatever processes used must follow the exact language as that in the item set.

101

101

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Scoring BIMS

C0200. Repetition of Three Words	
Enter Code 	Ask patient: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed****. Now tell me the three words."* **Number of words repeated after first attempt** 0. **None** 1. **One** 2. **Two** 3. **Three** After the patient's first attempt, repeat the words using cues *("sock, something to wear; blue, a color; bed, a piece of furniture")*. You may repeat the words up to two more times.

C0300. Temporal Orientation (Orientation to year, month, and day)	
Enter Code 	Ask patient: *"Please tell me what year it is right now."* A. **Able to report correct year** 0. **Missed by > 5 years** or no answer 1. **Missed by 2-5 years** 2. **Missed by 1 year** 3. **Correct**
Enter Code 	Ask patient: *"What month are we in right now?"* B. **Able to report correct month** 0. **Missed by > 1 month** or no answer 1. **Missed by 6 days to 1 month** 2. **Accurate within 5 days**
Enter Code 	Ask patient: *"What day of the week is today?"* C. **Able to report correct day of the week** 0. **Incorrect** or no answer 1. **Correct**

102

102

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Scoring BIMS

C0400. Recall	
Enter Code [1]	Ask patient: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"* If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. A. **Able to recall "sock"** 0. **No** – could not recall 1. **Yes, after cueing** ("something to wear") 2. **Yes, no cue required**
Enter Code [1]	B. **Able to recall "blue"** 0. **No** – could not recall 1. **Yes, after cueing** ("a color") 2. **Yes, no cue required**
Enter Code [1]	C. **Able to recall "bed"** 0. **No** – could not recall 1. **Yes, after cueing** ("a piece of furniture") 2. **Yes, no cue required**

C0500. BIMS Summary Score	
Enter Score [11]	**Add scores** for questions C0200-C0400 and fill in total score (00-15) **Enter 99 if the patient was unable to complete the interview**

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CAM (Confusion Assessment Method)

- Standardized evidence-based tool that enables non-psychiatrically trained clinicians to identify and recognize delirium quickly and accurately in both clinical and research settings.
- Four features found to have the greatest ability to distinguish delirium from other types of cognitive impairment.
- Assists to alert clinician to potential delirium in older adults
- Within OASIS E must be completed AFTER completion of BIMS
- ***OASIS E C1310 A-D***

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CAM (Confusion Assessment Method)

C1310. Signs and Symptoms of Delirium (from CAM©)		
Code **after completing** Brief Interview for Mental Status and reviewing medical record.		
A. **Acute Onset of Mental Status Change**		
Enter Code ☐	**Is there evidence of an acute change in mental status** from the patient's baseline? 0. **No** 1. **Yes**	
Coding: 0. **Behavior not present** 1. **Behavior continuously present, does not fluctuate** 2. **Behavior present, fluctuates** (comes and goes, changes in severity)	↓ **Enter Codes in Boxes**	
	☐	B. **Inattention** – Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	☐	C. **Disorganized thinking** – Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	☐	D. **Altered level of consciousness** – Did the patient have altered level of consciousness, as indicated by any of the following criteria? ▪ **vigilant** – startled easily to any sound or touch ▪ **lethargic** – repeatedly dozed off when being asked questions, but responded to voice or touch ▪ **stuporous** – very difficult to arouse and keep aroused for the interview ▪ **comatose** – could not be aroused

Adapted from: Inouye SK, et al. Ann Intern Med. 1990; 113: 941-948. Confusion Assessment Method. Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

105

105

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CAM (Confusion Assessment Method)

- Identification of delirium is crucial due to association with mortality, functional decline, incontinence issues, behavior problems, activity withdrawal, rehospitalizations/length of stay
- **DELIRIUM:** mental disturbance characterized by new or acutely worsening condition, disordered expression of thoughts, change in level of consciousness or hallucinations.
  - ***Delirium may be often misdiagnosed as dementia***
- Deterioration in cognitive function may indicate delirium, which may be reversible if detected early on
- INATTENTION: Reduced ability to maintain attention to external stimuli and appropriately shift attention to new external stimuli. Pt seems unaware or out of touch with environment
- FLUCTUATION: The behavior tends to come and go and/or increase or decrease in severity. Behavior may fluctuate over the course of the interview or during the assessment period. Fluctuating behavior may be noted by the assessing clinician, reported by staff or family or documented in the medical record.

106

106

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CAM (Confusion Assessment Method)

- **DISORGANIZED THINKING:** Evidenced by rambling, irrelevant or incoherent speech

- **ALTERED LEVEL OF CONSCIOUSNESS:**
  - VIGILANT- startles easily to sound or touch
  - LETHARGIC- repeated dozes off when you are asking question but responds to voice or touch
  - STUPOR – very difficult to arouse and keep aroused for the interview
  - COMATOSE - cannot be aroused despite shaking and shouting

107

107

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CAM (Confusion Assessment Method)

- Responses/scoring may be based on observation of patient, review of medical record and consult with other staff, family, caregivers – determine baseline vs. current condition
- Consider all relevant information and use clinical judgment to determine if an acute change in mental status has occurred.
- Indication of delirium by the CAM requires presence of
  - Item A = 1 OR Item B, C, or D =2
    - AND Item B = 1 or 2
      - AND EITHER Item C = 1 or 2 OR ITEM D = 1 or 2

108

108

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CAM (Confusion Assessment Method)

C1310. Signs and Symptoms of Delirium (from CAM©)		
Code **after completing** Brief Interview for Mental Status and reviewing medical record.		
A. **Acute Onset of Mental Status Change**		
Enter Code [1]	**Is there evidence of an acute change in mental status** from the patient's baseline? 0. **No** 1. **Yes**	
Coding: 0. **Behavior not present** 1. **Behavior continuously present, does not fluctuate** 2. **Behavior present, fluctuates** (comes and goes, changes in severity)	**↓ Enter Codes in Boxes**	
	[1]	B. **Inattention –** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	[1]	C. **Disorganized thinking –** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	[0]	D. **Altered level of consciousness** – Did the patient have altered level of consciousness, as indicated by any of the following criteria? ▪ **vigilant** – startled easily to any sound or touch ▪ **lethargic** – repeatedly dozed off when being asked questions, but responded to voice or touch ▪ **stuporous** – very difficult to arouse and keep aroused for the interview ▪ **comatose** – could not be aroused

SCORE INDICATES DELIRIUM = A=1 AND B =1 AND C=1

109

109

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CAM (Confusion Assessment Method)

C1310. Signs and Symptoms of Delirium (from CAM©)		
Code **after completing** Brief Interview for Mental Status and reviewing medical record.		
A. **Acute Onset of Mental Status Change**		
Enter Code [0]	**Is there evidence of an acute change in mental status** from the patient's baseline? 0. **No** 1. **Yes**	
Coding: 0. **Behavior not present** 1. **Behavior continuously present, does not fluctuate** 2. **Behavior present, fluctuates** (comes and goes, changes in severity)	**↓ Enter Codes in Boxes**	
	[1]	B. **Inattention –** Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	[2]	C. **Disorganized thinking –** Was the patient's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
	[2]	D. **Altered level of consciousness** – Did the patient have altered level of consciousness, as indicated by any of the following criteria? ▪ **vigilant** – startled easily to any sound or touch ▪ **lethargic** – repeatedly dozed off when being asked questions, but responded to voice or touch ▪ **stuporous** – very difficult to arouse and keep aroused for the interview ▪ **comatose** – could not be aroused

SCORE INDICATES DELIRIUM A= 0, BUT C & D = 2 (either/or B,C,D must be 2 if A = 0), AND B=1

110

110

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CAM SCORING EXAMPLE 1

Patient was admitted to home health. The family reports that the patient was alert and oriented prior to the day of assessment. During the BIMS interview and assessment, the patient is lethargic and incoherent.

C1310A would be coded 1, yes.

This patient has had a clear shift in mental status from baseline

During the BIMS interview, the patient was not able to focus on the questions asked and their gaze wandered. However, the family confirmed that the patient was attentive 2 days prior to the nurse arriving for the home health visit. The patient was diagnosed with as UTI and COVID 2 days ago and has not been sleeping due to a cough and frequent urination. The inability to focus was consistent throughout the past day.

C1310B would be coded 1, behavior continuously present, does not fluctuate.

The patient was consistently inattentive throughout the assessment. The time frame for C1310 is day of assessment.

111

111

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CAM SCORING EXAMPLE 1

During the initial assessment for the same patient, any conversation with was mostly not relevant to the questions asked by the assessing clinician due to the patient's level of lethargy and fatigue. When asked questions, she mumbled mostly incoherent answers. The patient's family reported this was consistent in the previous 24 hours.

C1310C would be coded 1, behavior continuously present, does not fluctuate

All sources agree that the disorganized thinking is constant.

During the assessment, the patient is awake, but lethargic, she does fall asleep a few times and states "I'm just tired the past day or so", but arouses when spoken to.

C1310D would be coded 1, behavior continuously present, does not fluctuate.

The patient's lethargy was consistent throughout the assessment, and there is consistent validation from the caregivers.

THIS PATIENT'S CAM SCORING INDICATES DELIRIUM

112

112

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M1700 Cognitive Functioning

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

- Identifies day of assessment level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
- Consider patient interview and caregiver reported info, consider the signs/symptoms of cognitive dysfunction that have occurred over the past 24 hours, consider the amount of supervision and care required ***due to cognitive deficits.***
- Diagnoses such as dementia, delirium, developmental delay disorders, mental retardation, etc., will have various degrees of cognitive dysfunction.
- Patients with neurological deficits related to stroke, mood/anxiety disorders, or who receive opioid therapy may have cognitive deficits.

113

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M1710 When Confused (Reported or Observed in last 14 days)

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

- Identifies when (time of day or situation) that patient experiences confusion, if at all
- Interview patient, caregiver. Review referral info
- Assess specific to only last 14 days (SOC day = day 0)
- Codes 2, 3, and 4 differ from each other based on the time when the confusion occurred and the length of time the confusion persists.
- **Nonresponsive** = patient responds in a way that cannot make a clinical judgement about level of orientation or is unable to respond at all

114

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M1700 vs. M1710

Per Category 4 OASIS Q&A:

M1700 & M1710. What is the difference in what is measured in M1700 – Cognitive Functioning and M1710- When Confused?

M1700, Cognitive Functioning, is intended to report the patient's cognitive functioning, as evidenced by their level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands on the day of assessment (at the time of the assessment and in the preceding 24 hours). M1710, When Confused, is intended to identify the time of day or situations when the patient experienced confusion, if at all, during the past 14 days (Day of assessment and prior 14 days). M1710, Confusion, may not directly relate to M1700, Cognitive Functioning. Confusion is defined in Mosby's Medical Dictionary as "a mental state characterized by disorientation regarding time, place, person, or situation. It causes bewilderment, perplexity, lack of orderly thought, and inability to choose or act decisively and perform the activities of daily living. It is usually symptomatic of an organic mental disorder, but it may accompany severe emotional stress and various psychological disorders."

If a patient is demonstrating confusion on the day of the assessment, it would be reported both in M1700 and M1710. If a patient was ***NOT confused on the day of assessment, but had experienced confusion during the prior 14 days, it would only be reported in M1710****. If a patient has a cognitive impairment on the day of the assessment, that does NOT result in confusion, e.g., forgetfulness, learning disabilities, concentration difficulties, decreased intelligence, it would only be reported in M1700.*

115

115

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

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

- Identifies anxiety that occurred specific to only last 14 days (SOC day = day 0)
- Anxiety includes worry that interferes with learning and normal activities, feelings of being overwhelmed and having difficulty coping, or symptoms of anxiety disorders.
- **Nonresponsive** = patient responds in a way that cannot make a clinical judgement about level of orientation or is unable to respond at all
- If the patient is nonresponsive at the time of assessment, may obtain information from caregiver or other sources regarding if patient experienced any anxiety during the past 14 days.

116

116

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SECTION D: MOOD

This section contains items that address mood distress. The presence of indicators does not automatically mean that the patient has a diagnosis of depression or other mood disorder.

117

117

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D0150 Patient Mood Interview (PHQ 2 – 9)

- The PHQ-9 is a standardized tool that can function as a screening tool, an aid in diagnosis, and as a symptom tracking tool that can help track a patient's overall depression severity as well as track the improvement of specific symptoms with treatment.
- Identifies the presence of signs and symptoms of mood distress, a serious condition that is underdiagnosed and undertreated in home health and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among home health patients because these signs and symptoms can be treatable.
- Depression can be associated with: psychological and physical distress, decreased participation in therapy and activities, decreased functional status, and poorer outcomes

118

118

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D0150 Patient Mood Interview (PHQ 2 – 9)

- ROC, SOC, DC

- Guidelines for performing PHQ 2-9
  - Conduct in a private setting if possible
  - Conduct in the patient's preferred language
  - Questions should be asked in exact verbiage
  - Questions should be asked in exact sequence

- Should be **attempted** with ALL patients

119

119

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D0150 Patient Mood Interview (PHQ 2 – 9)

D0150. Patient Mood Interview (PHQ-2 to 9)			
Say to patient: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"			
If symptom is present, enter 1 (yes) in column 1, Symptom Presence. If yes in column 1, then ask the patient: "About how often have you been bothered by this?" Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.			
1. Symptom Presence 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank).	**2. Symptom Frequency** 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	**1. Symptom Presence**	**2. Symptom Frequency**
		↓ Enter Scores in ↓ Boxes	
A. ***Little interest or pleasure in doing things***		☐	☐
B. ***Feeling down, depressed, or hopeless***		☐	☐
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.			
C. ***Trouble falling or staying asleep, or sleeping too much***		☐	☐
D. ***Feeling tired or having little energy***		☐	☐
E. ***Poor appetite or overeating***		☐	☐
F. ***Feeling bad about yourself – or that you are a failure or have let yourself or your family down***		☐	☐
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***		☐	☐
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual***		☐	☐
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***		☐	☐

120

120

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D0150 Patient Mood Interview (PHQ 2 – 9)

- Enter code **9** if the patient was unable or chose not to complete the interview or responded nonsensically and/or the agency was unable to complete the assessment.
  - A nonsensical response is one that is unrelated, incomprehensible, or incoherent or not informative
- Yes response – follow by determining frequency - Start by asking the patient the number of days that they were bothered by the symptom
  - 0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day

121

121

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D0150 Patient Mood Interview (PHQ 2 – 9)

- Determine if the patient is rarely/never understood verbally, in writing, or using another method. If rarely/never understood: Code D0150A1 and D0150B1 as 9 (No response) and leave D0150A2 and D0150B2 blank, end the PHQ-2 interview and skip D0160.
- Determine whether to complete the PHQ-9 (i.e., ask the remaining seven questions: D0150C to D0150I. Whether or not further evaluation of a patient's mood is needed depends on the patient's responses to the PHQ-2 (D0150A and D0150B).
  - If both D0150A2 and D0150B2 are less than 2 there is no need to continue to the PHQ-9. **END** the PHQ-2 and enter the total score from D0150A2 and D0150B2 in D0160 – Total Severity Score.
  - If both D0150A2 and D0150B2 are blank, *then end the PHQ-2 and skip D0160.*
  - If either D0150A2 or D0150B2 are 2 or 3, then you must complete the PHQ-9. Proceed to ask the remaining seven questions (D0150C to D0150I) of the PHQ-9 and complete D0160 – Total Severity Score.

122

122

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D0160 Total Severity Score

- This item identifies the severity **score calculated from responses to the PHQ-2 to 9**, item D0150.
- Do not add up the score while conducting the PHQ 2 – 9
- If only the PHQ-2 is completed because D0150A2 and D0150B2 are less than 2 (but not blank) add the numeric scores from these two frequency items and enter the value in D0160
- If the PHQ-9 was completed (D0150C-I were not skipped due to the responses in D0150A and B), and if the patient answered the frequency responses of at least 7 of the 9 items on the PHQ- 9; add the numeric scores from D0150A2-D0150I2 and enter in D0160 Total Severity Score.

123

123

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D0160 Total Severity Score

- If symptom frequency is blank for 3 or more items, the interview is deemed NOT complete. Total Severity Score should be coded as "99"
- The Total Severity Score will be between 00 and 27 (or "99" if symptom frequency is blank for 3 or more items).
- ***DASH is valid but should be infrequent!***
- **COMPUTING SEVERITY SCORE:**
  - Sum of values from nine D0150 items
  - If any of the items in Column 2 are skipped or equal to dash, then omit their values when computing the sum.
  - If the number of missing items in Column 2 is equal to one, then compute the simple sum of the eight items in Column 2 that have non-missing values, *multiply the sum by 9/8 (1.125), and place the result rounded to the nearest integer in item D0160*
  - If the number of missing items in Column 2 is equal to two, then compute the simple sum of the seven items in Column 2 that have non-missing values, *multiply the sum by 9/7 (1.286), and place the result rounded to the nearest integer in item D0160.*
  - **If the number of missing items in Column 2 is equal to three or more, then item D0160 must equal [99].**

124

124

Scoring the PHQ9

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D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the patient: "About how often have you been bothered by this?"
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence	2. Symptom Frequency	1. Symptom Presence	2. Symptom Frequency
0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank).	0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	↓ Enter Scores in ↓ Boxes	
A. ***Little interest or pleasure in doing things***		1	1
B. ***Feeling down, depressed, or hopeless***		0	0
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.			
C. ***Trouble falling or staying asleep, or sleeping too much***			
D. ***Feeling tired or having little energy***			
E. ***Poor appetite or overeating***		SKIP	
F. ***Feeling bad about yourself – or that you are a failure or have let yourself or your family down***			
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***			
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual***			
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***			

D0160. Total Severity Score

Enter Score	
01	**Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

Scoring the PHQ9

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D0150. Patient Mood Interview (PHQ-2 to 9)

Say to patient: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the patient: "About how often have you been bothered by this?"
Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence	2. Symptom Frequency	1. Symptom Presence	2. Symptom Frequency
0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank).	0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	↓ Enter Scores in ↓ Boxes	
A. ***Little interest or pleasure in doing things***		0	0
B. ***Feeling down, depressed, or hopeless***		1	2
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.			
C. ***Trouble falling or staying asleep, or sleeping too much***		1	1
D. ***Feeling tired or having little energy***		0	0
E. ***Poor appetite or overeating***		1	
F. ***Feeling bad about yourself – or that you are a failure or have let yourself or your family down***		0	0
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***		1	2
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual***		0	0
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***		0	0

 5 x 1.125 = 5.625 (Column 2 missing 1 value

D0160. Total Severity Score

Enter Score	
06	**Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

Scoring the PHQ9

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D0150. Patient Mood Interview (PHQ-2 to 9)			
Say to patient: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"			
If symptom is present, enter 1 (yes) in column 1, Symptom Presence. If yes in column 1, then ask the patient: "About how often have you been bothered by this?" Read and show the patient a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.			
1. Symptom Presence 0. **No** (enter 0 in column 2) 1. **Yes** (enter 0-3 in column 2) 9. **No response** (leave column 2 blank).	**2. Symptom Frequency** 0. **Never or 1 day** 1. **2-6 days** (several days) 2. **7-11 days** (half or more of the days) 3. **12-14 days** (nearly every day)	**1. Symptom Presence**	**2. Symptom Frequency**
		↓ Enter Scores in ↓ Boxes	
A. *Little interest or pleasure in doing things*		0	0
B. *Feeling down, depressed, or hopeless*		1	2
If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.			
C. *Trouble falling or staying asleep, or sleeping too much*		1	1
D. *Feeling tired or having little energy*		0	0
E. *Poor appetite or overeating*		0	
F. *Feeling bad about yourself – or that you are a failure or have let yourself or your family down*		0	0
G. *Trouble concentrating on things, such as reading the newspaper or watching television*		1	2
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual*		0	0
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*		0	0

5 x1.125 = 5.625 (Column 2 missing one value)

D0160. Total Severity Score	
Enter Score 06	**Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more required items)

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D0160 Summary Score Examples

Ex : Two Missing Values in D0150

- D0150A2 = 1
- D0150B2 = 2
- D0150C2 =
- D0150D2 = 0
- D0150E2 = 3
- D0150F2 = 0
- D0150G2 =
- D0150H2 = 3
- D0150I2 = 1
- **D0160 = 11**

11 x 1.286= 14.146 (round to 14)

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PHQ 9/D0150 Potential Issues & How to manage

Question: My agency forgot to complete the Patient Mood Interview when completing the patient's Discharge assessment. How should D0150 - Patient Mood Interview (PHQ-2 to 9) and D0160 - Total Severity Score be coded? What if the agency only missed asking 1 of the symptom presence (Column 1 of D0150) questions?

Answer: When the agency misses asking the patient one or more of the symptom presence questions from D0150 - Patient Mood Interview (PHQ-2 to 9) code Column 1: Symptom Presence with a dash (–) and leave Column 2: Symptom Frequency blank. If no assessment is conducted for Symptom Presence, enter a dash (–) in Column 1 and skip Column 2 in each row of D0150A-I, then code 99 for D0160 - Total Severity Score. A dash (–) is a valid response for D0150 Column 1: Symptom Presence. ***A dash (–) is not a valid response for D0150 Column 2: Symptom Frequency or D0160 - Total Severity Score***.

**Note that this guidance supersedes instruction provided in the draft OASIS-E Guidance Manual, posted May 2022. Use this more recent guidance when implementing OASIS-E in January 2023. **

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D0700 Social Isolation

D0700. Social Isolation How often do you feel lonely or isolated from those around you?	
Enter Code ☐	0. Never 1. Rarely 2. Sometimes 3. Often 4. Always 7. Patient declines to respond 8. Patient unable to respond

- Patient self report item. Identifies the patient's actual or perceived lack of contact with other people, such as living alone or residing in a remote area
- Response should be based on patient's stated perception of social isolation, regardless of clinician's perceive support system, number of caregivers, living situation, etc. Use ONLY the patient's stated reported information
  - As the patient, "How often do you feel lonely or isolated from those around you?"
- **Social isolation definition: actual or perceived lack of contact with other people, such as living alone or residing in a remote area**
- Identifies the patient's actual or perceived lack of contact with other people, such as living alone or residing in a remote area

M1740: Cognitive, behavioral, and psychiatric symptoms

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M1740. Cognitive, Behavioral, and Psychiatric Symptoms that are demonstrated at least once a week (Reported or Observed):	
↓ Check all that apply	
☐	1. **Memory deficit:** failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
☐	2. **Impaired decision-making:** failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
☐	3. **Verbal disruption:** yelling, threatening, excessive profanity, sexual references, etc.
☐	4. **Physical aggression:** aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
☐	5. **Disruptive, infantile, or socially inappropriate behavior** (excludes verbal actions)
☐	6. **Delusional, hallucinatory, or paranoid behavior**
☐	7. **None of the above behaviors demonstrated**

- Identifies specific behaviors associated with significant neurological, developmental, behavioral, or psychiatric disorders.
- Behaviors reported could be identified by a formal diagnosis and/or determined by clinical judgment of the assessing clinician.
- Behaviors which are severe enough to make the patient unsafe to self or others, cause considerable stress to the caregivers and/or require supervision or intervention should be included.
- Assessment for this item should include physical assessment, patient obs, clinical record review (H&P/physician documentation)

131

131

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M1740- Including behaviors that result from neurological, cognitive, behavioral, developmental or psychiatric limitations or conditions

Question: M1740. If a patient is alert and oriented, but decides not to use their cane because they think they don't need it (they are unsafe without it) or they decide they aren't going to take their diuretic because they are going to the doctor and don't want to have any accident, would you select Response "2 – Impaired decision-making"?

Answer: The intent of M1740, Cognitive, behavioral, and psychiatric symptoms, is to capture specific behaviors that are a result of significant neurological, cognitive, behavioral, developmental or psychiatric limitations or conditions. It is not the intent of M1740 to report nonadherence or risky choices made by cognitively intact patients who are free of the aforementioned conditions. The assessing clinician will have to determine if the patient has a disorder that is causing her non-adherence or is the patient making a choice not to comply completely with physician's orders, cognizant of the implications of that choice.

132

132

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M1740- Including behaviors that result from neurological, cognitive, behavioral, developmental or psychiatric limitations or conditions

Question: M1740. Would "hoarding" be considered disruptive behavior triggering a "yes" response on M1740 – Cognitive, behavioral, and psychiatric symptoms?

Answer: M1740 identifies specific behaviors associated with significant neurological, developmental, behavioral, or psychiatric disorders that are demonstrated at least once a week. If a patient had a diagnosis, such as hoarding disorder, and the clinician determined the associated behaviors resulted in concern for the patient and/or caregiver's safety or wellbeing, then it would meet the intent of M1740. In such a case, the assessing clinician may determine that the hoarding behaviors meet the intent of Response 2 – Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions and/or Response 5 – Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions).

133

133

M1745: Frequency of Disruptive Behavior Symptoms (Reported or Observed)

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

- Identifies the frequency of any behaviors that are disruptive or dangerous to the patient or the caregivers.
- Consider any and all disruptive/dangerous behaviors to respond to this item, not just the behaviors listed in M1740. Then consider how frequently these behaviors occur.
- Include behaviors considered symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders, identified by diagnosis and/or the assessing clinician's professional judgment.
- Examples of disruptive/dangerous behaviors include but are not limited to sleeplessness, "sun-downing," agitation, wandering, aggression, combativeness, and/or getting lost in familiar places.
- Sources for item may include interview with patient/cg/family, observation/assess, review of clinical record

134

134

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M1745 – Included Behaviors

Question: Are the behaviors to be considered in responding to this item limited to only those listed in M1740?

Answer: No, there are behaviors other than those listed in M1740 that can be indications of alterations in a patient's cognitive or neuro/emotional status resulting in behaviors of concern for the patient's safety or social environment. Other behaviors such as wandering can interfere with the patient's safety, and if so, the frequency of these should be considered in responding to the item.

Include BOTH behaviors from M1740 AND any other behaviors that interfere with patient safety/are potentially injurious to self or others. NOTE: if the behaviors reported are reflective of those in M1740, the response in M1745 should be at least 3, 4 or 5 (at least "several times each month") as a positive response in M1740 indicates the behavior occurs "at least weekly."

135

135

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SECTION F: PREFERENCES FOR CUSTOMARY ROUTINE ACTIVITIES

This section identifies the patient's living situation including types, sources and amounts of assistance needed for routine activities.

136

136

M1100: Patient Living Situation

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M1100. Patient Living Situation Which of the following best describes the patient's residential circumstance and availability of assistance?					
	Availability of Assistance				
Living Arrangement	Around the Clock	Regular Daytime	Regular Nighttime	Occasional/ Short-Term Assistance	No Assistance Available
	↓Check one box only↓				
A. Patient lives alone	☐01	☐02	☐03	☐04	☐05
B. Patient lives with other person(s) in the home	☐06	☐07	☐08	☐09	☐10
C. Patient lives in congregate situation (for example, assisted living, residential care home)	☐11	☐12	☐13	☐14	☐15

- Two step item. Identifies a) whether the patient is living alone or with other(s) and b) the availability of caregiver(s)other than home health agency staff to provide in-person assistance.
- Interview patient and caregiver. For patients in assisted living, may review facility agreements
- FIRST determine if patient lives alone or with others. SECOND determine availability of assistance – how frequently caregiver(s) other than home health staff are in the home and available to provide needed assist.
  - Item documents the time caregiver(s) are in the home and available ***without regard to the amount or types of assistance the patient requires, or whether the caregiver(s) are able to meet all or only some of the patient's needs.***

137

137

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STEP ONE- LIVING ARRANGEMENT

- **Lives Alone**
  - Lives in an independent/non-assisted setting such as home, apartment or room in a boarding house
    - Includes when the only caregivers are paid live-in help (even if 24/7 assist – response 01)
    - If a caregiver is temporarily staying with patient but normally lives elsewhere
    - A life-line or can obtain emergency help by phone but no other people are living with them.
- **Lives with Others**
  - Lives in an independent/non-assisted setting with a spouse, family member or another significant other
    - Person who lives with others and is occasionally alone when caregivers travel, is still considered to be living with others.
- **Congregate Situation**
  - Assistance, supervision and/or oversight are provided as part of the living arrangement, such as an assisted living facility, residential care home or personal care home
    - patient may live alone, or with a spouse or significant other, in an apartment or room in an assisted living facility, for example, and still be considered living in a congregate situation

138

138

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STEP TWO- AVAILABILITY OF ASSISTANCE

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

139

139

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Tips for Responding to M1100

- Availability of assistance refers to the expected availability and willingness of caregiver(s) for this upcoming quality episode.
- If a person is living in the patient's home but is completely unable to or unwilling to provide any assistance to the patient, do not count them as a caregiver.
- If a person is in an assisted living or congregate setting with a call-bell that summons onsite, in-person help, this is considered in-person assistance. If its use is restricted to emergencies only, report the availability as occasional/short-term assistance unless other caregiver's availability meets a higher level
- Assistance refers to any type of in-person assistance provided in the home of the patient, including but not limited to ADLs and IADLs

140

140

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M1100 Examples

Example 1:

Patient lives with their spouse who has significant cognitive and functional impairments, is wheelchair bound, and is unable to provide the patient with any assistance. A member of the church comes by one evening a week and brings groceries.

Code 09, Patient lives with another person in the home, Occasional/short term assistance

EXAMPLE 2:

Patient lives alone in their own apartment. Since the patient's discharge from the hospital, their two daughters alternate staying with them during the day and night so that one of them is always there, except for the times when one goes out to run an errand or pick up a child at day care.

Code 01, Patient lives alone, caregiver available around the clock

Patient still considered to be living alone, since daughters are only staying there temporarily. Daughters are providing round-the-clock care, even if one occasionally needs to be out of the house for brief periods

141

141

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M1100 Family Paid Caregiver

Question: M1100. How do you answer M1100, Patient Living Situation, when the patient lives with their family member and the family member is being paid to care for the patient, either by the patient or by a state funded program?

Answer: When answering M1100, Patient Living Situation, if a patient lives with their family, Row b., Patient lives with other person(s) in the home, would appropriately depict their living arrangement, even if the patient pays their family member to provide care or the family member is being paid through another source, e.g. another family member or state funded program.

142

142

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M2102: Types and Sources of Assistance – SOC/ROC, DC

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

143

143

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M2102: Types and Sources of Assistance – SOC/ROC, DC

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

144

144

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M2102: Types and Sources of Assistance – SOC/ROC, DC

- Identifies ability and willingness of the caregiver(s) (other than home health agency staff) to provide categories of assistance needed by the patient at various time points SOC, ROC, and DC
- **SOC/ROC**, only M2102f applies/must be answered.
  - Report what is known on the day of assessment regarding ability and willingness of nonagency caregivers to provide supervision and safety ***due to a cognitive impairment for the upcoming episode of care***
- **Discharge**, M2102a,c,d & f must be answered.
  - Report what is known on the day of the discharge assessment regarding the ability and willingness of non-agency caregivers to provide assistance to the patient in the various categories of assistance at the time of the discharge.
- At Discharge, report what is known on the day of the discharge assessment regarding the ability and willingness of non-agency caregivers to provide assistance to the patient in the various categories of assistance at the time of the discharge. Consider area requiring greatest need if varies within a single category
  - e.g. – if need for assist varies within ADL assist

145

145

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Tips for responding to M2102

- **Medication administration** refers to any type of medication (prescribed or OTC) and any route of administration including oral, inhalant, injectable, topical, or administration via g-tube/j-tube, etc.
- **Medical procedures/treatments** include procedures/treatments that the ***physician/allowed practitioner or physician-designee has ordered for the purpose of improving health status***. Some examples of these procedures/treatments include wound care and dressing changes, range of motion exercises, intermittent urinary catheterization, postural drainage, electromodalities, etc.
- **Supervision and safety** includes needs related to the ability of the patient to safely remain in the home. ***This category of assistance needs should focus on supervision and safety necessary due to cognitive or mental health issues***. The need for supervision and safety due to cognitive or mental health issues does not require a specific diagnosis.
- Do not consider the application of physician ordered DME such as anti-embolism stockings, prosthetics, orthotics, etc. when responding to M2102a, ADL assistance. These would be considered in M2102c, Medical procedures

146

146

decisionhealth

SECTION G: FUNCTIONAL STATUS

The items in this section address the patient's ability to safely perform personal care activities. The items identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "adherence" are not the focus of these items. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

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

147

147

decisionhealth

M1800 Grooming

VBP Change in Self Care ITEM

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

- EXCLUDES bathing, shampooing hair, and toileting hygiene

- Preferred method for item assessment is direct observation.
  - Consider that item INCLUDES accessing items/obtaining all items needed for performing tasks included in the item. Item ALSO INCLUDES getting to/from area where patient will perform task
    - For example: Patient who ambulates to and from bathroom with a walker and has grooming items set up on a shelving system with pull out labeled drawers next to sink which has a seat in front for patient to sit on. Clinician needs to assess/consider assessment of patient's ability to ambulate with walker to/from bathroom, ability to pull out the chair and transfer on/off in front of sink, obtain items from the drawers (can the patient read the labels on the drawers, pull them out, select the appropriate items, open things like toothpaste, denture paste, etc., recap, close containers, put back close drawers, etc.), turn water on and off/distinguish hot from cold water?

148

148

decisionhealth

M1800 Grooming

- Items that are performed more often should be given more weight (washing hands for example)
- For items where patient's ability varies, greater weight should be given to those where patient has more difficulty also
- **ASSISTANCE:** Can vary from cuing to supervision to hands on assistance. If patient requires cues, for example, to select appropriate item to perform a task or to add a necessary step, this is considered assistance needed

149

149

decisionhealth

M1800 Grooming – Accessing

QUESTION: M1800. Please confirm that the assessment of the patient's ability to perform the grooming tasks identified in M1800 also includes getting to where the grooming utensils are stored

ANSWER: Patient access must be considered when determining grooming ability (e.g., grooming aids, mirror, sink). If there is an environmental barrier preventing safe access or the patient has an impairment that causes him/her to require someone's assistance to gain access to needed items or locations, whether the assistance was to take the items to the patient, or to assist the patient to get to the items, Response "1-Grooming utensils must be placed within reach before able to complete grooming activities" would be appropriate, assuming the patient could then groom independently in a majority of the more frequently performed grooming tasks. The current OASIS Guidance Manual M1800 Item Intent states "These items address the patient's ability to safely perform grooming given the current physical and mental/emotional/cognitive status, activities permitted and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by ...environmental barriers (e.g., accessing grooming aids, mirror and sink)."

150

150

M1810: Current Ability to Dress Upper Body

decisionhealth

VBP Change in Self Care ITEM

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

- INCLUDES ability to obtain, put on, and remove upper body clothing. Assess ability to put on whatever clothing is routinely worn. This specifically includes the ability to manage zippers, buttons, and snaps if these are routinely worn.
- Preferred method for item assessment is direct observation.
  - Consider that item INCLUDES accessing items/obtaining all items needed for performing tasks included in the item. Item ALSO INCLUDES getting to/from area where patient will perform task(s)

151

151

decisionhealth

M1810 Current Ability to Dress Upper Body

- Prosthetic, orthotic, or other support devices applied to the upper body (for example, upper extremity prosthesis, cervical collar, or arm sling) should be considered as upper body dressing items/tasks
- Time Frame for consideration for M1810 = Day of assessment. Response should reflect what is true for patient 50% of the time period under consideration
- If clothing is modified due to cognitive or physical limitations, modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing.
  - The clinician will need to determine which clothes should be considered routine.

152

152

decisionhealth

M1810 – Upper body dressing and SOB

QUESTION: M1810. What if the patient must dress in stages due to shortness of breath? What response must be marked?

ANSWER: If the patient is able to dress herself/himself independently, then this is the response that should be marked, even if the activities are done in steps. If the dressing activity occurs in stages because verbal cueing or reminders are necessary for the patient to be able to complete the task, then Response 2 is appropriate. (Note that the shortness of breath would be addressed in M1400.)

153

153

decisionhealth

M1810 – Upper body dressing and Adapted items

QUESTION: M1810 & M1820. In the dressing items, how do you answer if a disabled person has everything in their home adapted for them; for instance, closet shelves & hanger racks have been lowered to be accessed from a wheelchair. Is the patient independent with dressing?

ANSWER: M1810 & M1820, Upper and Lower Body Dressing, Response 0 indicates a patient is able to safely access clothes and put them on and remove them (with or without dressing aids). Because in these specific OASIS items, the use of special equipment does not impact the score selection, at the assessment time point, if the patient is able to safely access clothes, and safely dress, then Response 0 would be appropriate even if the patient is using adaptive equipment and/or an adapted environment to promote independence.

**NOTE- if patient is using adapted modifications, but due to functional decline is not safe at present due to other factors, 0 would NOT be an appropriate response. Consider SAFE level of function regardless of adapted modifications.

154

154

decisionhealth

M1810 – Upper body dressing and wound dressings

QUESTION: M1810 & M1820. Are wound dressings included as an upper and lower body dressing task when determining a patient's ability for M1810 and M1820, Ability to Dress Upper/Lower Body?

ANSWER: Wound dressings are NOT one of the included dressing items when scoring M1810, Upper Body Dressing and M1820, Lower Body Dressing. Note that elastic bandages, including ACE Wrap brand, worn for support and compression should be considered as a lower body dressing item, but wraps utilized solely to secure a wound dressing would not be considered a dressing (clothing) item for M1810 or M1820.

155

155

decisionhealth

M1820: Current Ability to Dress Lower Body

VBP Change in Self Care ITEM

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

- INCLUDES ability to dress lower body, including the ability to obtain, put on, and remove lower body clothing. Assess ability to put on whatever clothing is routinely worn.
- Preferred method for item assessment is direct observation.
  - Consider that item INCLUDES accessing items/obtaining all items needed for performing tasks included in the item. Item ALSO INCLUDES getting to/from area where patient will perform task(s)

156

156

decisionhealth

M1820 Current Ability to Dress Lower Body

- Prosthetic, orthotic, or other support devices applied to the lower body (for example, lower extremity prosthesis, ankle-foot orthosis [AFO], or anti-embolism stockings) should be considered as lower body dressing items/tasks.
- Time Frame for consideration for M1820 = Day of assessment. Response should reflect what is true for patient 50% of the time period under consideration
- If clothing is modified due to cognitive or physical limitations, modified clothing selection will be considered routine if there is no reasonable expectation that the patient could return to their previous style of dressing.
  - The clinician will need to determine which clothes should be considered routine.

157

157

decisionhealth

M1830: Bathing *VBP Change in Self Care ITEM*

M1830. Bathing Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).	
Enter Code ☐	0. Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1. With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2. Able to bathe in shower or tub with the intermittent assistance of another person: a. for intermittent supervision or encouragement or reminders, OR b. to get in and out of the shower or tub, OR c. for washing difficult to reach areas. 3. Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4. Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. 5. Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person. 6. Unable to participate effectively in bathing and is bathed totally by another person.

- INCLUDES ability to bathe entire body and the assistance that may be required to safely bathe, including transferring in/out of the tub/shower.

158

158

decisionhealth

M1830 Bathing

- The patient's status should not be coded based on a patient's ability to perform a task with equipment they have not been assessed using (or do not have)
- Time Frame for consideration for M1830 = Day of assessment. Response should reflect what is true for patient 50% of the time period under consideration
- Must consider BOTH need for supervision during bathing/showering AND the need for assist with transfer in and out of shower.
  - If patient requires both supervision AND transfer assist, then must respond 3
    - NOTE that response 2 "or" indicates that pt. requires assist with only one of these areas, if the patient requires a

159

159

decisionhealth

M1830 – Bathing- Medical Restriction

QUESTION: M1830. My patient is allowed to bathe in the tub, but is medically restricted from getting the cast on his lower leg and foot wet. He is unable to put the water protection sleeve on, but once someone applies the protective sleeve for him, he can get into and out of the bathtub using a transfer bench and wash all of his body with a handheld shower. Does this medical restriction impact the patient's ability when scoring M1830, Bathing?

ANSWER: Medical restrictions that impact the OASIS-included bathing tasks are considered when determining the score for 1830, Bathing. Therefore, the tasks required to allow compliance with medically prescribed precautions for bathing could impact the patient's ability. In the scenario above, Response 2 is appropriate since the patient needs intermittent human assistance.

160

160

decisionhealth

M1830 – Bathing - Access

QUESTION: Please clarify how the patient's ability to access the tub/shower applies to M1830?

ANSWER: The intent of the bathing item is to identify the patient's ability to wash the entire body. Guidance for this item indicates that when medical restrictions, environmental or other barriers prevent the patient from accessing the tub/shower, his/her bathing ability will be 'scored' at a lower level. The ability to transfer into and out of the tub/shower is evaluated and also impacts the score when responding to M1830. If the patient requires assistance to transfer into or out of the tub/shower, they would be scored a 2 or 3, based on the amount of human supervision or assistance is required throughout the bath.

decisionhealth

M1840 Toilet Transferring *VBP Change in Mobility ITEM*

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

- INCLUDES ability to safely **get to and from and transfer on *and* off the toilet or bedside commode**.
- Excludes toileting hygiene and clothing management.
- If the patient requires ambulation supervision, this would include ambulation to and from the bathroom for toileting, indicating response 1
- If the patient requires transfer assist/support (including if this is limited to standby, supervision or cuing) this would include toilet transfer, indicating response 1
- If the patient can get to and from the toilet during the day independently, and transfer independently but uses the commode at night **for convenience** code 0.
- If the patient is able to wheel self independently to the bathroom but cannot complete transfer (is dependent for transfer), then must respond 4. PATIENT MUST DO BOTH PARTS. If dependent for EITHER = 4

decisionhealth

M1840 Toilet Transferring

- **Respond 3** if the patient who is unable to get to/from the toilet or bedside commode is able to place and remove a bedpan (and urinal if applicable) independently, whether or not a patient requires assistance to empty the bedpan/urinal.

- **Respond 4** if the patient, who is unable to get to/from the toilet, is not able to use the bedside commode or bedpan/urinal as defined in the responses, or if such equipment is not present in the home to allow assessment.

decisionhealth

M1840 Toilet Transferring – patient with urinary catheter

QUESTION: M1840. If my patient has a urinary catheter, does this mean he is totally dependent in toileting transferring?

ANSWER: M1840 does not differentiate between patients who have urinary catheters and those who do not. The item simply asks about the patient's ability to get to and from the toilet or bedside commode and their ability to transfer on and off toilet/commode. This ability can be assessed whether or not the patient uses the toilet for urinary elimination.

decisionhealth

M1840 Toilet Transferring – Availability of Assistance

QUESTION: If a patient is able to safely get to and from the toilet and perform the transfer with assistance of another person, but they live alone and have no caregiver so they are using a bedside commode, what should be the response to M1840?

ANSWER: The OASIS item response should reflect the patient's ability to safely perform a task, regardless of the presence or absence of a caregiver. If the patient is able to safely get to and from the toilet and transfer with assistance, then Response 1 should be selected, as this reflects their ability, regardless of the availability of a consistent caregiver in the home.

decisionhealth

M1845 Toileting Hygiene *VBP Change in Self Care ITEM*

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

- INCLUDES ability to manage personal hygiene and clothing when toileting
- INCLUDES pulling clothes up or down, wiping/cleaning the perineal area
- INCLUDES patient's ability to maintain hygiene related to catheter care and the ability to cleanse around all stomas that are used for urinary or bowel elimination (for example, urostomies, colostomies, ileostomies).
- Includes ability to manage clothing/personal hygiene tasks included in this item with or without assistive devices
- Code 2, if the patient can participate in hygiene and/or clothing management but needs some assistance with either or both activities noted here – toileting hygiene and/or clothing adjustment.

1850: Transferring *VBP Change in Mobility ITEM*

decisionhealth

M1850. Transferring Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.	
Enter Code ☐	0. Able to independently transfer. 1. Able to transfer with minimal human assistance or with use of an assistive device. 2. Able to bear weight and pivot during the transfer process but unable to transfer self. 3. Unable to transfer self and is unable to bear weight or pivot when transferred by another person. 4. Bedfast, unable to transfer but is able to turn and position self in bed. 5. Bedfast, unable to transfer and is unable to turn and position self.

- Identifies patient ability to safely transfer from bed to chair (and chair to bed), or position self in bed if bedfast
- For most patients, the transfer between bed and chair will include **transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair, and back into bed from the chair or sitting surface.**
- If there is no chair in the patient's bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, report the patient's ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and then sit on whatever surface is applicable to the patient's environment and need, (for example, a chair in another room, a bedside commode, the toilet, a bench, etc.). Include the ability to return back into bed from the sitting surface.

167

167

decisionhealth

M1850 Transferring

- **Able to bear weight** refers to the patient's ability to support the majority of their body weight through any combination of weight-bearing extremities (for example, a patient with a weight-bearing restriction of one lower extremity may be able to support their entire weight through the other lower extremity and upper extremities).
- **Bedfast** refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed.
- "**Minimal human assistance"** applies when the helper is contributing less than 25% of the total effort required to complete the task.
- Response 1 = Transfers either with minimal human assistance (but not a device), or with the use of a device (but no human assistance).
- Response 2 =
  - Patient requires minimal human assist AND an assistive device
  - Can both bear weight and pivot, but requires more than minimal human assistance
- Response 3 = Patient cannot either bear weight OR patient cannot pivot

168

168

decisionhealth

M1850 Transferring - Assistance

QUESTION: M1850. If a patient takes extra time and pushes up with both arms, is this considered using an assistive device?

ANSWER: Taking extra time and pushing up with both arms can help ensure the patient's stability and safety during the transfer process but does not mean that the patient is dependent. If standby human assistance were necessary to assure safety, then a different response level would apply.

169

169

decisionhealth

M1850 Transferring – Bedfast vs. Chair confinement

QUESTION: M1850. A quadriplegic is totally dependent, cannot even turn self in bed, however, he does get up to a gerichair by Hoyer lift. For M1850, is the patient considered bedfast?

ANSWER: A patient who can tolerate being out of bed is not “bedfast.” If a patient is able to be transferred to a chair using a Hoyer lift, Response 3 is the option that most closely resembles the patient’s circumstance; the patient is unable to transfer and is unable to bear weight or pivot when transferred by another person. Because he is transferred to a chair, he would not be considered bedfast (“confined to the bed”) even though he cannot help with the transfer. Responses 4 and 5 do not apply for the patient who is not bedfast. The frequency of the transfers does not change the response, only the patient’s ability to be transferred and tolerate being out of bed.

170

170

M1860 Ambulation/Locomotion *VBP Change in Mobility ITEM*

decisionhealth

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

- Identifies 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 their environment and may vary based on the individual residence.
- If a patient does not require human assistance, but safely ambulates with a walker in some areas of the home, and a cane in other areas (due to space limitations, distances, etc.), enter the response that reflects the device that best supports safe ambulation on all surfaces the patient routinely encounters.

171

171

decisionhealth

M1860 Ambulation/Locomotion

- **Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed.**
- **Response 2 or 3**, if the patient requires human assistance (hands on, supervision and/or verbal cueing) to safely ambulate, regardless of the need for an assistive device. Response 2 if the assistance required is intermittent. Code 3 if the assistance required is continuous.
- **Response 2**, if the patient is:
  - Able to safely ambulate without a device on a level surface, but requires minimal assistance on stairs, steps, and uneven surfaces.
  - Able to safely ambulate with a walker in the hallway or living room, even if there are some situations in the home where a cane provides adequate support as long as the patient does not require continuous human assistance. ***Note that assistance can be in the form of supervision, cuing, or standby***
- **Response 3**, if a patient does not have a walking device but is clearly not safe walking alone, unless the patient is chairfast.
- **Response 4 or 5**, if a patient:
  - Is unable to ambulate even with the use of assistive devices and/or continuous assistance.
  - **Demonstrates ability to take one or two steps to complete a transfer but is otherwise unable to ambulate. - **THIS IS NOT FUNCTIONAL AMBULATION****

172

172

decisionhealth

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

Section includes:

GG0100 Prior Functioning: Everyday Activities
GG0110 Prior Device Use
GG0130 Self Care
GG0170 Mobility

GG0100: Prior Functioning: Everyday Activities

decisionhealth

GG0100. Prior Functioning: Everyday Activities Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury.		
Coding: 3. **Independent** – Patient completed all the activities by themself, with or without an assistive device, with no assistance from a helper. 2. **Needed Some Help** – Patient needed partial assistance from another person to complete any activities. 1. **Dependent** – A helper completed all the activities for the patient. 8. **Unknown** 9. **Not Applicable**	↓ Enter Codes in Boxes	
	☐	A. **Self Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, and eating prior to the current illness, exacerbation, or injury.
	☐	B. **Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.
	☐	C. **Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
	☐	D. **Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

- Identifies the patient's usual ability with everyday activities, prior to the current illness, exacerbation or injury
- May include patient/family/CG interview as well as review of clinical records (physician and other inpatient/outpatient record documentation) to obtain information regarding patient's prior functioning with everyday activities

decisionhealth

GG0100 Prior Functioning: Everyday Activities

- Report the patient's functional ability **prior to the onset of the current illness, exacerbation of a chronic condition, or injury, whichever is most recent**, that initiated this episode of care.
- **RESPONSE 8, UNKNOWN** may be reported if all attempts to obtain information about prior functioning using all resources have been exhausted and no information is available.
- **Completing the stair activity for GG0100C** indicates that a patient previously went up and down the stairs, by any safe means, with or without handrails or assistive devices or equipment (such as a cane, crutch, walker or stair lift), and/or with or without some level of assistance. *"By any safe means" may include a patient scooting up/down stairs on buttocks. Stairs include internal or external without a defined number.*
  - **Going up and down a ramp is *not* considered going up and down stairs**

175

175

decisionhealth

GG0100 Prior Functioning: Everyday Activities

- **Response 3 Independent** – patient previously required NO assistance of a caregiver/helper and was able to complete by themself with or without a device
- **Response 2, Needed Some Help** - patient previously needed partial assistance from another person to complete activities.
- **Response 1, Dependent** - helper completed ALL the activities for the patient, **OR** the patient required the assistance of two or more helpers to complete the activities.
- **Response 9, Not Applicable** - if the activities were not applicable to the patient prior to the current illness, exacerbation, or injury. For example, the patient did not climb stairs of any number at all prior to the current illness, exacerbation, or injury (*helper/caregiver cannot climb stairs for the patient and patient did not perform at all even with assist)
- DASH is allowed for all GG0100 items A, B, C & D but should be a rare occurrence

176

176

GG0110. Prior Device Use

decisionhealth

GG0110. Prior Device Use Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury.	
↓ Check all that apply	
☐	A. Manual wheelchair
☐	B. Motorized wheelchair and/or scooter
☐	C. Mechanical lift
☐	D. Walker
☐	E. Orthotics/Prosthetics
☐	Z. None of the above

- Identifies the patient's use of devices and aids immediately prior to the most recent illness, exacerbation, or injury.
- May include patient/family/CG interview as well as review of clinical records (physician and other inpatient/outpatient record documentation) to obtain information describing the patient's use of prior devices and aids.

177

177

GG0110. Prior Device Use

decisionhealth

- Report the devices used by the patient **prior to the onset of the current illness, exacerbation of a chronic condition, or injury, whichever is more recent**, that initiated this episode of care
- **Multiple responses are allowed-** check ALL that apply
- CMS does not provide an exhaustive list of assistive devices that may be used when coding prior device use
- Devices include those that may have been used indoors and/or outdoors

178

178

decisionhealth

GG0110. Prior Device Use

- **GG0110C, Prior Devices: Mechanical lift** includes any mechanical device or equipment a patient or caregiver requires for lifting or supporting the patient's bodyweight.
  - Examples include, but are not limited to: Stair lift, Hoyer lift, bathtub lift, sit-to-stand lift, stand assist, electric recliner and full-body style lifts, if required.
  - Clinical judgment may be used to determine whether other devices, meet the mechanical lift definition provided.

- **GG0110D, Walker** refers to all types of walkers. Examples include but are not limited to: pick-up walkers, hemi-walkers, rolling walkers, and platform walkers.

179

179

decisionhealth

General Guidelines for Responding to GG0130 & GG0170

- For GG0130 and GG0170 the assessing clinician would code each activity based on the type and *amount of assistance needed to complete the activity safely, not based on the availability of such assistance.*

- Patients with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity (for example, due to choking risk due to rate of eating, amount of food placed into mouth, risk of falling). Code based on the type and amount of assistance required to perform the activity safely.

- When using patient or caregiver reports, it is expected that the patient and caregivers are reporting on the patient's status within the time period under consideration (e.g., reporting on the patient's ability to complete an activity within the past 24 hours).

- When a GG function activity is not completed entirely during one clinical observation (i.e., a patient transfers bed-to-chair in the morning, and transfers chair-to-bed at night), code based on the type and amount of assistance required to complete the ENTIRE activity.

180

180

General Guidelines for Responding to GG0130 & GG0170

decisionhealth

- Communicating the activity request itself would not be considered verbal cueing. If additional prompts are required for the patient to safely complete the activity that may be considered verbal curing the assessing clinician may need to use clinical judgment to determine the most appropriate code.
- Activities may be completed with or without an assistive device. This includes the use of any new or previously utilized assistive device(s) or equipment. Use of a device or equipment may result in the patient needing less assistance from a helper.
- **"Prior to the benefit of services" means prior to provision of any care by your agency staff that would result in more independent coding. Responses should always reflect the patient's condition PRIOR TO the benefit of any home health services/intervention.**
- At SOC/ROC, the self-care or mobility performance code is to be based on a functional assessment that occurs at or soon after the patient's SOC/ROC.
- At SOC/ROC, the self-care or mobility performance code is to be based on a functional assessment that occurs at or soon after the patient's SOC/ROC.

181

181

General Guidelines for Responding to GG0130 & GG0170

decisionhealth

SOC/ROC DC GOALS

- Agencies are required to complete a discharge goal for a minimum of one of the following self-care or mobility activities: GG0130A,B, or C2 OR GG0170B,C,D,E,F,J,K,R, or S2
- Agencies may choose to complete more than one self-care or mobility discharge goal and should dash any remaining self-care or mobility goals where a discharge goal is not established.
- Agencies may report a discharge goal for all GG0130 and GG0170 activities.
- Once a discharge goal is established, there is no need to update it if circumstances change or additional information becomes available either within or after the SOC/ROC assessment timeframe.
- Discharge goal(s) may be coded the same as SOC/ROC performance, higher than SOC/ROC performance, or lower than SOC/ROC performance.
- Discharge goal(s) may be coded the same as SOC/ROC performance, higher than SOC/ROC performance, or lower than SOC/ROC performance

182

182

General Guidelines for Responding to GG0130 & GG0170

decisionhealth

ACTIVITY NOT ATTEMPTED or NA Responses

- Should occur only after determining that the activity is not completed, and the performance code cannot be determined based on patient/caregiver report, collaboration with other agency staff, or assessment of similar activities.
- **Response 07, Patient refused,** if the patient refused to complete the activity and no other Performance or "activity not attempted" code is applicable.
- **Response 09, Not applicable,** if the patient did not attempt to perform the activity and did not perform this activity prior to the current illness, exacerbation, or injury.
- **Response 10, Not attempted due to environmental limitations**, if the patient did not attempt this activity due to environmental limitations. Examples include lack of equipment, and weather constraints.
- **Response 88, Not attempted due to medical condition or safety concerns**, if the activity was not attempted due to medical condition or safety concerns, and the activity was completed prior to the current illness, exacerbation, or injury.

183

183

GG0130 Self Care

decisionhealth

SOC/ROC
GG0130. Self-Care Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).
Coding: **Safety** and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** – Patient completes the activity by themself with no assistance from a helper. 05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity. 04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. **If activity was not attempted, code reason:** 07. **Patient refused** 09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury. 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 88. **Not attempted due to medical condition or safety concerns**

184

184

GG0130 Self Care

decisionhealth

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

185

185

decisionhealth

GG0130A Eating

- **EATING Definition:** The ability to use suitable utensils to bring food to the mouth and swallow food and/or liquid once the meal is placed before the patient.
- If the patient requires assistance including supervision or cueing to swallow safely, respond based on the type and amount of assistance required for feeding **AND** safe swallowing, BUT if a patient swallows safely, exclude swallowing from consideration when responding to GG0130A.
- **If the patient eats and drinks by mouth and relies partially on obtaining nutrition and liquids via tube feedings or parenteral nutrition, code eating *based on the amount of assistance the patient requires to eat and drink by mouth ONLY***

186

186

decisionhealth

GG0130A Eating

- Assistance with providing tube feedings and administration of parenteral nutrition is **not considered** when responding to this GG0130A
- If the patient does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or total parenteral nutrition (TPN) ***due to a new (recent-onset) medical condition then GG0130A = 88***
- If the patient does not eat or drink by mouth at the time of the assessment, and the patient did not eat or drink by mouth prior to the current illness, injury or exacerbation then GG0130A =09

187

187

decisionhealth

GG0130A Eating

EXAMPLE:

The patient does not have any food consistency restrictions, but often needs to swallow two or three times so that the food clears their throat due to difficulty with pharyngeal peristalsis. They require verbal cues to use the compensatory strategy of extra swallows to clear the food.

GG0130A, Eating would be Response 04, Supervision or touching assistance.

The patient swallows all types of food consistencies and requires verbal cueing (supervision) from the helper. Respond based on assistance from the helper. The response is not based on whether the patient had restrictions related to food consistency

188

188

decisionhealth

GG0130B Oral Hygiene

- **ORAL HYGEINE Definition:** The ability to use suitable items to clean teeth. Dentures (if applicable): the ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

- For a patient who is edentulous, code oral hygiene based on the type and amount of assistance needed from a helper to clean the patient's gums.

EXAMPLE:

During SOC, the cg reports that she tries to give the patient as much independence as possible in self care and that the patient has been completing her own oral hygiene twice a day with no assistance. The patient has a diagnosis of mild Alzheimer's dementia with no behavioral disturbances and has demonstrated no issues in responding to questions during interview. However, when the clinician observes the patient performing grooming tasks, the patient selects a tube of hair gel and applies it to her toothbrush to brush her teeth. When asked, the patient reads the tube and says "yes this is right." The caregiver states she did not realize the patient was not able to select the proper items and will supervise and assist with this task.

GG0130B SOC performance = 04, Supervision or touching assistance

GG0130B DC Goal = 04, Supervision or touching assistance **The patient's need for supervision is unlikely to change due to her dementia*

189

189

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GG0130C Toileting Hygiene

- **TOILETING HYGEINE Definition:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

- Can be assessed and coded regardless of the patient's need to void or have a bowel movement at the time of the assessment.

- When the patient requires different levels of assistance to perform toileting hygiene after voiding vs after a bowel movement, code based on the type and amount of assistance required to complete the ENTIRE activity

- If the patient has an indwelling urinary catheter and has bowel movements, **code the Toileting hygiene item based on the type and amount of assistance needed by the patient when moving their bowels**. This may necessarily include the need to perform perineal hygiene to the indwelling urinary catheter site after the bowel movement.
  - If a patient has an indwelling catheter, toileting hygiene includes perineal hygiene to the indwelling catheter site, but not management of the equipment.

190

190

decisionhealth

GG0130E Shower/bathe self

- **SHOWER/BATHE SELF Definition:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). *Does not include transferring in and out of shower/tub.*
- Includes the ability to wash, rinse and dry the face, upper and lower body, perineal area and feet, regardless of where the bathing takes place.
- If the patient can complete bathing tasks only after a helper retrieves or sets up supplies necessary to perform the included tasks then response 05 is most appropriate (*If patient also requires supervision or additional assist then 01-04 may be more appropriate)
- If the **ONLY** assist needed is to cover wound dressings, then response 05 is best

191

191

decisionhealth

GG0130E Shower/bathe self

EXAMPLE:

During SOC, patient states that the she cannot get in and out of tub/shower due to the height of step in and out but can bathe at bedside. She states she prefers to just have the aide do her set up and she can do the rest herself and doesn't like to have them do to much for her. While the assessing clinician is there, the aide sets up the bath and the clinician observes that the aide not only sets up the bath and provides extensive cueing, but also has to wash the patient's entire lower body, including genital region, buttocks, as well as go back over the patient's underarm region. The aide reports that the patient has difficulty reaching these areas more recently since she fell and has more pain, limited range of motion, and her balance has become poor. Previously she only had to remind her to do this. Therapy will be seeing the patient due to the recent falls and will be addressing these issues.

GG0130E SOC performance = 02, Substantial/maximal assistance (*Helper completed more than half of the activity)

GG0130E DC Goal = 04, Supervision/touching assistance (*Goal is that therapy interventions will address and improve since decline is recent)

192

192

decisionhealth

GG0130F, GG0130G, and GG0130H

- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the patient dresses and undresses themself and the only help the patient requires is for a helper to retrieve or put away the patient's clothing before or after the activity, then code 05, Setup or clean-up assistance
- Upper body and lower body dressing and footwear include dressing and undressing in clothing and footwear routinely worn by the patient.
  - Clinician can determine what clothing is routine for the patient if clothing has been modified due to physical or cognitive needs
- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the patient dresses and undresses themself and the only help the patient requires is for a helper to retrieve or put away the patient's clothing before or after the activity then response 05 is most appropriate.
- Timing of when dressing occurs should not be considered when responding. A patient may dress several times a day or put on several different clothing items at different times and all portions of this are included

193

193

decisionhealth

GG0130F, GG0130G, and GG0130H

- **UPPER BODY DRESSING**
  - There is no specific list of items that are included in upper body dressing, however, the following DME ARE included: thoracic-lumbar-sacrum-orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic.

EXAMPLE:

The patient has right-side upper extremity weakness as a result of a stroke and has received therapy to relearn how to dress their upper body. During the day, they require a helper to place clothing next to the bedside. The patient can then use compensatory strategies to put on their bra and top without any assistance. At night they remove their top and bra independently and put the clothes on the nightstand and the helper puts them away.

GG0130F SOC performance Response 05, Set up or clean up assistance

The patient dresses and undresses their upper body and requires a helper only to retrieve and put away their clothing; that is, setting-up the clothing for patient use.

194

194

decisionhealth

GG0130F, GG0130G, and GG0130H

- **LOWER BODY DRESSING- excludes footwear**
  - There is no specific list of items that are included in lower body dressing, however, the following DME ARE included: nee brace, elastic bandage, stump sock/shrinker, above knee or below knee lower-limb prosthesis

EXAMPLE:

The patient has severe rheumatoid arthritis and multiple fractures and sprains due to a fall. They have been issued a knee brace to be worn during the day. The patient threads their legs into their garments and pulls up and down their clothing to and from just below the hips. Only a little assistance from a helper is needed to pull up their garments over the hips. The patient requires the helper to fasten the knee brace because of grasp and fine motor weakness.

GG0130G SOC performance Response 03, Partial/moderate assistance

A helper provides only a little assistance when the patient is putting on their lower extremity garments and fastening the knee brace. The helper provides less than half of the effort

195

195

decisionhealth

GG0130F, GG0130G, and GG0130H

FOOTWEAR

- There is no specific list of items that are included in footwear, however, the following DME ARE included: ankle foot orthosis (AFO), elastic bandages, foot orthotic, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).
- This item may still be answered even if the patient wears only shoes(no socks) or only socks (no shoes)
- For patients with bilateral lower extremity amputations with or without use of prostheses, the activity of putting on/taking off footwear may not occur – consider if the patient uses a prosthetic to which the patient applies socks and shoes or if the patient does not use a prosthesis or put socks/shoes onto a prosthetic at all and respond accordingly

EXAMPLE:

A patient has progressed with therapy and is being discharged. He is able to sit at the side of his bed and has now modified his footwear and obtained a sock donner/doffer which he sets up the night before and places on his bedside table. He now uses spiral elastic shoelaces so he can easily slide on his shoes which are placed at the bedside. At the discharge visit, the PT observes that he dons the socks that he set up and slides on the shoes with no issues and is also able to slide the shoes off and remove the socks with the doffer with no assist or need for set up.

GG0130H – Discharge performance – 06, Independent

At discharge the patient is able to perform with no helper assist

196

196

GG0170 Mobility

decisionhealth

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

Coding:

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

Activities may be completed with or without assistive devices.

06. **Independent** – Patient completes the activity by themself with no assistance from a helper.
05. **Setup or clean-up assistance** – Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** – Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

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

197

197

GG0170 Mobility

decisionhealth

1. SOC/ROC Performance	2. Discharge Goal	
↓Enter Codes in Boxes↓		
☐☐	☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with no back support.
☐☐	☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	☐☐	G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88, →Skip to GG0170M, 1 step (curb)*
☐☐	☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
☐☐	☐☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
☐☐	☐☐	L. **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	M. **1 step (curb):** The ability to go up and down a curb or up and down one step. *If SOC/ROC performance is coded 07, 09, 10 or 88, → Skip to GG0170P, Picking up object.*
☐☐	☐☐	N. **4 steps:** The ability to go up and down four steps with or without a rail. *If SOC/ROC performance is coded 07, 09, 10 or 88, → Skip to GG0170P, Picking up object.*
☐☐	☐☐	O. **12 steps:** The ability to go up and down 12 steps with or without a rail.

198

198

GG0170 Mobility

SOC/ROC GG0170. Mobility – Continued		
1. SOC/ROC Performance	2. Discharge Goal	
☐☐	☐☐	P. **Picking up object**: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		☐ Q. **Does patient use wheelchair and/or scooter?** 0. **No** ➔ *Skip to M1600, Urinary Tract Infection* 1. **Yes** ➔Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	R. **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		☐ RR1. **Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	S. **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		☐ SS1. **Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

199

199

GG0170A, GG0170B, and GG0170C

- **BED MOBILITY - GG0170A - Roll left and right, GG0170B – Sit to lying, and GG0170C - Lying to sitting on side of bed**
  - If the patient does not sleep in a bed, assess bed mobility activities using the preferred or necessary sleeping surface used by the patient.
  - Clinical judgment should be used to determine what is considered a “lying” position for the patient. For example, a clinician could determine that a patient’s preferred slightly elevated resting position is “lying” for that patient.
  - If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions, but could perform this activity prior to the current illness, exacerbation or injury, then response 88 is most appropriate
  - If at the time of the assessment the patient is unable to lie flat due to medical conditions or restrictions and could not perform the activity prior to the current illness, exacerbation or injury, then response 09 is most appropriate

200

200

decisionhealth

GG0170A Roll left and right

- **Roll left and Right Definition:** The ability to roll from lying on back to left and to right side and return to lying on back in bed
- Should be assessed on usual lying surface
- If the clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated due to the patient's medical condition, code GG0170A, Roll left and right, using the appropriate "activity not attempted" code.

decisionhealth

GG0170B Sit to lying

- **Sit to lying Definition:** The ability to move from sitting on side of bed to lying flat on bed
- Should be assessed on usual sleeping surface
- If the patient does not sleep in a bed, assess the patient's ability to move from sitting on side of the patient's preferred or necessary sleeping surface to lying flat on the patient's preferred or necessary sleeping surface.

EXAMPLE: At SOC, the patient requires assistance from two helpers to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on their right side, obesity, and cognitive limitations. One of the helpers explains to the patient each step of the sitting to lying activity. The patient is then fully assisted by the 2 helpers to get from sitting to a lying position on the bed. The patient makes no attempt to assist when asked to perform the incremental steps of the activity.

GG0170B, SOC Performance = 01 Dependent

2 or more helpers are required to assist the patient

decisionhealth

GG0170C Lying to sitting on side of bed

- **Lying to sitting Definition:** The ability to move from lying on the back to sitting on the side of the bed with no back support
- Includes patient transitions from lying on their back to sitting on the side of the bed and sitting upright on the bed, or alternative sleeping surface, without back support. Back support refers to an object or person providing support for the patient's back.
- It is **not required that the patient's feet be flat on the floor** to consider the activity as being completed. *Note that the reference to the patient having their feet flat on the floor has been removed from GG0170C in the OASIS-E instrument.*

203

203

decisionhealth

GG0170D Sit to stand

- **Sit to stand Definition:** The ability to come to a standing position from sitting in a chair, wheelchair, or sitting on the side of the bed
- The activity includes the patient coming to a standing position from any sitting surface.
- If the only help a patient requires to complete the sit to stand activity is for a helper to retrieve an assistive device or adaptive equipment, such as a walker or ankle foot orthosis then the most appropriate response is 05, Set up or clean up assistance.
- If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer, **and even with assistance the patient is not able to complete the sit to stand activity, code GG0170D, Sit to stand with the appropriate "activity not attempted" code.**
- If a sit to stand lift is used **and the patient requires the assistance of two helpers to get from a sitting to standing position, code as 01, Dependent.**

204

204

decisionhealth

GG0170E Chair/bed-to-chair transfer

- **Chair/Bed to Chair transfer Definition:** The ability to transfer to and from a bed to a chair (or wheelchair)
- The activity reflects a transfer between (to and from) any two sitting surfaces. This could be a chair-to chair transfer that does not include the bed.
- Includes stand-pivot, squat-pivot, slide board, or stand and transfer
- If a mechanical lift is used to assist in transferring a patient for a chair/bed-to-chair transfer and the patient *requires the assistance of two helpers code as 01, Dependent, even if the patient assists with any part of the chair/bed-to-chair transfer.*
- ***NOTE:*** *The activities of GG0170B - Sit to lying and GG0170C - Lying to sitting on side of bed are two separate activities that are not assessed as part of GG0170E – Chair/Bed to Chair Transfer*

205

205

decisionhealth

GG0170G Car transfer

- **Car transfer Definition:** The ability to transfer in and out of a car or van on the passenger side. Does NOT include the ability to open/close door of fasten belt.
- If the patient remains in a wheelchair and does not transfer in and out of a car or van seat, the activity is not considered completed and the appropriate "activity not attempted" code would be used. **If patient is transferred into the vehicle via an accessible lift and never transfers into vehicle seat then either 88 or 09 is the best response**
- The setup and/or clean-up of an assistive device that is used for walking to and from the car, but not used for the transfer in and out of the car seat, would not be considered when coding the car transfer activity.

206

206

decisionhealth

GG0170G Car transfer

EXAMPLE:

A patient who is quadriplegic has a handicap accessible van with a lift and motorized chair. She is able to propel the chair to the van and once the door is open wheel herself onto the ramp and elevate the lift then wheel into the van where she is secured into the vehicle and she is transported to appointments this way.

GG0170 SOC performance = 09, Not applicable

GG0170 DC Goal = 09, Not applicable

The patient does not transfer into a vehicle seat and did not previously do this activity

decisionhealth

GG0170I, GG0170J, GG0170K, and GG0170L

- Assessment of the walking activities starts with the patient in a standing position.
- Responses to GG0170 ambulation items should reflect amount of assist needed for safety with or without assistive device (*use of assistive device should not presume more dependent code)
- Patient may take a STANDING rest break during the activity. If the patient must take a SEATED rest break, consider the activity incomplete/unable to complete
- The patient must participate in ambulation and stair climbing activities in order for activity to consider activity completed. If two helpers are needed and patient is able to participate, assign response 01
- If the only assistance that the patient needs is to retrieve device then assign response 05, Set up and clean up assistance.

Ambulation with turns – GG0170J MUST include

decisionhealth

The turns included in the items GG0170J (Walk 50 feet with two turns) **are 90 degree turns.** The turns may occur at any time during the 50-foot walk. The turns may be in the same direction (two 90-degree turns to the right or two 90 degree turns to the left) or may be in different directions (one 90 degree turn to the left and one 90 degree turn to the right). The 90-degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).

Per CMS Q&As - If completing a 90-degree turn is unsafe even with assistance of 1 or more helpers, then consider the walking with 2 turns activity to not have been completed and use the appropriate "activity not attempted" code.

209

209

Ambulation Examples

decisionhealth

Example 1:

The patient has recent endurance limitations due to an exacerbation of heart failure and is only walking about 30 feet before they tire, lose strength and must sit and rest. They report they were walking 150 feet or more with their cane prior to this exacerbation of their heart failure.

GG0170K, Walk 150 ft = 88, Not attempted due to medical conditions or safety concerns

The activity was not completed due to the patient's recent endurance limitations and current medical condition, and **a helper cannot complete the walking activity for a patient.** The patient was able to complete the activity prior to the recent exacerbation of their condition.

210

210

decisionhealth

GG0170M, GG0170N, and GG0170O

- Stair activities include going up and down stairs by ANY safe means, with or without devices
  - This can include use of stair lifts, walking up and down, scooting on buttocks, using railing
- Does NOT include accessing/getting to/from the stairs
- Patient does not have to climb stairs sequentially
- Wheelchair bound patient can be assessed going up and down curb/1 step or other stairs in wheelchair if able
- If the patient requires a helper to provide total assist, code 01, Dependent (for example, a patient requires total assist from a helper to move up and down a curb in their wheelchair).
- If at the time of the assessment the patient is unable to complete the activity due to a physician prescribed restriction (for instance, no stair climbing for 2 weeks), but could perform this activity prior to the current illness, exacerbation or injury, code 88, Not attempted due to medical condition or safety concerns.

211

211

decisionhealth

GG0170M, GG0170N, and GG0170O

QUESTION:

Question 6:What is specifically assessed when a patient uses a stair lift to ascend/descend stairs for GG0170 - Mobility? Should the GG activities be coded based on the type and amount of assistance required to get on and off the stair lift? Or is it the type and amount of assistance required to use the stair lift itself?

ANSWER:

The intent of the GG0170 stair activities is to assess the patient's ability to go up and down 1 step/curb, 4 steps, and 12 steps. Clinicians should code based on the type and amount of assistance required for the patient to complete the stair activities as independently and safely as possible. Completing the stair activities indicates that a patient goes up and down the stairs, by any safe means, with or without any assistive devices (including cane, walker, railing, or stair lift) and with or without some level of assistance. Going up and down stairs by any safe means includes the patient walking up and down stairs on their feet or bumping/scooting up and down stairs on their buttocks. ***When using a stair lift to ascend/descend stairs code based on the type and amount of assistance the patient requires to ascend/descend stairs beginning once the patient is seated and ending when the patient is ready to transfer out of the seat.***

212

212

decisionhealth

GG0170P Picking up object

- The ability to bend/stoop **from a standing position** to pick up a small object such as a spoon, from the floor
  - Assistive device(s) and adaptive equipment may be used, for example a cane to support standing balance and/or a reacher to pick up the object.
  - Patient must be able to stand

EXAMPLE:

The patient has recently undergone a hip replacement. At SOC, they walk with a walker without assistance. When they drop a hairbrush from their walker basket, they ask a helper to locate their long-handled reacher and bring it to them. Using the reacher, the patient bends slightly, and safely picks up the hairbrush with the reacher, without need of additional assistance or verbal cues.

GG0170P= 05, Set up or clean up assistance

The helper provides set-up assistance only by retrieving the reacher and then the patient is able use the device to pick up the hairbrush safely.

213

213

decisionhealth

GG0170Q, GG0170R, GG0170RR, GG0170S, and GG0170SS

- The intent of the wheelchair mobility items is to assess the ability of patients who use a wheelchair and/or scooter under any condition. This includes patients who are learning how to self-mobilize using a wheelchair or scooter, those who require assistance from a helper to mobilize using a wheelchair/scooter, and those who require a helper to push them in a wheelchair.
- During episode at different OASIS time points, response may reflect different performance for wheelchair use GG0170Q
  - For example, at SOC a patient may never have used a wheelchair before and is currently not using one under any condition. GG0170Q at SOC is coded 0-No. During the episode, the patient does begin instruction in wheelchair use, and at Discharge the patient is able to mobilize the manual chair for short distances. GG0170Q at Discharge is coded 1-Yes

214

214

decisionhealth

GG0170R, GG0170RR, GG0170S, and GG0170SS

- Clinician may choose to combine assessment of multiple wheelchair activities and should use clinical judgement to determine assistance needed for each activity individually
- A helper can assist a patient to complete the wheelchair distance or make turns if required. If the activity can still be completed with the assistance of a helper, a performance code should be assigned.

- ***TURNS:***
  - The turns included in the item GG0170R (wheeling 50 feet with 2 turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90 -degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90- degree turn should occur at the person's ability level
- ***TYPES OF WHEELCHAIRS:***
  - If at the time of assessment, the patient uses both a manual and a motorized wheelchair or scooter to complete the Wheel 50 feet with two turns activity, **code the activity based on the type of wheelchair/scooter with which the patient requires the most assistance.**

215

215

decisionhealth

GG0170R, GG0170RR, GG0170S, and GG0170SS

- **150 ft distance:** If the patient's environment does not accommodate wheelchair/scooter use of 150 feet without turns, but the patient demonstrates the ability to mobilize the wheelchair/scooter with or without assistance 150 feet with turns without jeopardizing the patient's safety, code using the 6-point scale.

EXAMPLE

The patient uses a below-the-knee prosthetic limb. The patient has peripheral neuropathy and limited vision due to complications of diabetes. Via observation and patient report, the assessing clinician determines that the patient's usual performance is that a helper is needed to provide verbal cues for safety due to vision deficits, and the patient mobilizes their manual wheelchair a distance of 150 feet within their home.

GG0170S = 04 Supervision or touching assistance

GG0170SS Wheelchair type = manual

Using a manual wheelchair, the patient requires the helper to provide verbal cues for their safety as they propel themself in their wheelchair for 150 feet.

216

216

decisionhealth

SECTION H: Bladder and Bowel

The items in this section assess bowel and bladder function to identify situations that could impact patient health status or their plan of care.

Includes:

M1600

M1610

M1620

M1630

decisionhealth

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

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

- Identifies if patient was treated for a urinary tract infection in the past 14 days
- Past 14 days = 2 week period prior to the SOC. This means that for purposes of counting the 14- day period, the Start of Care date is day 0 and the day immediately prior to the Start of Care date is day 1. For example, if the patient's SOC date is August 20, any treatment for a UTI occurring on or after August 6 would be considered.
- If the patient is on prophylactic antibiotic treatment but develops active UTI, then respond yes (1)

decisionhealth

M1610: Urinary Incontinence or Urinary Catheter Presence

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

- Type of urinary catheter is not addressed by item. All urinary catheters are included in this item. All types of urinary incontinence are included
- If patient is Anuric (dialysis patients), has ostomy for urinary drainage or pouched urinary diversion, then best response =0
- Patient dependent on timed voiding program to manage urinary incontinence would still be marked as 1, Patient is incontinent
- If patient is BOTH incontinent AND requires catheter (intermittent or external at night for example), then respond 2, Patient requires a urinary catheter
- If a catheter was discontinued during the comprehensive assessment or if a catheter is both inserted and discontinued during the comprehensive assessment, Code 0 or 1 would be appropriate, depending on whether or not the patient is continent.
- A catheter solely utilized for irrigation of the bladder or installation with an antibiotic is not reported in this item

219

219

decisionhealth

M1620: Bowel Incontinence Frequency

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

- Identifies how often the patient experiences bowel incontinence. Excludes the cause of incontinence
- "On a daily basis" refers to incontinence that occurs only once a day. If occurs more than once a day, response 5 is more appropriate.
- This item excludes the treatment of incontinence of the bowel, such as a bowel program.
  - Per CMS Q&As: **Such a patient (on a bowel program) may additionally have occurrences of bowel incontinence, but there is no assumed presence of bowel incontinence simply because a patient is on a regular bowel program.**

220

220

decisionhealth

M1630 Ostomy for Bowel Elimination

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

- Applies to any type of ostomy for bowel elimination (for example: colostomy, ileostomy).
- This item only addresses bowel ostomies, not other types of ostomies (for example: urinary ostomies, tracheostomies).
- If a bowel ostomy is present, determine if the ostomy was related to a change in the past 14 days (medication, inpatient stay, treatment regimen)
  - Consider factors such as complications, infection, ostomy function, dietary changes, etc.
- ***If an ostomy has been reversed, then the patient does not have an ostomy at the time of assessment.***

221

221

decisionhealth

SECTION I: ACTIVE DIAGNOSIS

222

222

decisionhealth

M1028: Active Diagnoses – Comorbidities and Co-existing Conditions

M1028. Active Diagnoses – Comorbidities and Co-existing Conditions	
↓ Check all that apply	
☐	1. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐	2. Diabetes Mellitus (DM)
☐	3. None of the above

- Identifies whether two specific diagnoses – PVD or PAD and DM are present and active. These diagnoses influence a patient's functional outcomes or increase a patient's risk for development or worsening of pressure ulcers/injuries.
- **ACTIVE DIAGNOSES-** Diagnoses that have a direct relationship to the patient's current functional, cognitive, mood or behavior status; medical status; medical treatments; nurse monitoring; or risk of death at the time of assessment.
- Diagnoses must be identified by an allowed diagnosing provider – NP, PA, MD, DO, DPM
- Do NOT include resolved conditions
- **If information regarding active diagnoses is learned after the end of the assessment timeframe, the OASIS item should not be revised to reflect this new information. The OASIS should reflect what was documented at the time of the assessment.**

223

223

decisionhealth

M1028: Active Diagnoses – Comorbidities and Co-existing Conditions

- For diabetic patients who have both Diabetes and PVD/PAD, mark both 1 AND 2

EXAMPLE:
A patient is prescribed insulin for diabetes mellitus. They require regular blood glucose monitoring to determine whether blood glucose goals are achieved by the current medication regimen. The physician progress note documents diabetes mellitus.

M1028 = 2, Diabetes Mellitus
Physician has provided diagnosis documentation and there is ongoing medication treatment and monitoring

224

224

decisionhealth

M1028: Active Diagnoses – Comorbidities and Co-existing Conditions

EXAMPLE:
During the SOC/ROC assessment, a patient told Nurse J, RN that they have had diabetes for 20 years. Nurse J reviewed the transfer documents from the acute care facility and all clinical records on the patient but was unable find a documented diagnosis of Diabetes Mellitus by physician, nurse practitioner, physician assistant or authorized licensed staff member in their state. There is no documented diagnosis of PVD or PAD.

M1028 = 3, None of the above
No physician diagnosis of diabetes was able to be confirmed and there is no documented diagnosis of PVD or PAD

decisionhealth

SECTION J: Health Conditions

This section includes seven items to assess risk for hospitalization, pain interfering with activities, frequency of falls and shortness of breath.

decisionhealth

M1033: Risk of Hospitalization

M1033. Risk for Hospitalization Which of the following signs or symptoms characterize this patient as at risk for hospitalization?	
↓ Check all that apply	
☐	1. History of falls (2 or more falls – or any fall with an injury – in the past 12 months)
☐	2. Unintentional weight loss of a total of 10 pounds or more in the past 12 months
☐	3. Multiple hospitalizations (2 or more) in the past 6 months
☐	4. Multiple emergency department visits (2 or more) in the past 6 months
☐	5. Decline in mental, emotional, or behavioral status in the past 3 months
☐	6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
☐	7. Currently taking 5 or more medications
☐	8. Currently reports exhaustion
☐	9. Other risk(s) not listed in 1-8
☐	10. None of the above

- Risk Adjustment item, identifies factors placing patient at risk for hospitalization
- Falls includes both witnessed and unwitnessed
- Multiple hospitalizations includes ONLY acute care hospitalizations. Psychiatric and LTCH are excluded. Hospitalizations must be >24 hr. stay
- Emergency department visits exclude urgent care visits

decisionhealth

M1033: Risk of Hospitalization

- Decline in mental, emotional, or behavioral status (Response 5) refers to significant changes occurring within the past 3 months that may impact the patient's ability to remain safely in the home and increase the likelihood of hospitalization. A decline is considered a change in which the patient, family, caregiver or physician has noted a decline regardless of cause. A decline can be temporary or permanent. Physician consultation may or may not have occurred.
- Medications (Response 7) include prescribed and over-the-counter (OTC) medications, nutritional supplements, vitamins, and homeopathic and herbal products administered by any route and as noted on the reconciled medication profile. Medications may also include total parenteral nutrition (TPN) and oxygen
- Other risk(s), (Response 9) may be selected if the assessing clinician finds characteristics other than those listed in Responses 1-8 that may indicate risk for hospitalization (for example, slower movements during sit to stand and walking).

decisionhealth

M1033: Risk of Hospitalization

QUESTION:
When a clinician is responding to M1033, how should exhaustion be defined? Does this refer to mental or physical exhaustion, or both?

ANSWER:
M1033. The assessing clinician may consider both physical and/or mental exhaustion when responding to M1033. Note that the information can be gathered by report, and refers to the patient's "current" (day of assessment) status.

decisionhealth

J0510-J0530: Pain Interview

J0510. Pain Effect on Sleep

Enter Code ☐

Ask patient: "*Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night***"

0. **Does not apply – I have not had any pain or hurting in the past 5 days** → *Skip to M1400, Short of Breath at SOC/ROC; Skip to J1800, Any Falls Since SOC/ROC at DC*
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0520. Pain Interference with Therapy Activities

Enter Code ☐

Ask patient: "*Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?***"

0. **Does not apply – I have not received rehabilitation therapy in the past 5 days**
1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

J0530. Pain Interference with Day-to-Day Activities

Enter Code ☐

Ask patient: "*Over the past 5 days,* ***how often you have limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?***"

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
8. **Unable to answer**

decisionhealth

J0510, J0520, J0520 Pain interview

- The intent of the items in this section is to assess the effect of pain on sleep, pain interference with therapy activities, and pain interference with day-to-day activities.
- **PAIN-** any type of physical discomfort in any area of the body – may be generalized or localized. May be acute or chronic, continuous or intermittent, at rest or with movement. Pain is subjective and whatever the person experiencing says it is and exists whenever they say it does.
- **ALL ITEMS J0510, J0520, J0530 HAVE A 5 DAY LOOKBACK**
- Directly ask the patient each item in J0510 through J0530 in the order provided.
  - Use other terms for pain or follow-up discussion if the patient seems unsure or hesitant. Some patients avoid use of the term "pain" but may report that they "hurt." Patients may use other terms such as "aching" or "burning" to describe pain.
- If the patient is unsure about whether the pain effect or interference occurred in the 5-day time interval, prompt the patient to think about the most recent episode of pain and try to determine whether it occurred within the look-back period.
- **How pain is treated/pain management approaches are not specific to these items and should not impact how J0510-J0530 are assessed**

231

231

decisionhealth

J0510: Pain Effect on Sleep

- **Patient should NOT be offered pre-determined responses when determining best response to this or other pain items**
- If the patient's response does not lead to a clear answer, repeat the patient's response and then try to narrow the focus of the response**. For example, if the patient gives a "non-answer" or vague answer try to redirect the response to narrow down**
- The key difference between code 0, Does not apply and code 1, Rarely or not at all is that for code 0, the patient reports no pain/hurting in the past 5 days, and code 1, the patient reports pain/hurting HAS been present in the past 5 days, but has rarely or not at all impacted sleep.
- If the patient reports they had pain in the past 5 days and the pain does not interfere with the patient's sleep (e.g., because the patient is using pain management strategies successfully), code 1, Rarely or not at all.

232

232

decisionhealth

J0520: Pain Interference with Therapy Activities

- **Patient should NOT be offered pre-determined responses when determining best response to this or other pain items**

- Confirm first that the patient has been offered rehabilitation therapies during the reference timeframe.
  - **If no therapy has been offered/ordered in the past 5 days, then response 0 is most appropriate**
  - **Rehabilitation therapy – Special healthcare service or programs that help a person regain physical, mental and/or (thinking and learning) abilities that have been lost or impaired as a result of disease, injury or treatment. Can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.**

- Rehabilitation therapies may include treatment supervised in person by a therapist or nurse or other staff, or the patient/family/caregivers carrying out a prescribed therapy program without agency staff present.
  - ***PER CMS Q&As- Includes Maintenance therapies***

decisionhealth

J0530: Pain Interference with Day-to-Day Activities

- **Patient should NOT be offered pre-determined responses when determining best response to this or other pain items**

- EXCLUDES REHAB THERAPIES

- Day to Day activities that patient routinely performs would be included

EXAMPLE
Assessing clinician: "Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"
Patient: "Although I have some pain in my back, I'm still able to read, eat my meals, and take walks like I usually do."

J0530 =1, Rarely or not at all
The patient reports that pain has not limited participation in day-to-day activities.

decisionhealth

J1800: Any Falls Since SOC/ROC

J1800. Any Falls Since SOC/ROC, whichever is more recent	
Enter Code ☐	Has the patient **had any falls since SOC/ROC,** whichever is more recent? 0. **No** → *Skip to M1400, Short of Breath at DC; Skip to M2005, Medication Intervention at TRN and DAH* 1. **Yes** →Continue to J1900, Number of Falls Since SOC/ROC

- **Intercepted falls are considered a fall (*When a patient would have fallen but caught themselves or was caught by another person)**
- Include all falls since the most recent SOC/ROC, regardless of where the fall occurred.
- Report falls that occurred at any time during the quality episode, regardless of where the fall occurred. For example,
  - a fall that occurred at the doctor's office during the HH quality episode would be reported
  - a fall that occurred during a qualifying inpatient facility transfer (e.g., hospital or SNF) would not be reported as it did not occur within a HH quality episode
- Response to J1800 will determine J1900 response

235

235

decisionhealth

1900: Number of Falls since SOC/ROC

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

- ONLY answered if fall reported in J1800
- Injury related to fall- documented injury secondary to fall. Injury may have been reported at the time of the fall or within a period after the fall and ATTRIBUTED TO THE FALL (this must be documented as such)
- Injury (except major) – skin tears, abrasions, superficial bruising, hematomas, sprains, and fall related pain
- Major injury- fractures, dislocations, closed head injury with altered consciousness, subdural hematomas, etc.
- Determine the number of falls and injuries related to each (major and minor, no injury falls)

236

236

decisionhealth

1900: Number of Falls since SOC/ROC

- Agencies are encouraged to correct errors as accurate information regarding fall-related injuries becomes known. For example,
  - Injuries can present themselves later than the time of the fall.
  - The agency may not learn of the level of injury until after the OASIS assessment is completed (e.g., because the patient was transported to ER and admitted to an inpatient facility post-fall).
  - **Errors should be corrected following the agency's correction policy. *The M0090 date would not necessarily be changed***

EXAMPLE

A patient fell, lacerated their head, and was sent to the emergency room, where a head computerized tomography (CT) scan revealed a subdural hematoma. The patient received treatment and returned home after 2 days

J1900C Major Injury =1

Subdural hematoma is a major injury, and it occurred as a result of the fall.

237

237

decisionhealth

M1400: When is the patient dyspneic or noticeably Short of Breath?

VBP Improvement in Dyspnea ITEM

M1400. When is the patient dyspneic or noticeably **Short of Breath?**	
Enter Code ☐	0. **Patient is not short of breath** 1. **When walking more than 20 feet, climbing stairs** 2. **With moderate exertion** (for example, while dressing, using commode or bedpan, walking distances less than 20 feet) 3. **With minimal exertion** (for example, while eating, talking, or performing other ADLs) or with agitation 4. **At rest** (during day or night)

- If the patient uses oxygen continuously, code the response based on assessment of the patient's shortness of breath while using oxygen
- If the patient uses oxygen intermittently, code the response based on the patient's shortness of breath without the use of oxygen.
  - ***Responses are based on the patient's actual use of oxygen in the home, not on the physician's oxygen order***
- Chairfast patients can be assessed for dyspnea during ADLs and transfers

238

238

M1400 Chairfast/Bedfast SOB

decisionhealth

QUESTION

M1400. How should I best evaluate dyspnea for a chairfast (wheelchair-bound) patient? For a bedbound patient?

ANSWER

M1400 asks when the patient is noticeably short of breath. In the response options, examples of shortness of breath with varying levels of exertion are presented. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest. If the patient does not have shortness of breath with moderate exertion, then either Response 0 or Response 1 is appropriate. If the patient is not short of breath on the day of assessment, then Response 0 applies. If the patient only becomes short of breath when engaging in physically demanding transfer activities, then Response 1 seems most appropriate. In the case of the bedbound patient, the level of exertion that produces shortness of breath should also be assessed. The examples of exertion given for Responses 2, 3, and 4 also provide assessment examples. Response 0 would apply if the patient were never short of breath on the day of assessment. Response 1 would be most appropriate if demanding bed mobility activities produce dyspnea.

decisionhealth

SECTION K: SWALLOWING/NUTRITION STATUS

This section includes three items. Height and weight to calculate body mass, nutritional approaches and assessment of the ability to eat, chew and swallow food.

M1060
K520
M1870

M1060 Height and Weight

M1060. Height and Weight – While measuring, if the number is X.1-X.4 round down; X.5 or greater round up.	
☐☐ inches	A. **Height** (in inches). Record most recent height measure since the most recent SOC/ROC
☐☐☐ pounds	B. **Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

- Whenever possible, a current height and weight should be obtained by the agency as part of the SOC/ROC assessment.
- Record height to the nearest whole inch (round off)
  - May not report patient self reported height or height derived from another provider's documentation
- Record weight to the nearest whole pound (round off)
  - May not report patient self reported weight or weight derived from another provider's documentation
- A DASH must be reported if height or weight is outside of item parameters as follows:
  - Height parameters <50 in, >80in
  - Weight parameters <65lb, >440lb
- A DASH should be reported if ht/wt cannot be measured in time frame and agency staff has not obtained one in prior 3o days (sch as on a ROC OASIS)

241

241

M1060 height and weight

- When reporting height for a patient with bilateral lower extremity amputation, measure and record the patient's current height (i.e., height after bilateral amputation).
- When there is an unsuccessful attempt to measure a patient's height or weight, at SOC/ROC, an **agency obtained** height or weight from a documented home health visit conducted within the previous 30-day window may be used to complete this item.
  - ***May NOT use ht/wt obtained from another healthcare provider or patient stated height or weight***

242

242

decisionhealth

K0520 Nutritional Approaches

SOC/ROC	
K0520. Nutritional Approaches	
1. On Admission Check all of the nutritional approaches that apply on admission	1. On Admission Check all that apply ↓
A. **Parenteral/IV feeding**	☐
B. **Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐
C. **Mechanically altered diet** – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐
Z. **None of the above**	☐

243

243

decisionhealth

K0520 Nutritional Approaches

Discharge		
K0520. Nutritional Approaches		
4. **Last 7 days** Check all of the nutritional approaches that were received in the last 7 days 5. **At discharge** Check all of the nutritional approaches that were being received at discharge	4. Last 7 days ↓ Check all that apply ↓	5. At discharge
A. **Parenteral/IV feeding**	☐	☐
B. **Feeding tube** (e.g., nasogastric or abdominal (PEG))	☐	☐
C. **Mechanically altered diet** – require change in texture of food or liquids (e.g., pureed food, thickened liquids)	☐	☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)	☐	☐
Z. **None of the above**	☐	☐

244

244

decisionhealth

K0520 Nutritional Approaches

- **Parenteral/IV-** Nutrition provided by means other than the GI tract
- **Feeding tube-** Presence of any tube that can deliver food/nutrition directly to the gastrointestinal system
- **Mechanically altered diet-** Diet specifically prepared to alter the texture or consistency of foods (puree, ground meats, etc.)
- **Therapeutic diet-** Diet intervention prescribed by provider or authorized by a non physician practitioner by any route as part of disease process to modify micro/macro nutrients in diet.

245

245

decisionhealth

K0520 Nutritional Approaches

- **Guidance for SOC/ROC:**
  - May reference clinical record, patient interview/assessment, family/caregiver interview, collaboration with providers/clinicians
  - Check ALL that apply for the time period under consideration
  - Dash is allowed but should not be frequently used
- **Guidance for DC:**
  - Check ALL nutritional approaches that were in place within the last 7 days for column 1. Check only those in use at the time of assessment for column 2.

246

246

decisionhealth

K0520 Nutritional Approaches

- **DO NOT CONSIDER THE FOLLOWING AS PARENTERAL/IV NUTRITION:**
  - IV Flushes
  - Parenteral IV fluids administered in conjunction with chemotherapy or dialysis
  - IV fluids administered routinely with a diagnostic procedure/operative procedure
  - IV medications (these are reported in O0110H, IV medications)
  - IV fluids for reconstitution

- **DO NOT CONSIDER FEEDING TUBES NOT IN USE**
  - Enteral feeding (tube feed) should not be considered a mechanically altered diet
  - ONLY considered enteral feeding to ALSO be a therapeutic diet when the ordered type of enteral feeding is specifically for the treatment of a clinical condition such as diabetes (for example, Diabetisource via PEG)

247

247

decisionhealth

M1870 Feeding or Eating

VBP Change in Self Care ITEM

M1870. Feeding or Eating Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.	
Enter Code ☐	0. Able to independently feed self. 1. Able to feed self independently but requires: a. meal set-up; OR b. intermittent assistance or supervision from another person; OR c. a liquid, pureed, or ground meat diet. 2. Unable to feed self and must be assisted or supervised throughout the meal/snack. 3. Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. 4. Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. 5. Unable to take in nutrients orally or by tube feeding.

- Identifies patient ability to feed themself, including the process of eating, chewing, and swallowing food.
  - Specific to identify patient ability and safety not actual performance
- Code this item based on the assistance needed by the patient to feed themself once the food is placed in front of them. Assistance can include cueing, supervision or hands on assistance.
- Consider what the patient is able to do on the day of the assessment. If the patient's ability varies over the day of the assessment, respond to item to reflect what is true 50% or more of the time.
- if all nutrition is received intravenously (such as TPN) or for patients who are receiving only intravenous hydration, Response 5, Unable to take in nutrients orally or by tube feeding is most appropriate.

248

248

decisionhealth

M1870 Feeding or Eating

- If a patient is being weaned from tube feeding, response 3 or 4 will continue to apply until the patient no longer uses the tube for nutrition, at which time, response 0, 1, or 2. *This is true, even if the tube remains in place, unused for a period of time.*

249

249

decisionhealth

SECTION M: SKIN CONDITIONS

This section includes items that assess the presence of pressure ulcers, stasis ulcers and surgical wounds.

M1306
M1307
M1311
M1322
M1324
M1330
M1332
M1334
M1340
M1342

250

250

M1306 Unhealed Pressure Ulcer/Injury at Stage 2 or Higher

M1306. Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)	
Enter Code ☐	0. **No** → *Skip to M1322, Current Number of Stage 1 Pressure Injuries at SOC/ROC; Skip to M1324, Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable at DC* 1. **Yes**

- SOC, ROC, Follow up/Recert, DC
- **PRESSURE ULCER/INJURY DEFINED: Localized injury to the skin and/or soft tissue usually over a bony prominence, as a result of intense and/or prolonged pressure, or pressure in combination with shear and/or friction. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.**
- Identifies Risk for further complications (skin and otherwise) – Risk adjustment item
- Presence of pressure ulcers/injuries should be determined by observation and physical assessment of the skin as close to the initial assessment/SOC as possible (First Skin Assessment)
  - . Medical records, patient/caregiver report and physician input ***may be used for historical purposes only to identify the presence of an existing ulcer/injury or the stage of a previously healed pressure ulcer.***

251

251

M1306 Unhealed Pressure Ulcer/Injury at Stage 2 or Higher

- **Pressure ulcers may NOT be back staged:**
  - If an ulcer was previously staged at a higher stage than what is currently observed, as long as it remains stageable, continue to classify at the highest numerical stage
- **Use of the NPIAP staging guidelines**
  - These have been ADAPTED for OASIS purposes and do not perfectly align between OASIS and NPIAP described staging
  - Where discrepancies exist, clinicians should rely on OASIS instructions
- ONLY REPORT ULCERS/INJURIES WHERE PRESSURE IS THE CAUSE
  - Do not report wounds where pressure may have influenced healing, but is not the CAUSE of the injury.
    - For example, a patient has a laceration to the lower leg that was not sutured closed and has been treated with irrigation, packing, xeroform, a cover dressing, and kerlix/tape. The wound has been slow to heal because the patient consistently rests this area of his leg against the leg rest of his wheelchair, putting pressure on the area, despite instruction not to and pillows placed behind the area, which the patient removes. ***This wound is considered due to TRAUMA, with a confounding factor of pressure resulting in slow healing and would not be considered a pressure ulcer/injury.***

252

252

decisionhealth

M1306 Unhealed Pressure Ulcer/Injury at Stage 2 or Higher

- **Stage 1 pressure injuries and Deep Tissue Injury (DTI),** although closed (intact skin), would not be considered healed. Unstageable pressure ulcers/injuries, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.
- **Stage 2 (partial thickness) pressure ulcers** heal through the process of regeneration of the epidermis across a wound surface, known as "re-epithelialization."
  - When Stage 2 ulcers close, these are considered HEALED in full and if a new pressure ulcer/injury occurs in this area, this would be staged at the numeric stage it is observed to be as the prior stage 2 is resolved.
- **Stage 3 and 4 (full thickness) pressure ulcers** heal through a process of granulation (filling of the wound with connective/scar tissue), contraction (wound margins contract and pull together), and re-epithelialization (covers with epithelial tissue from within wound bed and/or from wound margins).
  - Once the pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial Stage 3 and 4 (full thickness) pressure ulcers heal through a process of granulation (filling of the wound with connective/scar tissue), contraction (wound margins contract and pull together), and re-epithelialization (covers with epithelial tissue from within wound bed and/or from wound margins). Once the pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered closed, and will continue to remodel and increase in tensile strength. ***For the purposes of scoring the OASIS, the wound is considered healed at this point, and should no longer be reported as an unhealed pressure ulcer.***

253

253

decisionhealth

M1306 Unhealed Pressure Ulcer/Injury at Stage 2 or Higher

QUESTION

If you have two Stage 4 pressure ulcers with intact skin in-between them and a tunnel that connects them underneath the wound surface, do you have one pressure ulcer or two?

ANSWER

If a patient develops two pressure ulcers that are separated by intact skin but have a tunnel which connects the two, they remain two pressure ulcers.

QUESTION

M1306. We are seeking direction regarding serum filled blisters that are caused by shoes rubbing against the foot. Some of our clinicians consider these "trauma wounds" and others consider them "stage 2 pressure ulcers". Please advise.

NSWER

If the cause of a wound ***is solely a friction force which leads to visible skin impairment, such as the serum filled blister cited in the scenario, it would NOT be categorized as a pressure ulcer.*** The 2009 International NPUAP-EPUAP Pressure Ulcer Prevention and Treatment Clinical Practice Guideline eliminated reference to friction as a primary factor in pressure ulcer development.

254

254

M1307: The Oldest Stage 2 Pressure Ulcer that is present at discharge

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

- Item is ONLY answered at the DISCHARGE OASIS time point
- **STAGE 2 PRESSURE ULCER: characterized by partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an open/ruptured serum filled blister.**

  *****NOT ALL SERUM FILLED BLISTERS = STAGE 2 PRESSURE*****
- Do not reverse stage back to stage 1 when covered with epithelium. When stage 2 is closed it is no longer reported and is considered "Healed". A new wound presenting in the area is new and is staged at the stage observed based on clinical presentation.
- An ulcer that is suspected of being a Stage 2, but is Unstageable due to non-removable dressing/device at the time of discharge, should not be identified as the "oldest Stage 2 pressure ulcer" (See M1311 for definition of Unstageable due to non-removable dressing/device).

255

255

M1307: The Oldest Stage 2 Pressure Ulcer that is present at discharge

- **Quality (OUTCOMES) item**
- **Report ALL stage 2 ulcers that are present at DC in this item**
  - If the oldest/only stage 2 remaining present was present at the last SOC/ROC (during this start of this quality episode), respond 1
  - If the oldest/only stage 2 remaining present developed since the last SOC/ROC (during this quality episode), respond 2 and add the date the ulcer was first identified
  - This includes if no ulcer was present at the start of the quality episode (SOC/ROC) and the ulcer began as a stage 1 and later developed into a stage 2
- **Dash is not valid for this item**

256

256

M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

decisionhealth

- **SOC/ROC & Discharge**

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

257

257

M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

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Discharge	
M1311. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number ☐	A1. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** – If 0 →*Skip to M1311B1, Stage 3*
Enter Number ☐	A2. **Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number ☐	B1. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** – If 0 →*Skip to M1311C1, Stage 4*
Enter Number ☐	B2. **Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number ☐	C1. **Stage 4:** Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** – If 0 →*Skip to M1311D1, Unstageable: Non-removable dressing/device*
Enter Number ☐	C2. **Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number ☐	D1. **Unstageable: Non-removable dressing/device**: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** – If 0 →*Skip to M1311E1, Unstageable: Slough and/or eschar*
Enter Number ☐	D2. **Number of <u>these</u> unstageable pressure ulcers/injuries that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number ☐	E1. **Unstageable: Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** – If 0 →*Skip to M1311F1, Unstageable: Deep tissue injury*
Enter Number ☐	E2. **Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC
Enter Number ☐	F1. **Unstageable: Deep tissue injury** **Number of unstageable pressure injuries presenting as deep tissue injury** – If 0 →*Skip to M1324, Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable*
Enter Number ☐	F2. **Number of <u>these</u> unstageable pressure injuries that were present at most recent SOC/ROC** – enter how many were noted at the time of most recent SOC/ROC

258

258

M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

- **Quality (OUTCOMES) item**
- **Identifies total number of ulcers stage 2 and above or unstageable at each stage present at SOC, ROC, DC**
  - At discharge, this item also identifies if each pressure ulcer/injury present on the discharge assessment was observed at the same stage at the time of the most recent SOC/ROC
- Pressure ulcers should not be back staged
- Because the numerical stage of pressure ulcers may increase or become unstageable, it is necessary to perform the first skin assessment on or as close to the SOC/ROC visit as possible and report all pressure ulcers based upon this assessment**. *However, when, the assessing clinician is unable to complete a skin assessment at the first visit, the assessing clinician may collaborate with a second clinician who completes the first clinical skin assessment, within the assessment timeframe.***

259

259

M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - DEFINITIONS

NON REMOVABLE DRESSING/DEVICE

Examples of a non removable dressing or device include a dressing that is not to be removed per physician's/allowed practitioner's order (such as those used in NPWT, an orthotic device, or a cast).

SLOUGH TISSUE

Non viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

ESCHAR TISSUE

Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab like. Necrotic tissue and eschar are firmly adherent to the base of the wound and often the sides/edges of the wound.

DEEP TISSUE INJURY

A purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue.

260

260

M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Staging

decisionhealth

UNSTAGEABLE ULCERS: Slough/Eschar E1/E2

- Pressure ulcers that have eschar or slough tissue present such that the anatomic depth of soft tissue damage cannot be visualized in the wound bed, should be classified as unstageable.
- If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized, numerically stage the ulcer, and do not code this as unstageable. Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only when enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.
- *Any numerically stageable pressure ulcer/injury observed at SOC/ROC that is unstageable due to slough and/or eschar at discharge, should be considered new, and not coded as "present at the most recent SOC/ROC" for M1311E2*

261

261

M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Staging

decisionhealth

UNSTAGEABLE ULCERS: Deep Tissue Injury F1

- Deep tissue injury may be difficult to detect in individuals with dark skin tones
- A pressure ulcer/injury presenting with characteristics of a DTI is reported as a DTI unless full thickness tissue loss is present. For example, a DTI presenting as purple localized discoloration with tenderness caused by pressure, but without full thickness tissue loss would be coded as a DTI, even though the wound is not completely intact.

Example:

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

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

262

262

M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Guidance

decisionhealth

Pressure Ulcers treated with Flaps/Grafts

- Any type of flap procedure performed to surgically replace a pressure ulcer is reported as a surgical wound, until healed. It should not be reported as a pressure ulcer/injury on M1311.
- A pressure ulcer treated with any type of graft is no longer reported as a pressure ulcer/injury, and until healed, should be reported as a surgical wound on M1340.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer and should not be reported as a surgical wound on M1340

Pressure Ulcers under a non removable dressing/device

- If an unknown pressure ulcer/injury is discovered upon removal of a non-removable dressing/device, that pressure ulcer/injury should be considered new, and not be coded as "present at the most recent SOC/ROC" for M1311X2 at discharge.
- If a pressure ulcer/injury that is stageable at SOC is unstageable due to a non-removable dressing/device at discharge, it would be considered "present at the most recent SOC/ROC" if it had not 1) increased in numerical stage, or 2) become unstageable due to slough/eschar when the non-removable dressing/device was applied. This is because even though the stage of the pressure ulcer/injury is unknown at discharge, there is no documentation or indication that it increased in numerical stage or worsened during the stay.

263

263

M1311: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Guidance

decisionhealth

Deep Tissue Injuries

- A deep tissue injury with intact skin at SOC/ROC, that becomes stageable, is considered "present at the most recent SOC/ROC" at the stage at which it first becomes numerically stageable
- If a DTI that was observed at SOC/ROC does not evolve to be numerically stageable, but is subsequently classified as another type of unstageable pressure ulcer/injury, it would be considered and coded as "present at the most recent SOC/ROC" on the discharge assessment in that unstageable pressure ulcer/injury category (M1311X1=1 and M1311X2=1)

Unstageable Ulcers

- If the pressure ulcer/injury was unstageable at SOC/ROC, but becomes numerically stageable later, when completing the Discharge assessment, its "Present at the most recent SOC/ROC" stage should be considered the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, do not report the higher stage ulcer as being "present at the most recent SOC/ROC" when completing the Discharge assessment
- Any numerically stageable pressure ulcer/injury observed at SOC/ROC that is unstageable due to slough and/or eschar at discharge, should be considered new, and not coded as "present at the most recent SOC/ROC" for M1311E2 at discharge.

264

264

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M1311 Healed Full Thickness Ulcers

QUESTION

If a patient has an unstageable pressure ulcer due to black stable eschar at SOC and during the episode it peels off and leaves an area of newly epithelialized tissue, how should this be staged at Discharge on M1311?

ANSWER

Once the full thickness pressure ulcer is completely covered with new epithelial tissue, the wound is considered healed and no longer reportable as a pressure ulcer on the OASIS.

decisionhealth

M1306-M1324 Full Thickness Ulcers closed with a flap

QUESTION

If a Stage 3 pressure ulcer is closed with a muscle flap, what is recorded? What if the muscle flap begins to break down due to pressure?

ANSWER

If a pressure ulcer is closed with a muscle flap (defined as full thickness skin and subcutaneous tissue partially attached to the body by a narrow strip of tissue so that it retains its blood supply), the new tissue completely replaces the pressure ulcer. In this scenario, the pressure ulcer "goes away" and is replaced by a surgical wound. If the muscle flap healed completely, but then began to break down due to pressure, it would be considered a new pressure ulcer. If the flap had never healed completely, it would be considered a non-healing surgical wound.

decisionhealth

M1306-M1324 Mucosal Membrane Ulcers

QUESTION

M1306, M1311, M1322 & M1324. How are mucosal membrane pressure ulcers reported in the OASIS data set?

ANSWER

OASIS data set integumentary items only include wounds and lesions to the integumentary system and do not include mucosal membrane wounds or lesions. Pressure ulcers occurring to mucosal membranes would be reported in the comprehensive assessment and clinical documentation but not in any of the following OASIS M items - M1306, M1311, M1322, or M1324.

decisionhealth

M1311 Closed stage 4 ulcer reopens

QUESTION

My patient had a closed Stage 4 pressure ulcer at SOC. Two weeks later, it appeared to be a shallow open ulcer. Can I report it as a Stage 2 or do I have to say it is an Unstageable Stage 4 because I can't visualize bone, muscle or tendon?

ANSWER

A previously closed Stage 3 or Stage 4 pressure ulcer that opens again should be reported at its worst stage. As long as the wound bed is free of slough and eschar, it may be reported as a Stage 4. If slough or eschar is present that the clinician believes may be obscuring the visualization of Stage 4 structures (bone, muscle, tendon or joint capsule) in the wound bed, it may not be staged and is reported in M1311 as E1: Known but not stageable due to coverage of wound bed by slough and/or eschar.

decisionhealth

M1311 Stage 4 with Osteomyelitis

QUESTION

M1311. Is a pressure ulcer automatically a Stage 4 if osteomyelitis is present, despite what type of breakdown there might be (for example only superficial skin loss)?

ANSWER

A previously closed Stage 3 or Stage 4 pressure ulcer that opens again should be reported at The presence of osteomyelitis is not a characteristic used to stage a pressure ulcer/injury and does not automatically result in a Stage 4 ulcer. The pressure ulcer/injury stage should correspond to the clinician's visual assessment or ability to directly palpate on the day of assessment. The definitions for staging the pressure ulcer are available in Chapter 3 of the OASIS Guidance Manual.

269

269

decisionhealth

M1322: Current Number of Stage 1 Pressure Injuries

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

- **STAGE 1 PRESSURE INJURY: An observable, pressure-related alteration of intact skin whose indicators, as compared with an adjacent or opposite area on the body, may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin. In darker skin tones, the injury may appear with persistent red, blue or purple hues.**
- Identification of stage 1 pressure injuries and early treatment is critical to intervention and prevention of skin breakdown and identification of risk factors for pressure
- Stage 1 pressure injuries are characterized by closed intact skin, but are not considered healed until nonblanchable redness has resolved.

270

270

M1324: Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable

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

"MOST PROBLEMATIC": May be the largest, most advanced stage, most difficult to access for treatment, most difficult to treat/relieve pressure to area, may be infected, depending on patient's unique situation. Each situation should be evaluated individually to consider which ulcer is most problematic.

- If only one ulcer is present, that is the most problematic
- If only ulcer present is unstageable, then NA is the best response
- If patient has multiple ulcers and some are stageable and some are not, respond based upon the most problematic STAGEABLE ULCER

271

271

M1324: Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable

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- **Pressure Ulcers cannot be back staged**
  - If, at the last OASIS, ulcer was stage 4 and now is granulating and no visible muscle or bone structure, continue to report as stage 4

QUESTION: M1324: Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable

ANSWER: If you have a Stage 3 that is in the process of closing, it remains an observable Stage 3 unless the wound bed was covered with a dressing that could not be removed or the wound bed was obscured with slough/eschar. If the wound margins are open and have now closed to the point where the opening is a pinpoint, the pressure ulcer would remain a Stage 3 until completely re-epithelialized at which time it would no longer be reported as a pressure ulcer on OASIS.

272

272

decisionhealth

Pressure ulcer Scenario

A 76-year-old man was recently admitted to home health after undergoing surgery to treat a stage 4 pressure ulcer on his left heel with a skin graft. The surgical wound has not yet begun to epithelialize. He has depression and severe chronic obstructive bronchitis, for which he requires supplemental oxygen. The donor skin site is still healing and will receive care as well. It has just started to epithelialize.

OASIS M1306: Response 0, No – Pressure ulcers covered with/treated with a skin graft or flap graft are no longer reported as pressure ulcers and are reported as a surgical wound for OASIS purposes

OASIS M1340: Response 1, Yes

OASIS M1342: Response 3 Not healing - the wound hasn't yet started to re-epithelialize.

OASIS item M1342 is answered in regards to the grafted pressure ulcer, as it is the most problematic surgical wound. The skin donor site has begun to re-epithelialize and thus is not the most problematic surgical wound for this patient.

**NOTE: *Though a pressure ulcer treated with a skin graft becomes a surgical wound for the purposes of the OASIS assessment, it's still coded as a pressure ulcer. Because it's unstageable due to the skin graft covering the wound, it's coded as unstageable, according to coding guidelines. The plan of care will still report a pressure ulcer (unstageable).*

273

273

decisionhealth

M1330: Does this patient have a Stasis Ulcer?

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

Stasis Ulcers may be caused by stasis dermatitis or other forms of impaired venous circulation

- Item does NOT include arterial lesions or other ulcers resulting from non venous forms of PVD (arterial disease). Does not include diabetic ulcers
- Report stasis ulcers that are not observable due to a dressing or device. These ulcers can be identified as present by information obtained in physician records/documentation or known presence of the ulcer from prior records
- A stasis ulcer that has fully epithelialized is considered healed and should not be reported as a current stasis ulcer
- If the patient currently has BOTH observable and unobservable stasis ulcers, response 1 should be selected

274

274

decisionhealth

M1330 Does patient have a stasis ulcer? – Originally trauma

QUESTION: M1330. Our patient's lower extremity wound originated as a trauma wound due to a fall. The patient also has diagnoses of venous insufficiency and stasis dermatitis. The physician stated the wound is not healing due to the venous insufficiency. Is there a point in time when the wound is no longer classified as a traumatic wound and considered a stasis ulcer for M1330?

ANSWER: M1330, Does this patient have a Stasis Ulcer, identifies patients with ulcers caused by inadequate circulation in the area affected. The healing process of other types of wounds, e.g. traumatic wounds, surgical wounds, burns, etc., may be impacted by the venous insufficiency, but it would not change the traumatic or surgical wound into a venous stasis ulcer.

275

275

decisionhealth

M1330 Does patient have a stasis ulcer? – Mixed Ulcers

QUESTION: How do we answer the OASIS stasis ulcer questions when the patient diagnoses include Peripheral Arterial Disease and Venous Stasis Insufficiency? The nurse spoke with the physician who stated the patient had "mixed arterial and venous disease."

ANSWER: In a situation where the clinician visually assessed ulcers on the lower legs that the physician diagnosed as a mixture of venous stasis and arterial ulcers, the OASIS stasis ulcer items would be answered as follows: (Utilization of the WOCN's "Venous, Arterial, and Neuropathic LE Wounds: Clinical Resource Guide" located at www.wocn.org may be helpful when distinguishing the ulcers that have a venous disease etiology versus the arterial disease.) M1330, Does this patient have a Stasis Ulcer = Yes. M1332, Current Number of Stasis Ulcer(s) that are Observable would be answered reflecting only those ulcers that were a result of venous insufficiency, not arterial. Utilize WOCN's Clinical Resource Guide to help distinguish venous from arterial. M1334, Status of Most Problematic Stasis Ulcer that is Observable would be based on the one observable ulcer resulting from venous insufficiency that is the most problematic.

276

276

decisionhealth

M1330 Does patient have a stasis ulcer? – Mixed Ulcers

QUESTION: M1330. Cat 4b Q100.1 states that a patient with Peripheral Arterial Disease and Venous Stasis Insufficiency could have mixed arterial and venous stasis ulcers, which would be reported on M1330 – Stasis Ulcers. For a patient with an ulcer who has mixed arterial and venous disease, should M1330 always be "yes", that the patient has a Stasis Ulcer?

ANSWER: No. In a situation where the patient has a mixture of venous stasis and arterial disease, the wound appearance and characteristics will often help the physician determine if the ulcer is venous, arterial, or mixed. If the wound is determined to be a venous stasis ulcer, or a mixed arterial and venous ulcer, the assessing clinician would document the wound in M1330. If the wound is determined to be arterial, it would not be documented in M1330 and may be documented in the clinical record.

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M1332 Current Number of Stasis Ulcer(s) that are observable

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

Report all stasis ulcers that are OBSERVABLE only for this item.

- Do NOT include epithelialized Stasis Ulcers
- Do NOT include stasis ulcers covered with a dressing/device, such as a cast or Unna boot
- Do NOT include ulcers due to arterial disease, including diabetic ulcers

decisionhealth

M1332 Current Number of Stasis Ulcer(s) that are observable – one ulcer vs. two

QUESTION: M1332. My patient has a venous stasis wound of the lower extremity that covers the entire lower leg, but in the midst of the wound there are two dark areas. Do we count this as one ulcer or two?

ANSWER: If areas of venous stasis ulceration are contiguous and developed at the same time, the entire area would be counted as one stasis ulcer. If the patient had a venous stasis ulcer and then later developed another venous stasis ulcer, and eventually the wound margins met, it

decisionhealth

M1334: Status of Most Problematic Stasis Ulcer that is Observable

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

MOST PROBLEMATIC MAY BE DEFINED BY:

- **Size**
- **Healing status**
- **Potential infection or treatment resistance**
- **Location including factors such as difficult access for treatment**

- Stasis ulcers heal by granulation, then epithelialization. Once fully epithelialized and without symptoms of infection, the ulcer is considered healed and no longer reported

decisionhealth

M1334: Status of Most Problematic Stasis Ulcer that is Observable

- **Fully Granulating (response 1) when wound bed:**
  - **is filled with granulation tissue to the level of the surrounding skin or new epithelium**;
  - has no dead space;
  - has no avascular tissue;
  - has no signs or symptoms of infection; and,
  - has open wound edges.
- **Early/Partial Granulation (response 2) when wound bed:**
  - ≥ 25% of the wound bed is covered with granulation tissue;
  - there is minimal avascular tissue (that is, <25% of the wound bed is covered with avascular tissue);
  - may have dead space;
  - has no signs or symptoms of infection; and,
  - has open wound edges.

281

281

decisionhealth

M1334: Status of Most Problematic Stasis Ulcer that is Observable

- **Not Healing (response 3) when wound bed:**
  - >/_25% of the wound bed is avascular tissue – AND/OR
  - **signs/symptoms of infection are present** – AND/OR
  - the wound bed is clean but non-granulating – AND/OR
  - the wound edges are closed/hyperkeratotic – AND/OR
  - there is persistent failure to improve despite appropriate comprehensive wound management.
- **DASH is not allowed for this item**

282

282

decisionhealth

M1340: Does this patient have a Surgical Wound?

M1340. Does this patient have a **Surgical Wound?**	
Enter Code ☐	0. **No** → *Skip to N0415, High-Risk Drug Classes: Use and Indication* 1. **Yes, patient has at least one observable surgical wound** 2. **Surgical wound known but not observable due to non-removable dressing/device** → *Skip to N0415, High-Risk Drug Classes: Use and Indication*

Includes wounds resulting from a surgical procedure

- Wound debridement ("I&D") is not considered a surgical procedure
- *For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection.* After 30 days, it is generally described as a scar and should not be included in this item.
- Any skin assessment during the allowed assessment time frame may be used for response to M1340

283

283

decisionhealth

M1340: Does this patient have a Surgical Wound?

- Incision lines are considered surgical wounds, but the sites from staples and sutures placed to incisions are not surgical wounds
- Old scars or keloids related to prior surgical wounds are NOT included in M1340
- Pressure ulcers surgically closed with a flap or graft ARE reported as surgical and no longer reportable as pressure ulcers on OASIS
- Bowel ostomies are NOT considered surgical wounds except when reversal is done by a take down procedure. In these cases, a surgical wound is created.

284

284

decisionhealth

M1340: Does this patient have a Surgical Wound?

- Incision lines are considered surgical wounds, but the sites from staples and sutures placed to incisions are not surgical wounds
- Old scars or keloids related to prior surgical wounds are NOT included in M1340
- Pressure ulcers surgically closed with a flap or graft ARE reported as surgical and no longer reportable as pressure ulcers on OASIS
- Bowel ostomies are NOT considered surgical wounds except when reversal is done by a take down procedure. In these cases, a surgical wound is created.
  - All other ostomies (cystostomy, urostomy, etc.) are also excluded

285

285

decisionhealth

M1340: Does this patient have a Surgical Wound?

- The following ARE considered surgical wounds (*not exhaustive list):
  - Orthopedic pin sites,
  - Central line sites (centrally inserted venous catheters),
  - Wounds with drains,
  - Medi-port sites and other implanted infusion devices, or
  - Venous access devices
  - VANTAS© Implant (for prostate cancer treatment)
  - Dialysis access (AV graft/fistula, peritoneal, central line)
  - Excision
  - I&D in which a drain was placed
  - Cardiac cath via cut down
  - Shave, punch or excisional biopsy
  - Arthrocentesis site
  - LVAD Cannula exit site
  - On-Q catheter insertion sites if inserted into sites outside the surgical incision
  - Incision site for creation/insertion of VP shunt ONLY for 30 days post insertion of the shunt

286

286

decisionhealth

M1340: Does this patient have a Surgical Wound?

- Do NOT include (*not exhaustive list):
  - PICC lines
  - Any surgery to mucous membranes (cataract surgery, oral surgery, surgery via vaginal approach)
  - Non-implanted infusion devices
  - Ostomy site allowed to close on its own
  - Debridement of any wound
  - Cardiac cath via puncture
  - Lesion resulting from cryosurgery
  - Callous removal
  - Chest tube exit site (thoracostomy), including PleurX drain site being used to drain pleural fluid
  - Enterocutaneous or any other fistula even when present as a complication of a surgical wound site
  - Retention suture/button sites
  - On-Q catheter insertion sites if inserted into the surgical incision
  - Toenail removal
  - Mammosite implanted radiation (after insertion site incision healed)
  - Pressure ulcers closed by sutures

decisionhealth

M1340: Surgical wound with drain

QUESTION:

M1340. I understand that a simple I&D of an abscess is not a surgical wound. Does it make a difference if a drain is inserted after the I&D? Is it a surgical wound if the abscess is removed?

ANSWER

For purposes of scoring the OASIS integumentary items, a typical incision and drainage procedure does not result in a surgical wound. ***The procedure would be reported as a surgical wound if a drain was placed following the procedure. Also, if the abscess was surgically excised, the abscess no longer exists and the patient would have a surgical wound.*** It is considered a surgical wound until re-epithelialization has been present for approximately 30 days at which time it becomes a scar.

decisionhealth

M1340: Surgical wound with drain

QUESTION:

An I&D is not considered a surgery - but a drain inserted during this procedure makes the wound a surgical wound. Dilemma: This makes the OASIS answer for surgical wound a yes but we cannot code aftercare because we don't code the I&D as a surgery - but we do have surgical wound care. This is quite confusing.

ANSWER

The OASIS M0 item response will not always mirror diagnoses and ICD-10 codes found in M1021 and M1023. Continue to score the OASIS following current CMS guidance, and follow ICD-10 CM coding guidance for code selection for M1021 and M1023.

289

289

decisionhealth

M1340: Surgical wound with drain

QUESTION:

M1340. A patient, who has a paracentesis, has a stab wound to access the abdominal fluid. Is this a surgical wound?

ANSWER

When a surgical procedure creates a wound in which a drain is placed (e.g., an incision or stab wound), the presence of the drain (or drain wound site until re-epithelialization has been present for approximately 30 days at which time it becomes a scar) should be reported as a surgical wound. If a needle was inserted to aspirate abdominal fluid and then removed (no drain left in place), it should not be reported as a surgical wound.

290

290

decisionhealth

M1340: Surgical wound with drain

QUESTION:

M1340. A patient, who has a paracentesis, has a stab wound to access the abdominal fluid. Is this a surgical wound?

ANSWER

When a surgical procedure creates a wound in which a drain is placed (e.g., an incision or stab wound), the presence of the drain (or drain wound site until re-epithelialization has been present for approximately 30 days at which time it becomes a scar) should be reported as a surgical wound. If a needle was inserted to aspirate abdominal fluid and then removed (no drain left in place), it should not be reported as a surgical wound.

decisionhealth

M1340: Reporting surgical wounds & Epithelialization

QUESTION:

M1340 & M1342. Guidance states that a surgical wound becomes "healed" or no longer reportable as a surgical wound on M1340 once re-epithelialization has been present for approximately 30 days. Determining a specific timeframe in regards to complete epithelialization presents some issues. For instance, if we get a post-surgery patient who has been in the nursing home and then to home health, we may not know when complete epithelialization occurs. Please provide further clarification.

decisionhealth

M1340: Reporting surgical wounds & Epithelialization

ANSWER

If, at the SOC or other assessment time points, the clinician assesses the wound to be completely epithelialized (including no sign of infection or separation), and the date of complete epithelialization is unknown, the ***clinician will have to make a determination regarding the wound status based on the history of the date of surgery, any reported wound healing progress/complications and clinical assessment findings. Since for the purposes of the OASIS, a surgical wound is considered healed and no longer counted as a current surgical wound once re-epithelialization has been present for approximately 30 days (assuming no sign of infection or separation), then if based on the surgery date, it is clear that the completely epithelialized wound could not possibly have been fully epithelialized for at least 30 days,*** Response 0-Newly epithelialized should be reported. If the wound appears completely epithelialized (no sign of infection or separation) and the date of epithelialization is unknown, but based on the known wound history and date of surgery it is possible that the wound could have been fully epithelialized for at least 30 days, then the wound status is deemed “healed” and no longer reportable as a surgical wound

293

293

decisionhealth

M1340: Mediport

QUESTION:

Is a mediport "nonobservable" because it is under the skin?

ANSWER

Please refer to the definition of “not observable” used in the OASIS surgical wound items in the current OASIS Guidance Manual – “not observable” is an **appropriate response ONLY when a non-removable dressing is present**. This is not the case with a mediport. As long as the mediport is present, whether it is being accessed or not, the patient is considered as having a current surgical wound.

294

294

decisionhealth

M1342: Status of Most Problematic Surgical Wound that is Observable

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

MOST PROBLEMATIC MAY BE DEFINED BY:

- **Size**
- **Healing status**
- **Potential infection or treatment resistance**
- **Location including factors such as difficult access for treatment**

- If only one surgical wound is present, that wound will be considered most problematic

295

295

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M1342: Status of Most Problematic Surgical Wound that is Observable

Primary vs. Secondary intention healing

- **Primary Intention healing –** well approximated incision line, no dehiscence
  - Excludes presence of scabbing
  - Incisions healing by primary intention do not granulate as there is no exposed subcutaneous tissue
  - Primary intention wounds heal by epithelialization and should be observed for this
    - Epithelialization is characterized by “epithelial resurfacing” meaning the opening created during the surgery is covered by epithelial cells
    - Unless interrupted this begins within hours to 3 days of post op

- Secondary Intention healing – all or part of the incision is open/not approximated
  - May be due to dehiscence, interruption of the incision, or intentional secondary healing

296

296

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M1342: Status of Most Problematic Surgical Wound that is Observable

Primary vs. Secondary intention healing

- **Primary Intention healing –**
  - Only appropriate responses are 0 – Newly epithelialized OR 3 – Not healing
  - A surgical incision is not automatically coded Response 3 – "Not healing" solely due to the presence of staples
  - If there is not full re-epithelialization, such as in the case of a scab adhering to underlying tissue, the correct response is Response 3 – "Not healing"
  - If infection is present, the correct response is Response 3 – "Not healing"
- **Secondary Intention healing – all or part of the incision is open/not approximated**
  - Dehisced and open incisions heal by secondary intention
  - All responses to M1342 may be appropriate as wounds healing in this manner are healing by granulation

297

297

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M1342: Status of Most Problematic Surgical Wound that is Observable

Newly Epithelialized, Response 0

- the wound bed is completely covered with new epithelium;
- no exudate;
- no avascular tissue (eschar and/or slough);
- no signs or symptoms of infection.
- the incision site of an implanted venous access device or infusion device is healed and without signs and symptoms of infection.

Fully Granulating, Response 1

- the wound bed is filled with granulation tissue to the level of the surrounding skin and
- has no dead space,
- has no avascular tissue;
- has no signs or symptoms of infection;
- has open wound edges

298

298

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M1342: Status of Most Problematic Surgical Wound that is Observable

Early/Partial Granulation, Response 2

- ≥25% of the wound bed is covered with granulation tissue;
- < 25% of the wound bed is covered with avascular tissue,
- may have dead space; and
- wound bed has no signs or symptoms of infection;
- wound has open edges.

Not Healing, Response 3

- The wound bed has ≥25% avascular tissue – AND/OR
- signs/symptoms of infection – AND/OR
- the wound bed is clean but non-granulating – AND/OR
- wound edges are closed/hyperkeratotic – AND/OR
- persistent failure to improve despite appropriate comprehensive wound management.

299

299

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M1342: Status of Most Problematic Surgical Wound that is Observable

QUESTION

M1342. What standards are used to assess cemented surgical wounds when answering OASIS item M1342 Healing status**?**

ANSWERED

M1342: When assessing a surgical incision that has been cemented rather than sutured, follow the same guidance found in Chapter 3 of the OASIS Guidance Manual, M1342 Status of most problematic surgical wound. 1. If the wound can be visualized, it is observable. Only surgical wounds that have a dressing that cannot be removed by physician order and obscures visualization of the incision are considered non-observable. 2. For the purposes of determining the healing status, a surgical wound can be considered fully healed and not reportable as a current surgical wound approximately 30 days after complete epithelialization. The incision must be clean, dry and completely closed with no signs or symptoms of infection. 3. The Status of Most Problematic Surgical Wound that is Observable (M1342) is determined by assessment of the skilled clinician following the definitions developed by the WOCN in Chapter 3 of the OASIS Guidance Manual, M1342 Status of most problematic surgical wound.

300

300

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M1342: Status of Most Problematic Surgical Wound that is Observable

QUESTION

In reference to M1342, Status of Most Problematic Surgical Wound that is Observable, for surgical incisions healing by primary intention is it true that the only correct responses are “0-newly epithelialized” and “3-Not healing” as there are no open wound beds with granulation tissue?

ANSWERED

Surgical incisions healing by primary intention do not granulate. Because of this the only response that could be appropriate for a surgical wound healing by primary intention would be 0-Newly epithelialized or 3-Not healing. “Newly epithelialized” should be chosen if the surgical incision has epidermal resurfacing across the entire wound surface, and no signs/symptoms of infection exist.

decisionhealth

M1342: Status of Most Problematic Surgical Wound that is Observable

QUESTION

M1342. How do I mark the healing status of a Q-port that has needle access always in place? Would it be “non-healing?

ANSWERED

The assessing clinician must determine the healing status of a wound following guidance in Chapter 3 of the current OASIS Guidance Manual and the latest version of the WOCN’s OASIS Guidance Document. Some sites, because they are being held open by a line or needle, cannot fully granulate and may remain "non-healing" while the line or needle is in place.

decisionhealth

M1342: Status of Most Problematic Surgical Wound that is Observable

QUESTION

.M1342. If a patient is receiving antibiotics for a surgical site infection, but at the time of assessment, the patient no longer exhibits any signs or symptoms of infection, would the surgical wound be considered "not healing"? In other words, is treatment for an infection, in the absence of current symptoms of infection, considered a sign/symptom of infection?

ANSWERED

M1342 is reporting healing status based on the clinician's assessment of the patient and visualization of the wound. Since the patient could be at the point in the course of the antibiotic regimen where the infection has resolved, ongoing treatment for an infection should not be the sole basis for selecting 3 - Not healing, unless signs and symptoms of infection are currently present.

303

303

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M1342: SCENARIO- Condition of Primary intention incision

Scenario

A 68-year-old woman is admitted to home health for therapy only following surgery to replace her left hip due to localized osteoarthritis. She also has diabetes and hypertension. Her surgical wound, which is healing by primary intention has multiple small areas of scabbing and a few areas of separation (no significant depth, but 0.2 inch separation with clear drainage) and 2 areas with 0.3 x 0.4 in scabbing, but no symptoms of infection. There is no indication in her chart that the wound has been diagnosed as non-healing or complicated. Calls to the physician's office are unreturned.

M1340: Response 1, Yes

M1342= 3, Non-Healing At the time of the OASIS assessment, the patient's wound is marked as non-healing due to presence of scabbing and failure to be fully epithelialized. However, there is no documentation of the wound being infected or otherwise complicated, and the physician could not be reached for clarification.

304

304

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REPORTING OTHER ULCERS AND SKIN ISSUES ON OASIS

PATIENTS MAY HAVE A NUMBER OF OTHER SKIN LESIONS REQUIRING SKILLED CARE:

- Diabetic ulcers
- Ostomies
  - BOWEL ostomies only are reportable in M1630
- Trauma wounds, Superficial injuries, Contusions/Hematomas
- Fungating (cancerous) wounds/lesions
- Non-pressure ulcers not related to stasis
  - Arterial ulcers due to non diabetic atherosclerosis
- Frostbite lesions
- Rashes
- Burns

305

305

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REPORTING OTHER ULCERS AND SKIN ISSUES ON OASIS

PATIENTS MAY HAVE A NUMBER OF OTHER SKIN LESIONS REQUIRING SKILLED CARE:

- Report BOWEL ostomies in M1630
- Wounds not related to Pressure, Stasis, or Surgical wounds :
  - Should be documented in the clinical record
  - Assessment requirements are same as all other wounds
  - Continue to require orders for all wound care
  - Requirements for comprehensive assessment remain unchanged
    - Full skin assessment should still be completed and documentation including measurements, wound bed and surrounding tissue documented
    - Documentation of wound care should be documented including patient response, who will be responsible for wound care, if education is required, etc.
  - *Remember than mucosal membrane pressure ulcers/injuries are NOT included in M1306-M1324

306

306

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SECTION N: MEDICATIONS

The intent of the items in this section is to record whether:

- **the patient is taking any medications in high-risk drug classes, there is an indication noted and the patient/caregiver have been educated about the high-risk medications**
- **a drug regimen review was conducted**
- **the patient can manage oral and injectable medications.**

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N0415 High Risk Drug Classes: Use and Indications

N0415 High Risk Drug Classes: Use and Indications

SOC/ROC and Discharge		
N0415. High-Risk Drug Classes: Use and Indication		
1. **Is taking** Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes 2. **Indication noted** If Column 1 is checked, check if there is an indication noted for all medications in the drug class	**1. Is Taking** ↓ Check all that apply ↓	**2. Indication Noted**
A. **Antipsychotic**	☐	☐
E. **Anticoagulant**	☐	☐
F. **Antibiotic**	☐	☐
H. **Opioid**	☐	☐
I. **Antiplatelet**	☐	☐
J. **Hypoglycemic** (including insulin)	☐	☐
Z. **None of the Above**	☐	

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N0415 High Risk Drug Classes: Use and Indications

- First identify what medications the patient is taking and what classes these medications fall into.
  - It is CRITICAL that clinicians understand proper drug classifications and not misclassify drugs for this reason.
- All medications that patient is taking MUST have indication identified on the medication profile (not just those that are "as needed")
  - This is confirmed by column 2
  - Column 2 ONLY completed if Column 1 identifies a high risk medication
- ***Includes medications that are ordered as part of medication regime even if patient does not take on the day of assessment***

309

309

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M2001 Drug Regimen Review

M2001. Drug Regimen Review Did a complete drug regimen review identify potential clinically significant medication issues?	
Enter Code ☐	0. **No – No issues found during review** → *Skip to M2010, Patient/Caregiver High-Risk Drug Education* 1. **Yes – Issues found during review** 9. **NA – Patient is not taking any medications** → *Skip to O0110, Special Treatments, Procedures, and Programs*

- Drug regimen review in post acute care includes medication reconciliation, a review of all medications the patient is taking/all meds the patient is using and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.
- Potential and actual patient medication adverse consequences and errors are prevalent among post-acute care (PAC) settings and often occur during transitions in care.
- The drug regimen review includes all medications, prescribed and over the counter (OTC) including nutritional supplements, vitamins and homeopathic and herbal products, administered by any route (for example, oral, topical, sublingual and by infusion). The drug regimen review also includes total parenteral nutrition (TPN) and oxygen.

310

310

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M2001 Drug Regimen Review

- Potential or actual clinically significant medication issues may include, but are not limited to, the following:
  - adverse reactions to medications (such as a rash)
  - ineffective drug therapy (such as analgesic that does not reduce pain)
  - side effects (such as potential bleeding from an anticoagulant)
  - drug interactions (such as serious drug-drug, drug-food and drug-disease interactions)
  - duplicate therapy (such as generic name and brand name equivalent drugs are both prescribed)
  - omissions (such as missing drugs from a prescribed regimen)
  - dosage errors (either too high or too low)
  - nonadherence (purposeful or accidental)
- Any of the circumstances listed above must reach a level of clinical significance that in the clinician's professional judgment warrants notification of the physician/allowed practitioner (or physician-designee) for orders or recommendations by midnight of the next calendar day, at the latest.

311

311

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M2001 Drug Regimen Review

- The drug regimen review is part of the comprehensive patient assessment. The comprehensive patient assessment is the responsibility of and must ultimately be completed by one clinician, but collaboration is allowed. Agency policy and practice will determine this process and how it is documented Any of the circumstances listed above must reach a level of clinical significance that in the clinician's professional judgment warrants notification of the physician/allowed practitioner (or physician-designee) for orders or recommendations by midnight of the next calendar day, at the latest.
- If portions of the drug regimen review (for example, identification of potential drug-drug interactions or potential dosage errors) are completed by agency staff other than the clinician responsible for completing the SOC/ROC OASIS, information on drug regimen review findings must be communicated to the assessing clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2001 may be entered.
  - Collaboration is allowed but documentation between collaborating clinicians is expected.

312

312

M2003: Medication Follow-up

decisionhealth

M2003. Medication Follow-up Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?	
Enter Code ☐	0. No 1. Yes

- Identifies if actual or potential medication issues were communicated and recommended/prescribed actions (if any ordered) were carried out by midnight of the next calendar day
  - Timely communication ("Next calendar day")
- Determine whether the following criteria were met for all potential and actual clinically significant medication issues that were identified during the SOC/ROC drug regimen review;
  - Two-way communication between the agency and the physician/allowed practitioner (or physician designee) was completed by midnight of the next calendar day; AND
  - All physician/allowed practitioner (or physician-designee) prescribed/recommended actions were completed to the extent possible by midnight of the next calendar day
  - If physician does not respond to resolve issue or resolution is not carried out due to availability (for example, due to weekend/on call coverage, etc.), then recommended actions not completed.

313

313

M2001/M2003 – Clinically significant medication issues

decisionhealth

QUESTION

M2001 & M2003. The assessing clinician identifies a problem with medications. The patient has not picked up a prescription because she was not sure she absolutely needed it. If the assessing clinician's education results in the resolution of the situation prior to the completion of the comprehensive assessment, can the clinician indicate on M2001 that there is no clinically significant problem, eliminating the need to address it in M2003 Medication Follow-up?

ANSWER

If a medication related problem is identified and resolved by the agency staff not requiring physician/physician-designee contact by midnight of the next calendar day, the problem does not need to be reported as an existing clinically significant problem in M2001.

314

314

M2005 Medication Intervention

decisionhealth

M2005. Medication Intervention Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?	
Enter Code ☐	0. No 1. Yes 9. NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

- Identifies if potential or actual clinically significant medication issues identified at the time of or at any time since the most recent SOC/ROC were communicated to the physician/allowed practitioner (or physician designee) and to the extent possible, prescribed/recommended actions were completed by midnight of the next calendar day following their identification.
- To complete M2005, the assessing clinician (alone or in collaboration with other agency staff) reviews the patient's clinical record back to and including the most recent SOC/ROC, to determine if for each clinically significant medication issue identified, communication occurred and, to the extent possible, physician/allowed practitioner (or physician-designee) prescribed or recommended actions were completed by midnight of the next calendar day.
- Clinically significant issues same as defined in M2001
- 0, No vs. NA – No = patient HAD clinically significant issues identified but these were not reported. NA= no clinically significant issues or patient not taking medications

315

315

M2010: Patient/Caregiver High-Risk Drug Education

decisionhealth

M2010. Patient/Caregiver High-Risk Drug Education Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?	
Enter Code ☐	0. No 1. Yes NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

- High risk medications SHOULD be identified on med profile and in N0415 as well. Consult with med profile and review N0415 as well to identify certain high risk medications patient may be taking, as well as if indications for high risk medications are identified on the profile.
- Review documentation of the assessing clinician to identify documentation of education provided to the patient at SOC, during the episode or at the current OASIS time point.

316

316

M2010 High risk medication education

decisionhealth

QUESTION

M2010. Regarding M2010 Patient/Caregiver High Risk Drug Education, if the assessing clinician discovered the patient was taking a discontinued high risk medication in error and then correctly educated the patient to discontinue it and follow the current medication orders, which did not include any high-risk medications. How should the clinician complete M2010? Our dilemma focused on whether the clinician should consider only those medications currently prescribed, or, in this case, include high risk medications being taken but not presently prescribed for his/her use?

ANSWER

The current OASIS Guidance Manual M2010 Ch. 3 guidance states that M2010 identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes. High-risk medications are those identified by quality organizations as having considerable potential for causing significant patient harm when they are used erroneously. If the patient was taking a high risk medication in error, as you described, and was educated by your staff to discontinue the medication as well as the special precautions they need to take and how and when to report a problem that occurs as a result of taking that medication, M2010 may be answered "Yes".

317

317

M2020 Management of Oral medications

decisionhealth

VBP Improvement in management of oral medications ITEM

M2020. Management of Oral Medications Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)	
Enter Code ☐	0. **Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.** 1. **Able to take medication(s) at the correct times if:** a. **individual dosages are prepared in advance by another person; OR** b. **another person develops a drug diary or chart.** 2. **Able to take medication(s) at the correct times if given reminders by another person at the appropriate times** 3. **Unable to take medication unless administered by another person.** NA **No oral medications prescribed.**

- Item applies only to ORAL medications
- Intent is to assess patient's ability to take **ALL oral medications safely and reliably** as of the day of assessment, including as needed medications
  - **Excludes IV, All injectable meds, topical meds**
- May be impacted by physical impairment, cognitive impairment, environmental limitations, sensory barriers
- Includes accessing medications from where they are ROUTINELY stored and obtaining fluid to take medication orally

318

318

M2020 Management of oral medication

decisionhealth

- For a patient who resides in a facility, such as an assisted living facility (ALF), where the facility holds or locks up the patient's medications:
  - Report the patient's ability to take the correct oral medication(s) including proper dosage(s) reliably and safely at the correct times.
  - Determine ability based on observation and assessment of the complexity of the patient's drug regimen, as well as patient characteristics, including cognitive status, vision, strength, manual dexterity and general mobility.
  - Assessment includes consideration of whether a patient:
    - **can get to the location where the medications are routinely stored at the correct times, can recognize the correct medication dose(s) and take their oral medications, recognizing that someone would need to make the medication available to the patient once they are at the location (e.g., nursing office or medication cart)**

M2020 Management of Oral medications

decisionhealth

M2020. Management of Oral Medications Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)	
Enter Code ☐	0. **Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.** 1. **Able to take medication(s) at the correct times if:** a. **individual dosages are prepared in advance by another person; OR** b. **another person develops a drug diary or chart.** 2. **Able to take medication(s) at the correct times if given reminders by another person at the appropriate times** 3. **Unable to take medication unless administered by another person.** NA **No oral medications prescribed.**

- Item applies only to ORAL medications
- Intent is to assess patient's ability to take ALL oral medications safely and reliably as of the day of assessment, including as needed medications
  - Excludes IV, All injectable meds, topical meds
- May be impacted by physical impairment, cognitive impairment, environmental limitations, sensory barriers
- Includes accessing medications from where they are ROUTINELY stored and obtaining fluid to take medication orally

M2030 Management of Injectable medications

decisionhealth

M2030. Management of Injectable Medications Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.	
Enter Code ☐	0. Able to independently take the correct medication(s) and proper dosage(s) at the correct times. 1. Able to take injectable medication(s) at the correct times if: a. individual syringes are prepared in advance by another person; OR b. another person develops a drug diary or chart. 2. Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection 3. Unable to take injectable medication unless administered by another person. NA No injectable medications prescribed.

- Item applies only to Injectable medications
- Intent is to assess patient's ability to take ALL injectable medications safely and reliably as of the day of assessment, including as needed medications
  - **Excludes IV medications**
  - **Excludes infusions**
- May be impacted by physical impairment, cognitive impairment, environmental limitations, sensory barriers
- If the patient's ability to manage injectable medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.

321

321

M2030 Management of injectable medication

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- Includes assessment of the patient's ability to obtain the medication from where it is routinely stored, the ability to read the label (or otherwise identify the medication correctly, for example patients unable to read and/or write may place a special mark or character on the label to distinguish between medications), draw up the correct dose accurately using aseptic technique, inject in an appropriate site using correct technique, and dispose of the syringe properly.
- **Accessing and managing the supplies and disposal medications are important components in addition to the basic injection of the drug**

322

322

M2030 Management of injectable medication

decisionhealth

QUESTION

M2030. On my SOC visit, the patient did not have their insulin due to a problem at the pharmacy. How can I answer M2030, Management of Injectable Medications, when I was not able to assess my patient's ability to prepare and take the SQ medication?

ANSWER

When completing M2030, Management of Injectable Medications, you report the patient's ability to administer all injectable medications reliably and safely at all times, including safe needle and syringe disposal. If injectables are not in the home (whether currently due, due at a future point during the episode or prn) Response 3 - Unable to take injectable medication unless administered by another person is appropriate. If the injectable medication is in the home, but just not needed (prn) or due today, observe simulation/ask patient to describe steps, etc. and use clinical judgment to make an inference regarding the patient’s ability.

M2030 Management of injectable medication

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QUESTION

M2030. How do I score M2030 if the physician has ordered the RN to administer the medications?

ANSWER

If a physician orders the nurse to administer a prescribed injectable medication, the patient's ability is reported as "3-Unable to take injectable medications unless administered by another person." The order for the nurse to administer the medication represents a medical restriction against patient self-administration. When a patient is medically restricted from performing an activity, the impact of this medical restriction on the patient's ability must be considered.

NEW: Section O – Special Treatments, Procedures, and Programs

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O0110 Special Treatments, Procedures, and Programs -SOC, ROC,& DC

Discharge	
O0110. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that apply at discharge.	c. At Discharge Check all that apply ↓
Cancer Treatments	
A1. Chemotherapy	☐
A2 IV	☐
A3. Oral	☐
A10. Other	☐
B1. Radiation	☐
Respiratory Therapies	
C1. Oxygen Therapy	☐
C2. Continuous	☐
C3. Intermittent	☐
C4. High-concentration	☐
D1. Suctioning	☐
D2. Scheduled	☐
D3. As Needed	☐
E1. Tracheostomy care	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐
G1. Non-invasive Mechanical Ventilator	☐
G2. BiPAP	☐
G3. CPAP	☐

325

325

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NEW: Section O – Special Treatments, Procedures, and Programs

O0110 Special Treatments, Procedures, and Programs

Other	
H1. IV Medications	☐
H2. Vasoactive medications	☐
H3. Antibiotics	☐
H4. Anticoagulation	☐
H10. Other	☐
I1. Transfusions	☐
J1. Dialysis	☐
J2. Hemodialysis	☐
J3. Peritoneal dialysis	☐
O1. IV Access	☐
O2. Peripheral	☐
O3. Mid-line	☐
O4. Central (e.g., PICC, tunneled, port)	☐
None of the Above	
Z1. None of the Above	☐

326

326

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O0110 Special Treatments, Procedures, and Programs

- Risk adjustment
- Guidance advises to consult with patient, family, caregivers, providers/physician, clinical record, clinician collaboration
- Include treatments, programs and procedures performed by others and those the patient performed themselves independently or after set-up by agency staff or family/caregivers.
- **Include treatments performed both *IN and OUT of the patient's home***
- Do **NOT** include treatments only provide as part of a surgical/operative procedure
- O0110A1 (Chemotherapy), O0110B1 (Radiation), O0110J1 (Dialysis) only apply if treatment is current at the time of assessment (not prior history of)
  - *If patient to be DC and start chemo post DC, for example, it is not considered for this item*

327

327

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O0110 Special Treatments, Procedures, and Programs

- **O0110A1 (Chemotherapy) includes multiple routes**
  - O0110A2, Chemotherapy, IV = any chemotherapy administered intravenously
  - O0110A3, Chemotherapy, Oral = chemotherapy administered orally (e.g., pills, capsules, or liquids the patient swallows), ***ALSO applies if the chemotherapy is administered enterally (e.g., feeding tube/PEG).***
  - O0110A10, Chemotherapy, Other = chemotherapy administered in a way other than intravenously, enterally, or orally (e.g., intramuscular, intraventricular/intrathecal, intraperitoneal, or topical routes).
- **O0110B1 (Radiation) includes intermittent radiation OR radiation implant**
  - Not limited to neoplastic disease diagnosis
- **O0110C1 (Oxygen Therapy) includes both intermittent (defined as <14 hr.) and continuous oxygen**
  - Includes BiPap, CPAP, Mask, Cannula
  - Does NOT include Hyperbaric delivery

328

328

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O0110 Special Treatments, Procedures, and Programs

- **O0110C4, Oxygen Therapy, High concentration**
  - Oxygen delivered via a high concentration delivery system at a concentration that exceeds FiO2 of 40% (Oxygen-conserving nasal cannula systems with reservoirs should be included only if they are used to deliver an FiO2 greater than 40%)
    - can include either high or low-flow systems (simple face masks, partial and non-rebreather masks, face tents, venturi masks, aerosol masks, high-flow cannula or masks).
    - also includes invasive mechanical ventilators, non-invasive mechanical ventilators, or trach masks, if the delivered FiO2 of these systems exceeds 40%.
- **O0110D1, Suctioning**
  - only if tracheal and/or nasopharyngeal suctioning is performed. *Do not include oral suctioning here.*

329

329

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O0110 Special Treatments, Procedures, and Programs

- **O0110F1, Invasive Mechanical Ventilator**
  - any type of electrically or pneumatically powered closed-system mechanical ventilator support device in patient unable to support their own respiration.
- **O0110G1, Non-Invasive Mechanical Ventilator**
  - any type of respiratory support device that prevents airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling such as BiPAP or CPAP.
- **O0110H1, IV medications**
  - **Includes** any medication or biological is given by intravenous push, epidural pump, or drip through a central or peripheral port
  - **Includes** Epidural, intrathecal, and baclofen pumps
  - ***DOES NOT INCLUDE****: flushes to keep port or IV line patent, subcutaneous pumps, IV meds administered during dialysis or chemotherapy, Dextrose 50% or Lactated Ringers solution – do not include these under O0110H10*
  - **O0110H10, Other includes for example**: IV analgesics and IV diuretics

330

330

O0110 Special Treatments, Procedures, and Programs

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- **O0110I1, Transfusions,**
  - EXCLUDES transfusions administered during dialysis or chemotherapy
- **O0110O1, IV Access**
  - **Includes:** Intravenous catheter inserted into a vein for multiple reasons such as long-term medication administration, hemodialysis, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or in some instances the measurement of central venous pressure.
  - **O0110O2, Peripheral**, if IV access is peripheral access (catheter is placed in a peripheral vein) and ***remains peripheral.***
  - **O0110O3, Midline**, if IV access is midline access. Midline catheters are inserted into the antecubital (or other upper arm) vein and ***do not reach all the way to a central vein such as the superior vena cava.***
  - **O0110O4, Central** (e.g., PICC, tunneled, port), if IV access is ***centrally located*** (e.g., peripherally inserted central catheter [PICC], tunneled, port).

DASH IS VALID FOR O0110 BUT SHOULD BE RARE

331

331

O0110 Special Treatments, Procedures, and Programs

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QUESTION

For Special Treatments, Procedures, and Programs: Non-invasive Mechanical Ventilator O0110G2 - BiPAP and O0110G3 - CPAP, are these only selected if the BiPAP/CPAP was used during the assessment window? Sometimes a treatment may be ordered and available but the patient will refuse to wear it.

ANSWER

If the BiPAP or CPAP is part of the patient's current care/treatment plan, then mark O0110G1 - Non-Invasive Mechanical Ventilator and O0110G2 - BiPAP or O0110G3 – CPAP

****NOTE: Consideration is was treatment ordered at the time of the comprehensive assessment**

332

332

M1046 Influenza Vaccine Received

M1046. Influenza Vaccine Received Did the patient receive the influenza vaccine for this year's flu season?	
Enter Code ☐	1. **Yes;** received from your agency during this episode of care (SOC/ROC to Transfer/Discharge) 2. **Yes;** received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge) 3. **Yes;** received from another health care provider (for example, physician, pharmacist) 4. **No;** patient offered and declined 5. **No;** patient assessed and determined to have medical contraindication(s) 6. **No;** not indicated – patient does not meet age/condition guidelines for influenza vaccine 7. **No;** inability to obtain vaccine due to declared shortage 8. **No;** patient did not receive the vaccine due to reasons other than those listed in responses 4-7.

- For a patient with any part of the home health episode (SOC/ROC to Transfer/Discharge) occurring between October 1 and March 31, identifies whether the patient received an influenza vaccine for this year's flu season, and if not, the reason why
- ***Care episode = quality episode for this item***

- For response No, 4, It is not required that your agency offer the vaccine. Enter Response 4 only if the patient was offered the vaccine and it was refused.
  - The agency may offer resources where the patient can obtain the vaccine such as flu clinics
  - The patient may refuse the vaccine from other providers

333

333

M1046 Influenza Vaccine Received

- **Contraindications**
  - If contraindications are for medical reasons, then respond 5
    - Includes contraindications indicated by the physician but not on the CDC list of contraindications
  - If the patient does not meet age/condition guidelines listed by the CDC then respond 6

334

334

M2200 Therapy need

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.

- No longer used to calculate payment for PDGM
- Agencies may code M2200 Therapy Need with NA – Not Applicable for assessments where the data is not required for the patient's payer (including all Medicare FFS assessments)
- Therapy visits must **(a)** relate directly and specifically to a treatment regimen established by the physician/allowed practitioner through consultation with the therapist(s), and **(b)** be reasonable and necessary to the treatment of the patient's illness or injury.
  - **Must be a physician order for the therapy visits**
- Collaboration is allowed for this item
- When a ROC/Recert was done, the total number of therapy visits for the upcoming recertification should be entered

335

335

SECTION Q: Participation in Goal Setting

This section includes one item to identify interventions that were included in the physician-ordered plan of care and implemented.

336

336

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M2401 Intervention Synopsis

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

Plan/Intervention	No	Yes	Not Applicable	
	↓Check only one box in each row↓			
b. Falls prevention interventions	☐ 0	☐ 1	☐ NA	Every standardized, validated multi-factor fall risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no risk for falls.
c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐ 0	☐ 1	☐ NA	Patient has no diagnosis of depression AND every standardized, validated depression screening conducted at or since the most recent SOC/ROC assessment indicates the patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
d. Intervention(s) to monitor and mitigate pain	☐ 0	☐ 1	☐ NA	Every standardized, validated pain assessment conducted at or since the most recent SOC/ROC assessment indicates the patient has no pain.
e. Intervention(s) to prevent pressure ulcers	☐ 0	☐ 1	☐ NA	Every standardized, validated pressure ulcer risk assessment conducted at or since the most recent SOC/ROC assessment indicates the patient is not at risk of developing pressure ulcers.
f. Pressure ulcer treatment based on principles of moist wound healing	☐ 0	☐ 1	☐ NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

337

337

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M2401 Intervention Synopsis

- ***Note that DM interventions have been removed from M2401***
- Identifies if specific interventions were both included on the physician-ordered home health Plan of Care AND implemented as part of care provided at the time of or at any time since the most recent SOC/ROC assessment.
- **Step 1- Review POC to identify which POC interventions were ordered**
- **Step 2- Review clinical record to determine if ordered interventions were implemented and if interventions should have been ordered for certain conditions and were not**
  - Example: Is patient diabetic, but no diabetic foot care interventions ordered or was patient at risk for pressure ulcers per Braden scale but no pressure prevention intervention ordered
- Include interventions implemented any time during the quality episode (at the time of, or at any time since the most recent SOC/ROC assessment, to the time the Discharge or Transfer assessment is completed).
- Interventions referenced in this item do not have to be completed by any one specific clinician

338

338

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M2401 Intervention Synopsis

- For ROW D, Interventions to monitor and mitigate pain, the POC must include orders for BOTH monitoring and mitigation of pain and these must both have been implemented in order to mark 1, yes to this item.
- Depression interventions may be warranted based on symptoms exhibited, positive PHQ testing, diagnosis of depression or related syndromed.
  - Interventions for depression can include but are not limited to medication, therapy, referral for treatment or other resources
- Pressure ulcer treatments based on moist wound healing include, but are NOT limited to moisture retentive dressings.
  - Even if a pressure ulcer is no longer present at DC, if it was treated during the quality episode using moist wound healing, this should be marked yes.

339

339

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Key Concepts for OASIS E

340

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OASIS E Implementation

OASIS E Implementation Finalized for ALL OASIS with M0090 date of 1/1/23 and after

- Recerts with M0090 date of 1/1/23 and later regardless of start of Episode date
- SOC prior to 1/1/23 with M0090 date 1/1/23 (due to additional gathered data)
- SOC on or after 1/1/23 (due to M0090 date of 1/1/23
- All ROC, TRF, DAH, DC with M0090 of 1/1/23 or later

341

341

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OASIS E Implementation - Examples

SOC

- SOC visit done 12/29/22
- SN called MD to get additional foley orders and clarify meds, orders received 1/2/23. M0090 date = 1/2/23
- OASIS E will be required

Recert

- Recert completed 12/30/22 for cert period ending 1/1/23, new cert begins 1/2/23
- M0090 = 12/30/22
- OASIS D1 will be used
  - *OASIS E used only when M0090 = 1/1/23 or later regardless of episode date

342

342

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OASIS E Implementation - Examples

RECERT

- Recert completed 12/31/22 for cert period ending 1/3/23, new cert period begins 1/4/23
- PT eval completed 1/1/23
- SN clarifies medication and wound care on 1/2/23
- M0090 = 1/2/23
- OASIS E will be required

Transfer

- Patient goes to ER on 12/31/22 due to nausea, vomiting
  - Remains in ER under observation until 1/2/23
  - Admitted 1/2/23
- M0090 = 1/3/23 (Transfer completed when patient admitted for period of 24 hours or greater for reasons other than diagnostic testing)
- OASIS E required

343

343

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Implementing OASIS E

- ALL OASIS with M0090 of 1/1/2023 forward. 1/1/23 is also date of data collection start for expanded HHVBP performance year 1
- Agencies may begin using new assessment tools now with current OASIS D1
  - Not required but no restriction in practice to begin using now and clinicians require practice and will have questions.
- OASIS Q&As will continue to be updated quarterly will continued guidance on new, changed and existing items
- Understand data alignment and importance in conjunction with HHVBP Performance year 1

- 2022 October, July OASIS Q&A can be viewed at :

https://qtso.cms.gov/system/files/qtso/508_CMS_OAI_2nd_Qtr_2022_QAs_July_2022_final_0.pdf

https://qtso.cms.gov/system/files/qtso/508_CMS_OAI_Qtr%203_2022_QAs_October_2022_final.pdf

344

344

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Additional Resources

- Current version of OASIS E guidance manual can be viewed at: https://www.cms.gov/files/document/oasis-e-guidance-manual51622.pdf
- NPIAP Pressure Injury Staging Resource: https://npiap.com/page/PressureInjuryStages
- WOCN OASIS E Guidance document: https://cdn.ymaws.com/member.wocn.org/resource/resmgr/docs/OASIS-E_Best_Practice_Docume.pdf
- 2023 Home Health Final Rule: https://www.federalregister.gov/documents/2022/11/04/2022-23722/medicare-program-calendar-year-cy-2023-home-health-prospective-payment-system-rate-update-home

345

345

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QUESTIONS?

346

346