3M National OASIS Integrity Project

Recommended Questions and Techniques for OASIS M0 Items

May 21 & 22, 2003
Las Vegas, NV

November 1, 2003
Final Report

3M HOMECARE FAZZI ASSOCIATES

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M0 Items Continued:

M0 Items Continued:

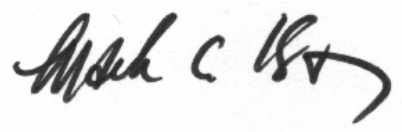
One year ago at the annual NAHC conference in Salt Lake City, 3M met with Bob Fazzi to discuss the contributions that we could make towards the critical issues facing the Home Health Care Industry. As part of that discussion, we talked about the OASIS assessment and the difficulty agencies had experienced to be able to achieve consistency in completing this document. The difficulties, it seemed, went beyond just the need for additional training. Furthermore, we all knew that in 2003, the industry would be mandated to publicly report data elements from the OASIS. We believed that inconsistencies in OASIS data would then lead to misinterpretations by CMS and the public at large and could have very unintended consequences.

The problem we could solve together then became very clear. Determine the OASIS questions that are the most problematic and find ways and develop tools that would allow clinicians to record a consistent set of answers to those questions given identical circumstances. We asked NAHC for feedback and blessing on our proposed project. Not only was NAHC very interested, but they also wanted to partner with Fazzi Associates and 3M in directing the project. As the discussion evolved, each organization would also have a specific role in addition to oversight of the project: 3M would provide funding for the project, Fazzi Associates would provide project execution, and NAHC would provide a strong voice to CMS, State Associations and the industry as to the progress of this project.

Thus was born the 3M National OASIS Integrity Project—a one year study involving the nation's top clinicians from nearly every state as nominated by their state associations. These clinicians worked within a framework to carefully consider the most inconsistently answered OASIS questions to understand just what circumstances contribute to variability in answering them. Once the variability of circumstances around each question were known, the clinicians collaborated on developing solutions that, if employed, would help agencies apply a consistent approach to OASIS questions—in other words, improve integrity of the data.

The result of our project is the following report. 3M is pleased to provide this information back to the entire industry as part of our continuing commitment to Home Health as well as our desire to see improved accuracy which we believe contributes to improved patient care and lower costs. We would like to thank Fazzi Associates and NAHC for co-partnering on this project with us—it was truly a collaborative effort. We would also like to extend thanks to the many state associations for nominating their top clinicians to participate with us. Finally, our biggest thanks to the numerous clinicians upon whose expertise this report was made possible. They contributed many countless hours in their desire to see the Home Care industry progress. From all of us who participated on the project, we hope you enjoy the results and can adopt the findings into your own agency's operations.

Warm regards,



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We are pleased to have been asked to design and facilitate the 3M National OASIS Integrity Project and to have the opportunity to partner in this project with the 3M Home Health Systems and with the National Association for Home Care. It is a project that we feel was not only incredibly successful; it was a project that ultimately generated recommendations that provide insights and tools that can benefit every agency in this country.

How important was this project? Over the past year alone, Fazzi Associates has conducted OASIS audits for agencies in every region of the country. In our most recent round of audits, we reviewed over 1,000 patient records and found significant errors in all three OASIS domains – clinical, functional and service utilization. These error rates had significant implications to quality measures, financial reimbursement and the OBQI risk adjusted scores that were reported in Home Care Compare.

This year-long national effort involved identifying and recruiting top home care OASIS experts from every state. In many cases, these senior clinicians were nominated by their state associations. In other cases, they were clinicians who were recognized by their peers. Many were presently involved in state, NAHC or CMS initiated OASIS related efforts. Collectively, they represented the highest levels of expertise and knowledge on OASIS in the home care field.

These national experts – over fifty of them – went through a systematic process to review every OASIS item and to collectively generate recommendations for improving clinicians' capacity to generate accurate and valid responses. These recommendations include new optimal questions that clinicians could consider using, new techniques and new tips for improving the accuracy of OASIS assessments. This report includes a summary of their findings and recommendations.

The 3M National OASIS Integrity Project was an incredibly important, exciting and dynamic national effort. We at Fazzi Associates would like to express our sincere appreciation to the 3M Home Health Systems and to the National Association for Home Care. We would also like to express a special thank you to the National Experts who participated in this process. We firmly believe that their dedication, commitment, knowledge and expertise has let to the creation of a product that has the potential of improving OASIS accuracy and the quality of care provided to patients throughout the country. Our sincere thanks to all.

Sincerely,

Robert Fazzi	Lynn Harlow	Kay Wright
Project Co-Director	Project Coordinator	Project Co-Director

3M National OASIS Integrity Project

History

Every home care agency in the country can quickly attest to the fact that clinicians face incredible difficulties in trying to generate accurate and reliable OASIS assessments. Even the most vocal advocates for the OASIS instrument, for example, will readily admit that some questions seem ambiguous. Others are hard to understand. Still others require far more subjective interpretation than one would hope for in an objective assessment tool.

At the same time, agencies are acutely aware of the importance of OASIS. OASIS affects providers' reimbursement. OASIS affects resources the provider has for services. OASIS affects the measures of quality that are used for assessing provider agencies. OASIS affects what is being reported to the public through CMS's new Home Care Compare initiative. And ultimately, OASIS affects the long term viability of provider agencies.

These two realities – the challenge of doing it right and the critical role that OASIS plays in shaping the future of every agency in the country – led to a national effort to develop a new set of clinician friendly recommendations for improving clinicians' understanding and appropriate use of the OASIS instrument.

Sponsored by the 3M Home Health Systems, NAHC and Fazzi Associates

In response to this reality, the 3M Home Health Systems, National Association for Home Care and Fazzi Associates initiated an incredibly innovative effort to address these challenges. Called the 3M National OASIS Integrity Project, the effort was designed to achieve three specific goals:

- To positively impact and improve the field's capacity to accurately complete OASIS assessments by developing easy-to-use free tools (simple and short) to help individual clinicians increase the accuracy of OASIS assessments.
- To identify possible process changes agencies can make to improve how they go about making and ensuring the accuracy of OASIS assessments.
- To provide CMS with input/feedback on a range of specific problems or questions that CMS needs to answer or address in order to improve the effectiveness and efficiency of the OASIS assessments.

To reach these goals, the Project recognized that the best answer could be found by going to experts, senior clinicians in each state who were dedicated to doing things right. These were clinicians who had studied all of the forms and manuals related to OASIS. They had attended trainings including trainings run by CMS. They had participated and overseen OASIS audits since its inception. And they continually strove to seek and test new techniques and approaches to ensuring that each item was presented to a patient in such a way that it consistently generates accurate and reliable responses.

A Project Designed to Take Advantage of Home Care Clinical Experts

Using an Expert Design model developed by Fazzi Associates, state associations throughout the country were asked to nominate senior clinicians that they felt were expert in the implementation of OASIS. Over a five month period, nearly three hundred senior clinicians were nominated. From this group, fifty clinicians were selected to participate in an intensive two day intensive Expert Design Forum. They represented all regions of the country and all sizes and segments of the home care field (s*ee list of participants on page 5*).

The Project included 39 clinical experts, 7 steering committee experts, and 11 leadership committee members. Participants met May 21 and 22 in Las Vegas and went through a systematic two day effort to review each OASIS item.

Over the course of two days, the Senior Clinicians reviewed all of the OASIS items, debated the best way to address each item and ultimately developed optimal questions, optimal technique or assessment tips that they collectively felt would help improve the chances that clinicians would consistently generate accurate and reliable responses to each OASIS item.

Once completed, the summary of the results and recommendations were placed on a password-protected web message board. Each of the fifty senior clinicians was asked to further review each item and to provide additional feedback and recommendations over a two month period. From this refined list, all of the items went through three more reviews before being presented in this report.

A Year Long Effort to Help Home Care Clinicians

The 3M National OASIS Integrity Project took nearly a year to complete. It involved associations throughout the country and clinicians in every region. It also required tremendous dedication and fortitude by all those involved in the process.

It is our hope that this report and the recommendations included within it provide clinicians throughout the country with a new set of tools and insights that will help them improve their capacity to conduct better and more accurate OASIS assessments. Improved OASIS assessments will lead to better quality outcomes, more appropriate reimbursement and in the long run, better services to our patients.

3M OASIS Integrity Project Participants

Clinical Experts

Region I

Anne Bergan, Rockingham VNA & Hospice, NH
Susan Manzo, VNA of South Central Connecticut, CT
Cheryl Pacella, Visiting Nurse Association of Boston, MA
Maureen Schnider, Partners Home Care, MA

Region II

Rose Madden Baer, Metropolitan Jewish Health System, NY
Donna Schade, Valley Home Care, NJ

Region III

Margaret Cesario, Care Partners, Inc., WV
Ruth McCain, Twin County Regional Home Health, VA
Therese Rossman, Community Nursing Service, PA

Region IV

Sandra S. Bassett, Alliance Home Care Service, TN
Linda Henning, Home Health Professionals, NC
Kim Kirk, Riverview Regional Medical Center Home Health Agency, AL
Gerrie Leppert, Visiting Nurse Association, KY
Sparkle Sparks, Lee Memorial Home Health, FL

Region V

Ida Blevins, St. John's Hospital Home Health Services, IL
Susan Brown, Interim Healthcare, OH
Deborah Mester, Heartland Home Health Care, IL
Joell Quiram, Albert Lea Medical Center, MN
Mary Ann Rayrat, St. John Home Care, MI
Cindy Struk, Visiting Nurse Health Care Partners of Ohio, OH
Karen Wells, 1st Call Home Health & Hospice, IN

Region VI

Brian Bienvenu, R & R Home Care, Inc., LA
Kathey Loftis, The Visiting Nurse Association of Texas, TX
LaWana Nelson, Mays Housecall Home Health, OK
Barbara Norman, Baptist Health Home Health Network, AR

Region VII

Joyce Eland, Visiting Nurse Association/Care Resources, IA
Rebecca Murrell, North Kansas City Hospital Home Health, MO
Julie S. Peterson, Alegent Home Care Services, NE

Region VIII

Erin Denholm, Centura Home Care and Hospice, CO
Rick Hall, Applegate Home Care, UT
Dianne Hansen, Partners In Home Care, Inc., MT
Kathy Shumaker, Mount Evans Home Health Care, CO

Region IX

James Kahler, Hale Makua Home Health Care Agency, HI
Libra Baker, Kaiser Permanente, CA

Region X

Rose Colwell, Homecare and Hospice Southwest, WA
Debra Robinson, Cascade Home Care, OR

National

Mary Crandall, Interim Healthcare, VA
Alice Ann Schwartz, Amedisys, LA
Pamela Teenier, Gentiva Health Services, TX

Steering Committee

Patrice Artress Cruise, Sunbelt Home Care, FL
Paulette Fletcher, St. Mary Medical Center Home Health Agency, CA
Beverly James Thompson, Beaumont Home Health Services, TX
Carolyn Krause, VNA of Wisconsin, WI
Stephanie Mello-Gaskell, VNA of Southeastern Massachusetts, MA
Susan Sender, Gentiva Health Services, NY
Mary Jo Vetter, Visiting Nurse Service of New York, NY

Project Staff

Bob Fazzi, Fazzi Associates
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Patricia Levesque, 3M Home Health Systems
Nancy Nelson RN, 3M Home Health Systems
Mary St. Pierre, National Association for Home Care & Hospice
Debra Thayer, 3M Medical Division
Rhonda Will, Fazzi Associates
Kay Wright, Fazzi Associates

Completion of OASIS is required when:

- Medicare is payer for any or all care provided, regardless of age (excludes Medicare B payer for outpatient therapy services)
- Medicaid is payer unless under age 18, services related to pre or postpartum care, receiving exclusively personal care services
- Other payer sources for patients receiving skilled care unless under age 18 or services related to pre or postpartum.

M0030 Start of Care Date:

__ __ / __ __ / __ __ __ __
Month Day Year

Item Clarification:

Recommendations from Expert Design Forum

Optimal Technique: Verify with agency administrative staff.

Tips: The Start of Care date is the date of the first *billable* visit to Medicare. It may not always be the date the assessment is completed.

M0030

M0032 Resumption of Care Date: (most recent):

__ __ / __ __ / __ __ __ __
Month Day Year

☐ UK - Unknown

Item Clarification:

Recommendations from Expert Design Forum

Optimal Technique: Agency intake personnel to obtain information from inpatient facility staff or billing department.

Tips: This is the date the care of the patient was resumed by the agency after the patient returns home after admission and discharge from an *inpatient* facility for 24 hours or longer for reasons other than diagnostic tests.

If there is more than one admission to an inpatient facility while the agency is providing services, this date reflects the most recent resumption of care by the agency.

M0032

M0040 Patient's Name

Item Clarification:

Recommendations from Expert Design Forum

Optimal Question: Obtain information from interview.

Optimal Technique: Look at Medicare card, Explanation of Benefits form or other health insurance identification card.

Tips: Use the same name found on the Medicare card, Private Insurance card or HMO identification card.

M0040

M0050 Patient State of Residence

Item Clarification:

Recommendations from Expert Design Forum

Tips: Identify the state in which the patient is located when receiving services.

M0050

M0060 Patient Zip Code

Item Clarification:

Recommendations from Expert Design Forum

Tips: Identify the zip code in which the patient is located when receiving services.

M0060

M0063 Medicare Number

Item Clarification:

Recommendations from Expert Design Forum

Optimal Question: Obtain information from interview.

Optimal Technique: Look at patient's Medicare card. If not available, number can also be found on Explanation of Benefits form. Agency office based personnel to verify number with Medicare computer system.

Tips: Record Medicare number regardless of whether Medicare is a payer for the episode.

Record number exactly as found on Medicare card or other official Medicare information.

Do not use social security number because Medicare may be through a spouse.

M0063

M0064 Social Security Number

Item Clarification:

Recommendations from Expert Design Forum

Optimal Question: Obtain information from interview.

Optimal Technique: Verify information with patient or caregiver. Look at social security card or other official document that includes social security numbers.

Tips: Mark "unknown" if patient refuses to divulge information.

M0064

M0065 Medicaid Number

Item Clarification:

Recommendations from Expert Design Forums

Optimal Question: Obtain information from interview.

Optimal Technique: Verify with patient or caregiver. Look at Medicaid card. Agency office based staff to verify current eligibility with Medicaid computer system.

Tips: Record Medicaid number regardless of whether Medicaid is a payer for the episode. Record number exactly as found on Medicaid card.

M0065

M0066 Date of Birth

__ __ / __ __ / __ __ __ __
Month Day Year

Item Clarification:

Recommendations from Expert Design Forum

Optimal Question: Obtain information from interview.

Optimal Technique: Verify with patient or caregiver.

Tips: If patient or caregiver is unable to verify, ask to see a legal document such as a driver's license or birth certificate or passport.

M0066

M0072 Primary Referring Physician ID:

_ _ _ _ _ _ _ _ _ _ _ _

☐ UK - Unknown or not available

Item Clarification:

Recommendations from Expert Design Forum

Optimal Technique: Intake staff to obtain and maintain list of physician UPIN numbers.

Tips: Record UPIN for physician who will be **signing** the home health plan of care. This may be different from the **referring** physician.

M0080 Discipline of Person Completing Assessment

Item Clarification:

Recommendations from Expert Design Forum

Tips: Nursing and rehab team members may collaborate regarding patient assessment findings but only one person takes responsibility for the completion of the form.

When nursing services are ordered at SOC (regardless of when the visit(s) are to occur in the episode), nursing must perform an assessment and complete the SOC form.

Occupational therapy services may not complete SOC assessment when Medicare is a payer for the episode.

M0080

M0090 Date Assessment Completed

__ __ / __ __ / __ __ __ __
Month Day Year

Item Clarification:

Recommendations from Expert Design Forum

Optimal Technique: Collaborate with rehab services when accuracy of functional assessment is in question prior to completing assessment.

Tips: The SOC, ROC, follow-up and discharge assessments must be completed through a face to face encounter with the patient. If the discharge unexpectedly occurs without opportunity or orders for a final visit refer to the clinical record and documentation of previous visits to complete assessment.

Usually this date is associated with a visit. However, if the clinician needs to follow-up off site with the patient's family, physician or other professional team member in order to complete any clinical data items, M0090 will reflect the date the assessment is completed.

Agency internal *supervisory review* of the document for completeness and accuracy would not affect this date as the actual assessment was completed prior to that process.

If agency policy allows for more than one visit to complete the assessment, M0090 will reflect the date the assessment is finished.

For transfer or death at home assessments record the date the agency learns of the event.

M0090

M0100 This Assessment is Currently Being Completed for the Following Reason

Item Clarification:

Recommendations from Expert Design Forum

Tips: Mark only one response.

Response 1: This is the start of care comprehensive assessment. A home care plan of care is being established and further visits are planned. *

Exception: Only one visit has been made *and* the agency will bill *Medicare* for the visit.

Response 3: This comprehensive assessment is conducted when the patient resumes care following an inpatient **admission** and stay of 24 hours or longer for reasons other than diagnostic tests. *

Note: Update patient tracking sheet.

Response 4: This comprehensive assessment is conducted **during the last 5 days** of the episode. *

Response 5: This comprehensive assessment is conducted due to a significant change (major decline or improvement) in patient condition not anticipated in the home health plan of care at a time other than during the last five days of the episode. As a result, about 50% of the plan of care will change related to services provided, or treatments, or frequency of visits, etc. This assessment is done to update the patient's plan of care.*

Response 6: Record data regarding the patient's **admission** to an inpatient facility for 24 hours or longer for reasons other than diagnostic testing. The patient is expected to resume agency care and is not discharged from the agency. **

Response 7: Record data regarding the patient's **admission** to an inpatient facility for 24 hours or longer for reasons other than diagnostic testing. The patient is discharged from the agency. **

Response 8: Report data regarding patient's death when death occurs at home, on route to the inpatient facility or in any department of the facility **prior** to actual **inpatient admission**. **

Response 9: This comprehensive assessment is conducted at the patient's discharge from the agency when the discharge is *not* a result of the patient's **admission** to an inpatient facility or death. *

Exception: A visit is not required when a patient is unexpectedly discharged, such as: the patient refuses, the physician orders a discharge without another visit, patient unexpectedly moves, or safety of the staff is in jeopardy. Complete assessment to best of ability from information obtained from the clinical record.

Discharge patient from agency when a **Medicare** patient remains in the inpatient facility beyond day 60 of PPS payment episode or if care was not resumed after inpatient facility discharge. OASIS *discharge* assessment is not required. The OASIS assessment completed at time of transfer to inpatient facility completes the OASIS reporting cycle.

* requires face to face patient contact on home visit for completion
** does not require home visit for completion.

M0100

MO140 Race/Ethnicity

Item Clarification:

Recommendations from Expert Design Forum

Optimal Question: To what population or group do you identify yourself with? List choices.

Optimal Technique: Ask patient or caregiver to choose from groups listed.

Tips: Requires asking patient or caregiver. Mark **all** groups with whom the patient identifies.

M0140

M0150 Current Payment Sources for Home Care

Item Clarification:

Recommendation from Expert Design Forum

Optimal Technique: Agency intake staff to identify potential payers.
Initial visiting clinician to collaborate with designated agency staff to determine home care eligibility criteria of payer. On initial visit, determine that patient meets eligibility criteria of payer.

Tips: On initial visit, clinician to validate that correct payers have been identified.

Mark **all** payers likely to be billed for home care services at this point in time.

Do not select 3 or 4 if **Medicaid** eligibility is "pending".

M0150

M0175 From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? **(Mark all that apply.)**

- ☐ 1 – Hospital
- ☐ 2 – Rehabilitation facility
- ☐ 3 – Skilled nursing facility
- ☐ 4 – Other nursing home
- ☐ 5 – Other (specify) _____
- ☐ 6 – NA Patient was not discharged from and inpatient facility ***[If NS at SOC/ROC, go to M0200, if NA at Follow-Up, go to M0230]***

Item Clarification: Identifies whether the patient has recently (within past 14 days) been discharged from an inpatient facility. Past 14 days encompasses the two-week period immediately preceding the start of care/resumption of care or the first day of the new certification period.

Recommendation from Expert Design Forum

Optimal Question: Were you in a hospital or other care facility in the last 14 days?
While you were in the hospital, were you moved to another room or floor?
What was the name of the hospital or care facility?

OR ask referral source:
Was the patient receiving Medicare Part A benefits from any facility in the past 14 days?

Optimal Technique: Intake or other personnel to collect inpatient stay information at time of referral.
Contact facility billing department if needed to determine if Medicare Part A benefits paid for services in the last 14 days.
Create a file of information identifying local inpatient facilities licensed as hospitals, SNF, and Rehab facilities. Identify which hospitals have swing beds, separately licensed skilled nursing facility beds and separately licensed rehabilitation beds.

Tips: Determine "past 14 days" by counting the day before SOC/ROC as day 1 and count back 14 days.

Failure to mark discharges from "ALL" inpatient stays within the past 14 days may result in incorrect payment.

Hospitals can have "swing beds", separately licensed skilled nursing facility beds and separately licensed rehabilitation beds within their walls. They may also have freestanding SNF and rehabilitation facilities on or off campus.

A skilled nursing facility can have Medicare A beds and beds not paid for by Medicare A.

“Other nursing home" includes days in SNF not paid by Medicare A and intermediate care facilities for the mentally retarded (ICF/MR).

M0180 Inpatient Discharge Date (most recent):

__ __ / __ __ / __ __ __ __
Month Day Year

☐ UK - Unknown

Item Clarification: Identifies the date of the most recent discharge from an inpatient facility (within last 14 days). Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.

Recommendations from Expert Design Forum

Optimal Question: Were you an inpatient in some hospital or care facility recently?
When did you leave there?

Optimal Technique: Look at any written discharge instructions the patient may have for information.
Intake or other office personnel to contact facility and verify discharge date.

Tips: Determine "past 14 days" by counting the day before SOC/ROC as day 1 and count back 14 days.

If patient discharged from more than one facility in past 14 days, record date of *most recent* discharge.

Avoid using "unknown" when Medicare is the payer.

M0180

M0190 Inpatient Diagnosis

Effective 10/1/2003

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

	Inpatient Facility Diagnosis	ICD-9-CM
a.	_____	(__ __ __ • __ __)
b.	_____	(__ __ __ • __ __)

Item Clarification: Identifies diagnosis(es) for which patient was receiving treatment in an inpatient facility within the past 14 days. Past 14 days encompasses the two-week period immediately preceding the start/resumption of care.

Recommendations from Expert Design Forum

Optimal Question: What did the doctor do for you while you were an inpatient? What did the doctor treat you for?

Optimal Technique: Intake or other office personnel to **c**ontact referral source, physician, and/or facility staff for clinical information related to treatment while an inpatient.

Tips: Record diagnosis(es) actively treated as inpatient.

Medication changes, surgical procedures and current treatment orders can provide clues to conditions treated during inpatient stay.

Determine "past 14 days" by counting the day before SOC/ROC as day 1 and count back 14 days.

Do not use surgical, V-codes or E-codes.

M0190

M0200 Medical Treatment Regimen Change Within Past 14 Days:

Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days?

☐ 0 – No
☐ 1 – Yes

Item Clarification: Item identifies if any change has occurred to the patient's treatment regimen, health care services, or medications due to a new diagnosis or exacerbation of an old diagnosis within past 14 days. Past 14 days encompasses the two-week period immediately preceding the start/resumption of care, or the discharge date.

Recommendations from Expert Design Forum

Optimal Question: When was the last time the doctor made any changes in your medications or treatments (wound care, diet, pain management, etc)?

Optimal Technique: Intake or other office personnel may help to determine change in medication, treatment or services (other than the initiation of home health care) in the past 14 days.
Look at medication bottle for new prescription dates.
At ROC and discharge, review clinical record for changes.

Tips: Medication, treatment and service changes result from a new diagnosis, exacerbation of an old diagnosis or adding another diagnosis to the home health plan of care and will result in a "yes" answer. Identify the diagnosis or condition in M0210.

If the initiation of home health services is the only change in treatment regimen within the last 14 days, "no" is the correct answer.

Identify medical condition or change in health status responsible for the initiation of services and list in M0210.

Determine "past 14 days" by counting the day before SOC/ROC as day 1 and count back 14 days. **Exception:** Medication, service or treatment changes that occur on the same day as SOC/ROC (*the 15th day*) may also be considered as part of the "past 14 days."

M0200

M0210 Medical Diagnosis

Effective 10/1/2003

List each Medical Diagnosis and ICD-9-CM code at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical, E-codes, or V-codes):

	Changed Medical Regimen Diagnosis	ICD-9-CM
a.	_____	(__ __ __ • __ __)
b.	_____	(__ __ __ • __ __)
c.	_____	(__ __ __ • __ __)
d.	_____	(__ __ __ • __ __)

Item Clarification: Identifies the diagnosis(es) that have caused an addition or change to the patient's treatment, regimen, health care services received, or medication within the past 14 days.. Past 14 days encompasses the two-week period immediately preceding the start/resumption of care (or the date of the discharge visit).

Recommendations from Expert Design Forum

Optimal Question: What was the reason your doctor changed your medications or treatments (wound care, pain management, symptom management)?

Optimal Technique: At SOC, review referral information. Interview referral source, patient and physician to determine the **medical diagnosis(es), condition(s) or change in health status that caused a change in medication, treatment or services within the past 14 days.** At ROC and discharge, review the clinical record for information.

Tips: Inpatient discharge summaries and discharge instructions may provide clues to reasons for changes in the patient's medical or treatment regimen resulting in a "yes" response to M0200.

Do not use surgical, V-codes or E-codes.

ICD Codes may be applied by other agency staff after the assessing clinician has determined the applicable diagnosis(es)/condition.

Determine "past 14 days" by counting the day before SOC/ROC as day 1 and count back 14 days. ***Exception*:** Medication, service or treatment changes that occur on the same day as SOC/ROC (the 15th day) may also be considered as part of the "past 14 days."

M0210

M0220 Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen.

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

Item Clarification: Identifies existence of condition(s) prior to medical regimen change or inpatient stay within past 14 days. Past 14 days encompasses the two-week period immediately preceding the start/resumption of care, or the discharge date.

Recommendations from Expert Design Forum

Optimal Question: How long have you had a problem with leaking urine? How long have you had a catheter? How long have you had this pain that won't go away? How long has he been acting like this? When did you first start noticing memory problems? Behavior problems?

Optimal Technique: Review patient history, referral information and at discharge, the home health clinical record.

Tips: If there has been an inpatient facility stay (identified in M0175) or a medical/treatment regimen change (identified as "yes" in M0200) in the past 14 days, then identify the conditions that existed for the patient **prior** to those occurrences.

Ask prompting questions of patient and caregiver after reviewing patient's history or performing current assessment.

Select **NA** if there has been **no** inpatient facility discharge **and no** change in medical or treatment regimen in the past 14 days.

M0220

M0230/240 Diagnoses and Severity Index

Effective 10/1/2003

List each diagnosis and ICD-9-CM code at the level of highest specificity (no surgical codes) for which the patient is receiving home care. Rate each condition using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) E-codes (for M0240 only) or V-codes (for M0230 or M0240) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnosis. If a V-code is reported in place of a case mix diagnosis, then M0245 Payment Diagnosis should be completed. Case mix diagnosis is a primary or first secondary diagnosis that determines the Medicare PPS case mix group.

Severity Rating

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

	(M0230) Primary Diagnosis	ICD	Severity Rating				
a.	_____	(__ __ __.__ __)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
	(M0240) Other Diagnoses	ICD	Severity Rating				
b.	_____	(__ __ __.__ __)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
c.	_____	(__ __ __.__ __)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
d.	_____	(__ __ __.__ __)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
e.	_____	(__ __ __.__ __)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
f.	_____	(__ __ __.__ __)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Item Clarification: Identifies each diagnosis for which the patient is receiving home care and its ICD code. Each diagnosis is then categorized according to its severity. The primary diagnosis (M0230) should be the condition which is the chief reason for providing home care. The principal diagnosis reported on the Plan of Care (CMS-485, item 11) and the UB-92 (CMS-1450, item 67) must match the M0230 diagnosis.

Recommendations from Expert Design Forum

Optimal Question: Primary diagnosis: What diagnosis is driving the home health plan of care?
Secondary Diagnoses: What diagnoses are addressed by the home health plan of care or have the potential to affect the plan of care, affect progress and rehabilitation potential or justify all services provided?

Optimal Technique: Determine diagnostic statements **after** completion of assessment, determining patient's needs and formulation of home health plan of care.
Develop "coding experts" within the agency.

M0230/ 240

M0230/240 Continued

Tips: Follow ICD coding guidelines (www.cdc.gov/nchs/data/icd9/icdguide.pdf) and use *current* coding books.
Follow directions in Home Health Agency Manual #11 (Sec. 234.7 (11-13).
Refer to CMS guidance document, "Diagnosis Coding for Medicare Home Health under PPS", (cms.hhs.gov/providers/hhapps/hhdiag.pdf) for examples.
Refer to CMS OASIS Implementation Manual, Chapter 8, Attachment D for the use of v-codes.

Primary Diagnosis:

- Diagnosis most related to the current plan of care developed by the agency.
- Represents the most acute condition and most intensive services.
- May not be related to the reason for hospitalization.
- May be best described by a v-code.

Secondary Diagnoses:

- Conditions addressed by the plan of care.
- Conditions that coexist and have the potential to affect the plan of care.
- Justify disciplines and services rendered.
- May be described as a V- or E-code.

Severity Ratings:

Evaluate to what extent presenting symptoms are controlled by current treatments and frequency of contacts with health care providers.

0 - Condition requires no treatment or medication.
1 - Current treatment, medications, services for this condition has not required change in recent past.
2 - Condition new or in exacerbation. Currently stable treatment regimen but new/changed enough to require observation and assessment.
3 - Condition unstable requiring close observation and assessment. Recent history of treatment or medication changes and more changes anticipated.
4 - Condition significantly unstable. In spite of treatment or medication changes, history of several hospitalizations in past year.

Severity ratings also apply to V-codes but exclude E-codes. When using a V-code, determine severity based on the individual patient's condition or response to treatment.

M0230/240

M0245 Payment Diagnoses (Optional)

Item Clarification: Correct agency payment is based on the correct use of this item.

Recommendations from Expert Design Forum

Optimal Technique: Coding specialist or designated staff to determine if use of V-code in M0230 replaces a case mix diagnosis that would have been used prior to October 1, 2003.

Tips: A case mix diagnosis is a primary diagnosis that assigns patients with selected conditions to an orthopedic, diabetes, neurological, or burns/trauma group for Medicare PPS case mix adjustment. A case mix diagnosis may involve manifestation coding and use of M0240 also. See list of case mix diagnoses at (www.cms.hhs.gov/providers/hhapps/hhppsfr.asp).

Explore all V-codes used in M0230 for applicability. Complete M0245 when case mix diagnosis is replaced by a V-code.

M0245

M0250 **Therapies** the patient receives at home:

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

Item Clarification: Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy at home.

Recommendations from Expert Design Forum

Optimal Question: Do you receive any medicine or food here at home other than what you take by mouth?

Optimal Technique When inspecting skin, observe for signs of vascular access devices (VAD), gastrostomy sites or other enteral delivery devices.

Tips: Include all infusion, enteral or parenteral therapies the patient is currently receiving **in his home** regardless of who administers/cares for it.

Include:

1. Subcutaneous, epidural, intrathecal infusions, and insulin pumps.
2. Intermittent medications, fluids or flushes via VAD.
3. Enteral nutrition or hydration.
4. Therapy initiated at SOC, planned after SOC, or is a result of SOC assessment and physician orders reflect treatment and start date.

Exclude:

1. Presence of feeding tube if no prescription for therapy which provides nutrition.
2. Feeding tube used for medication administration only.
3. Flushing feeding tube for tube maintenance or patency.
   (Flushing of a feeding tube does not provide nutrition and is not considered a therapy.)

M0250

M0260 Overall Prognosis: BEST description of patient's overall prognosis for recovery from this episode of illness.

- ☐ 0 – Poor: little or no recovery is expected and/or further decline is imminent
- ☐ 1 – Good/Fair: partial to full recovery is expected
- ☐ UK – Unknown

Item Clarification: Identifies the patient's expected overall prognosis for recovery at the start of this home care episode. Prognosis is based on professional judgment of clinician assessment.

Recommendations from Expert Design Forum

Optimal Question: What is your professional opinion as to how much the patient will recover, improve or progress?

Optimal Technique: After completing assessment, consider the patient's age, severity of symptoms, comorbidities, expected response to treatment.

Tips: Focus is on overall condition and expected recovery or improvement in condition given the impact of the patient's current condition, situation and past history.

M0260

M0270 Rehabilitative Prognosis: BEST description of patient's prognosis for functional status.

- ☐ 0 – Guarded: minimal improvement in functional status is expected; decline is possible
- ☐ 1 – Good: marked improvement in functional status is expected
- ☐ UK – Unknown

Item Clarification: Identifies the patient's expected prognosis for functional status improvement at the start of this episode. Prognosis is based on professional judgment of clinician assessment.

Recommendations from Expert Design Forum

Optimal Question: What is your professional opinion as to how much the patient will improve in ability to perform ADL/IADL tasks?

Optimal Technique: After completing assessment, consider the patient's age, severity of symptoms and comorbidities when making this determination.

Tips: Focus is on ability to improve ADL/IADL tasks.

M0270

M0280 Life Expectancy: (Physician documentation is not required.)

☐ 0 – Life expectancy is greater than 6 months
☐ 1 – Life expectancy is 6 months or fewer

Item Clarification: Identifies the patient for whom life expectancy is fewer than six months. Item is based on professional judgment of clinician completing assessment and other clinical input.

Recommendations from Expert Design Forum

Optimal Question: "Would I be surprised if this patient died in the next six months?"

Optimal Technique: Determine if physician has established prognosis by questioning referral source, physician office, patient or caregivers.

After completing assessment and in the absence of a physician's established prognosis, consider the patient's age, comorbidities, expected disease progression, and number of hospitalizations in past several months when making this determination.

Tips: Careful professional consideration of this item will help to reduce the number of unjustified adverse events charged to the agency on OBQM reports.

M0280

M0290 High Risk Factors characterizing this patient: **(Mark all that apply.)**

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

Item Clarification: Identifies specific factors that may exert a high impact on the patient's health status and ability to recover from this illness.

Recommendations from Expert Design Forum

Optimal Question: How much do you smoke? How much do you drink? How often do you use drugs?

Optimal Technique: Weigh patient. Observe patient and environment for evidence of high risk behaviors (used ash trays, empty bottles, snack food, drug paraphernalia).

Tips: After assessment, in your professional opinion, do you expect that any of these past *or* current behaviors or conditions do *or* will affect the patient's current health status, coping ability or ability to follow through with the home health plan of care?

M0290

M0300 Current Residence: characterizing this patient: **(Mark all that apply.)**

- ☐ 1 – Patient's owned or rented residence (house, apartment, or mobile home or rented by patient/couple/significant other)
- ☐ 2 – Family member's residence
- ☐ 3 – Boarding home or rented room
- ☐ 4 – Board and care or assisted living facility
- ☐ 5 – Other (specify) _____

Item Clarification: Identifies where the patient is residing during the current home care episode, even if temporary (e.g., where the patient is receiving care).

Recommendations from Expert Design Forum

Optimal Question: Where is patient living at time of assessment?

Optimal Technique: Determine where the patient is living at time of assessment.

Tips: Whether temporary or permanent, determine where patient is living/residing at time of assessment.

Definitions:
Boarding home - Fee paid in exchange for a place to live. Does not come with the provision of any health related services or supervision.

Board and care or assisted living facility - Pertains to licensing of facility. Fee paid in exchange for a place to live and includes some purchased care or health related services or supervision (meals, medication management or supervision, etc.)

M0300

M0340 Patient Lives With: (Mark all that apply.)

- ☐ 1 – Lives alone
- ☐ 2 – With spouse or significant other
- ☐ 3 – With other family member
- ☐ 4 – With a friend
- ☐ 5 – With paid help
- ☐ 6 – With other than above

Item Clarification: Identifies who the patient is living with at this time, even if temporary.

Recommendations from Expert Design Forum

Optimal Question: Who does the patient share living space or currently staying with at time of assessment, regardless whether situation is temporary or permanent?

Optimal Technique: Observe for another person dwelling in same location.

Tips: A person living in an assisted living situation does not live alone if they share a room.

Includes:
Family member/caregiver staying 24 hrs/day with the patient even if temporary.

Excludes:
Part time caregiver.

M0340

M0350 Assisting Person(s) Other than Home Care Agency Staff
(Mark all that apply)

- ☐ 1 – Relatives, friends, or neighbors living outside the home
- ☐ 2 – Person residing in the home (EXCLUDING paid help)
- ☐ 3 – Paid help
- ☐ 4 – None of the above [If None of the above, go to M0390]
- ☐ UK – Unknown

Item Clarification: Identifies the individuals who provide assistance to the patient (EXCLUDING the home care agency).

Recommendations from Expert Design

Optimal Question: Does anyone help you for any reason (personal care, household chores, errands, home maintenance, etc)? Who?

Tips: Paid help includes services purchased in board and care or assisted living arrangement or other private or community services paid by patient, family, special program or community funds.

M0350

M0360 Primary Caregiver taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff):

- ☐ 0 – No one person ***[If No One Person, go to M0390]***
- ☐ 1 – Spouse or significant other
- ☐ 2 – Daughter or son
- ☐ 3 – Other family member
- ☐ 4 – Friend or neighbor or community or church member
- ☐ 5 – Paid help
- ☐ UK – Unknown

Item Clarification: Identifies the person who is "in charge" of providing and coordinating the patient's care. A case manager hired to oversee care, but who does not provide any assistance, is not considered the primary caregiver. This person may employ others to provide direct assistance, in which case "paid help" is considered the primary caregiver.

Recommendations from Expert Design Forum

Optimal Question: Who helps you when you need help for any reason? Who gives you the most help? What is their relationship to you?

Tips: Determine who provides the most direct assistance or "hands on" care. Consider proximity to and frequency of contact with the patient. It might not be the person with power of attorney.

Select "0 - No one person" if

- the primary caregiver is the patient himself.
- there are multiple caregivers and each provides equal amounts of assistance and no one of them is "in charge".

M0360

M0370 How often does the patient receive assistance from the primary caregiver?

- ☐ 1 – Several times during the day and night
- ☐ 2 – Several times during day
- ☐ 3 – Daily
- ☐ 4 – Three or more times per week
- ☐ 5 – One to two times per week
- ☐ 6 – Less often than weekly
- ☐ UK – Unknown

Item Clarification: Identifies the frequency of the help provided by the primary caregiver (Identified in M0360).

Recommendations from Expert Design Forum

Optimal Question: How often do you receive help from the person designated in M0360?

Optimal Technique: Obtain information from interview and observation.

Tips: This item refers to the amount of help received from the person identified in M0360 and *not* the amount of help the patient receives from *all* people who assist.

M0370

M0380 Type of Primary Caregiver Assistance: (Mark All That Apply)

- ☐ 1 – ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
- ☐ 2 – IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances)
- ☐ 3 – Environmental support (housing, home maintenance)
- ☐ 4 – Psychosocial support (socialization, companionship, recreation)
- ☐ 5 – Advocates or facilitates patient's participation in appropriate medical care
- ☐ 6 – Financial agent, power of attorney, or conservator of finance
- ☐ 7 – Health care agent, conservator of person, or medical power of attorney
- ☐ UK – Unknown

Item Clarification: Identifies categories of assistance provided by the primary caregiver (Identified in M0360).

Recommendations from Expert Design Forum

Optimal Question: What kinds of things does the person identified in M0360 help you with?

Optimal Technique: Give patient examples from choices listed.

Tips: Selection "5" includes picking up prescriptions and rides to physician appointments.
This item refers to the type of help received from the person identified in M0360 and *not* the type of help the patient receives from *all* people who help.

M0380

M0390 **Vision** with corrective lenses if the patient usually wears them:

- ☐ 0 – Normal vision: see adequately in most situations; can see medication labels, newsprint.
- ☐ 1 – Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arms length.
- ☐ 2 – Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

Item Clarification: Identifies the patient's ability to see and visually manage (function) within his/her environment.

Recommendations from Expert Design Forum

Optimal Question: Do you routinely use any kind of glasses or magnifying glasses to read small print or see small items?

Optimal Technique: Ask patient to read medication label words or numbers. Notice if prescriptive glasses or reading glasses are routinely used to accomplish task.
Can patient see and pick up a small object in front of them?
With impaired cognition, interview caregiver. Observe patient movement/response during assessment visit and determine if there is an ability to see.

Tips: Focus is on sight/vision, ability to see, and not literacy/ability to read.

Determine if the patient's ability to respond to or function in his environment is altered. If yes, determine if it is due to an impairment of sight not compensated for by routine use of prescription or reading glasses.
Does a lack of uncorrected vision jeopardize safety, health and well being?

A person is considered

- Partially or severely impaired if magnifying glass is used to read small print or medication labels
- Severely impaired if there is lack of sight (blindness) or is nonresponsive to commands

If person cannot read, observe ability to count fingers at arm's length, see large and small objects or identify numbers.

M0390

M0400 Hearing and ability to Understand Spoken Language in patient's own language (with hearing aids if the patient usually uses them).

- ☐ 0 – No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation.
- ☐ 1 – With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice.
- ☐ 2 – Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance.
- ☐ 3 – Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, additional time.
- ☐ 4 – Unable to hear and understand familiar words or common expressions consistently, or patient nonresponsive.

Item Clarification: Identifies the patient's ability to hear and understand spoken language.

Recommendation From Expert Design Forum

Optimal Technique: Select response at the end of visit after observing patient respond to assessment. With back to patient, in normal tone, say "5-4-3-2-1". Face patient and ask him to repeat. OR Ask at least one question with back towards patient. Ask patient to repeat and respond to question. Notice if patient routinely wears hearing aids.

Tips: Focus is on receptive communication. Response will be affected by ability to hear **and** process information (cognitive status).

Evaluate hearing with hearing aids in place and turned on **only if** patient usually wears them.

Determine if patient speaks same language as clinician. Enlist assistance of interpreter to assess if needed.

"Nonresponsive" relates to level of alertness and ability to understand.

On a scale of 0-4, rate level of difficulty hearing and/or understanding.
0 - No difficulty hearing **or** understanding the spoken word in own language
1 - Minimal difficulty
2 - Moderate difficulty
3 - Severe difficulty
4 - Unable to hear and/or understand

M0400

M0410 Speech and Oral (Verbal) Expression of Language (In patient's own language):

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

Item Clarification: Identifies the patient's ability to communicate verbally (by mouth) in the patient's primary language. The item does not address communicating in sign language, in writing, or by any nonverbal means. Augmented speech (e.g., a trained esophageal speaker, use of an electrolarynx) is considered verbal expression of language.

Recommendations from Expert Design Forum

Optimal Technique: Observe patient's ability to speak and effectively express self (provide answers, ideas, needs, etc) and communicate during assessment visit**.** Notice choice of words, complexity of sentences or paucity of words used.

Tips: Focuses on verbal communication and ability to form words and produce sounds normally or by esophageal speech or use of electrolarynx.

Communication by sign language is considered an inability to speak.

Determine if patient speaks same language as clinician. Enlist assistance of interpreter and document the same.

"Nonresponsive" relates to level of alertness and ability to respond.

On a scale of 0-5, rate the level of difficulty expressing ideas or needs by uttering words and producing sounds.

0 - No difficulty expressing self by uttering words and producing sounds.
1 - Minimal difficulty.
2 - Moderate difficulty.
3 - Severe difficulty.
4 - Unable but not comatose or unresponsive.
5 - Unable to speak or unable to respond. Uses sign language.

M0410

M0420 Frequency of Pain interfering with patient's activity or movement:

- ☐ 0 – Patient has no pain or pain does not interfere with activity or movement.
- ☐ 1 – Less often than daily
- ☐ 2 – Daily, but not constantly
- ☐ 3 – All of the time

Item Clarification: Identifies frequency of pain interfering with patient's activities, with treatment if prescribed.

Recommendations from Expert Design Forum

Optimal Question: What are you doing when you feel pain, discomfort, hurt (or other identifying word)? How does pain affect your sleeping, eating, socializing or performance of routine tasks?

Optimal Technique: Ask patient to walk into bathroom and demonstrate/simulate some ADL. Observe for limitations of movement or restricted ability to perform secondary to pain during assessment process.

Tips: In spite of pain medication and other relief measures, acute or chronic pain can interfere with activity or movement.

Pain that interferes will cause activity or movement to slow, be modified or postponed. It may cause the patient to stop and seek relief (take a pain pill) before performing actions. It may be the reason for a depressed mood, low motivation, anger, anxiety, sadness, isolation or staying in the same position for extended periods of time.

If patient chooses not to use pain relief measures, there is a high likelihood that pain interferes with movement and activity. Determine how often.

If nonverbal, evaluate facial expressions or physiologic responses to pain during activity or movement.

M0420

M0430 Intractable Pain: Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?

☐ 0 – No
☐ 1 – Yes

Item Clarification: Identifies the presence of chronic (intractable) pain.

Recommendations from Expert Design Forum

Optimal Question: Is pain, discomfort, hurt (or other identifying word) present despite taking analgesic medication as prescribed or use of other pain relief measures?

Optimal Technique: Obtain information from interview, observation and patient demonstration when applicable.

Tips: If M0420 is 2 or 3, M0430 is Yes.

It is possible for M0420 to be "0", but highly unlikely for pain to be intractable and not interfere with activities, mood, appetite or sleep.

M0430

M0440 Does this patient have a **Skin Lesion** or an **Open Wound**? This excludes "OSTOMIES."

☐ 0 – No ***[If No, go to M0490]***

☐ 1 – Yes

Item Clarification: Identifies the presence of a skin lesion or open wound. A lesion is a broad term used to describe an area of pathologically altered tissue. Sores, skin tears, burns, ulcers, rashes, surgical incisions, crusts, etc. are all considered lesions. All alterations in skin integrity are considered to be lesions, except alterations that end in "ostomy" (e.g., tracheostomy, gastrostomy, etc.) or peripheral IV sites. Persistent redness without a break in the skin is also considered a lesion.

Recommendations from Expert Design Forum

Optimal Question: Do you have any wounds, sores, scars (use word they can understand)?

Optimal Technique: Visually inspect skin.

Tips: Skin lesion:

- Area of pathologically altered tissue.
- Primary lesions (arising from previously normal skin) such as vesicles, pustules, wheals.
- Secondary lesions (resulting from changes in primary lesions) such as crusts, ulcers, scar.
- Changes in color or texture such as maceration, scale, lichenification.
- Changes in shape of skin surface such as edema, cyst, nodule.
- Breaks in skin surfaces such as abrasion, excoriation, fissure, incision.
- Vascular lesions such as petechiae, ecchymosis.

Includes but not limited to:

- Wounds, ulcers, rashes, crusts, bruises, sores.
- Skin tears.
- Burn.
- Surgical incisions, pin sites, wounds with staples or sutures.
- Central lines, PICC lines.
- Portacath, mediport, implanted infusion devices, venous access devices.
- Current surgical wound or healed scar of pacemaker insertion.

Excludes:

- Lesions ending in "ostomy" such as suprapubic catheter site (cystostomy), PEG site (gastrostomy), new colostomy, etc.
- Peripheral IV sites.

M0445 Does this patient have a **Pressure Ulcer?**

☐ 0 – No ***[If No, go to M0468]***
☐ 1 – Yes

Item Clarification: Identifies the presence of a pressure ulcer, defined as any lesion caused by unrelieved pressure resulting in tissue hypoxia and damage of the underlying tissue. Pressure ulcers most often occur over bony prominences.

Recommendations from Expert Design Forum

Optimal Question: How did you get this wound, sore, ulcer (word patient can understand)?

Optimal Technique: Visually inspect skin. Determine presence of active or healed pressure area. Determine patient history, wound etiology, consult with physician.

Tips: Pressure ulcer:

- Any lesion caused by unrelieved pressure resulting in tissue hypoxia and damage of the underlying tissue.
- Identify an ulcer that is active or "healed" regardless of the number of years it has been healed. Once a pressure ulcer, always a pressure ulcer. It must be supported by clinical documentation in the record.

M0445

M0450 Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.)

	Pressure Ulcer Stages	Number of Pressure Ulcers				
a)	Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.	0	1	2	3	4 or More
b)	Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.	0	1	2	3	4 or More
c)	Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.	0	1	2	3	4 or More
d)	Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.)	0	1	2	3	4 or More
e)	In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? ☐ 0 - No ☐ 1 - Yes					

Item Clarification: Identifies the presence of a pressure ulcers at each stage present at the time of assessment. Definitions of ulcer stages derived from the National Pressure Ulcer Advisory Panel.

Recommendations from Expert Design Forum

Optimal Technique: Visually inspect skin. Obtain wound history. Determine etiology of lesion. Classify ulcer at its worst stage.

Tips: Pressure ulcer:

- Lesion caused by unrelieved pressure resulting in tissue hypoxia and damage of underlying tissue.
- Remains when treated with skin graft.
- Remains when surgically debrided.
- Exists on foot of diabetic when etiology is pressure.
- Identified and classified even when healed.
- Becomes surgical wound when replaced with muscle flap.
- Partially granulated to the skin surface, leaving the ulcer open in more than one area is only 1 ulcer.

Nonobservable (M0450e):

- Eschar or slough present in wound bed.
- Dressing cannot be removed by physician order.
- Has cast covering.

Staging:

- Identify by worst stage achieved.
- Do not reverse stage.
- Cannot be done when eschar or slough present in wound bed.

Carry some kind of pocket guide reference tool.

Delay answering M0450 and M0460 if non observable ulcer will become observable within 5 days.

M0450

M0460 Stage of Most Problematic (Observable) Pressure Ulcer:

- ☐ 1 – Stage 1
- ☐ 2 – Stage 2
- ☐ 3 – Stage 3
- ☐ 4 – Stage 4
- ☐ NA – No observable pressure ulcer

Item Clarification: Identifies the most problematic pressure ulcer of those noted in M0450. "most problematic" may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation. Definitions of pressure ulcer stages (stated under M0450) are derived from the National Pressure Ulcer Advisory Panel.

Recommendations from Expert Design Forum

Optimal Technique: Visually inspect skin. Consider ulcer's location, severity, and complexity of treatment.

Tips: After assessment, in the clinician's professional opinion, ulcer that provides the greatest challenge to care and treatment for any reason.

Nonobservable;

- Eschar or slough present in wound bed.
- Dressing cannot be removed by physician order.
- Has cast covering.

Delay answering M0450 and M0460 if non observable ulcer will be visualized within 5 days of M0090.

An old or "healed" pressure ulcer with intact skin is fully granulating.

M0460

M0464 Status of Most Problematic (Observable) Pressure Ulcer:

- ☐ 1 – Full granulating
- ☐ 2 – Early/partial granulation
- ☐ 3 – Not healing
- ☐ NA – No observable pressure ulcer

Item Clarification: Identifies the degree of healing visible in the ulcer identified in M0460 as the most problematic observable pressure ulcer.

Recommendations from Expert Design Forum

Optimal Technique: Observe ulcer. Apply definitions from WOCN's OASIS Guidance Document to select status.

Tips: Refer to OASIS Guidance Document (www.wocn.org)
Document complete wound description in clinical record; location, size, depth, drainage, appearance of wound bed and surrounding skin.

Select "N/A" no observable pressure ulcer if:
- Presence of non removable dressing by physician order
- Presence of cast

Select "not healing" if pressure ulcer is:
- Stage I
- Infected
- Partially or wholly covered by necrotic tissue, scab

Definitions:

Fully granulating:
- Wound bed with granulation tissue to the level of surrounding skin or new epithelium; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open.
- "Healed" pressure ulcer.

Early/partial:
- 25% of the wound bed is covered with granulation tissue: there is minimal avascular tissue (i.e., < 25% of the wound bed is covered with avascular tissue):may have dead space: no signs or symptoms of infection: wound edges open.

Not healing:
- Wound with ≥ 25% avascular tissue OR signs/symptoms of infection OR clean but not granulating wound bed OR closed hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

 Sponsored by: 3M Home Health Systems, NAHC and Fazzi Associates, Inc.

M0468 Does this patient have a **Stasis Ulcer?**

☐ 0 – No
☐ 1 – Yes

Item Clarification: Identifies the presence of an ulcer caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis. Stasis ulcers do not include arterial circulatory lesions or arterial ulcers.

Recommendations from Expert Design Forum

Optimal Question: How did you get this wound?

Optimal Technique: Visually inspect skin. Obtain wound history. Determine etiology of lesion.

Tips: Refer to WOCN Clinical Fact Sheets re: assessment of leg ulcers and venous insufficiency (www.wocn.org)

Describe wound in clinical record; location, size, drainage, wound bed and surrounding skin, presence of pain.

Venous Stasis ulcer:

- Results from disturbance in the forward flow of blood in the lower extremities.
- May occur in presence of stasis dermatitis, brown/black discoloration of the LE or non-pitting (brawny) edema.
- Usually located medial aspect of LE and ankle, superior to medial malleolus and seldom, if ever, on foot or above knee.
- Appearance: irregular wound margins, color of base ruddy, granulation frequently present, shallow, superficial crater, exudate moderate to heavy.
- Surrounding skin with edema, possible induration, cellulitis.
- Associated with minimal pain.
- Treated with a skin graft remains a stasis ulcer.

Exclude:

- Stasis ulcers of arterial origin.

M0470 Current Number of Observable Stasis Ulcer(s):

- ☐ 0 – Zero
- ☐ 1 – One
- ☐ 2 – Two
- ☐ 3 – Three
- ☐ 4 – Four or more

Item Clarification: Identifies the number of visible stasis ulcers.

Recommendations from Expert Design Forum

Optimal Technique: Visually inspect skin.

Tips: "Non observable" stasis ulcers:

- Only those that are covered by a non removable dressing.

Exclude:

- Ulcers of arterial origin.

M0470

M0474 Does this patient have at least one **Stasis Ulcer that Cannot be Observed** due to the presence of a nonremovable dressing?

☐ 0 – No
☐ 1 – Yes

Item Clarification: Identifies the presence of a stasis ulcer which is covered by a dressing that home care staff are not to remove (e.g., an Unna's paste-boot).

Recommendations from Expert Design Forum

Optimal Technique: Check history, clinical information or contact physician if patient has non-removable dressing to determine what type of ulcer is present under dressing.

Tips: "Nonremoveable" dressing:

- Supported by physician order.

Delay answering this item if dressing will be removed and visualized within 5 days of M0090.

M0474

M0476 [At follow-up, skip this item if patient has no stasis ulcers] **Status of Most Problematic (Observable) Stasis Ulcer:**

- ☐ 1 – Full granulating
- ☐ 2 – Early/partial granulation
- ☐ 3 – Not healing
- ☐ NA – No observable stasis ulcer

Item Clarification: Identifies the degree of healing visible. "most problematic" may be the largest, the most resistant to treatment, one which is infected, etc., depending on the specific situation.

Recommendations from Expert Design Forum

Optimal Technique: Visually inspect lesion. Apply definitions from WOCN's OASIS Guidance Document to select status**.**

Tips: After assessment, in the clinician's professional opinion, this is the venous stasis ulcer that provides the greatest challenge to care and treatment for any reason.

Refer to OASIS Guidance Document (www.wocn.org).

Document complete wound description in record; location, size, depth, drainage, appearance of wound bed and surrounding skin.

If the only stasis ulcer is non observable, delay assessment if the wound will be visualized within 5 days of M0090.

Definitions:

Fully granulating:

- Wound bed with granulation tissue to the level of surrounding skin or new epithelium; no dead space, no avascular tissue; no signs or symptoms of infection; wound edges are open.

Early/partial:

- 25% of the wound bed is covered with granulation tissue; there is minimal avascular tissue (i.e., 25% of the wound bed is covered with avascular tissue): may have dead space: no signs or symptoms of infection; wound edges open.

Not healing:

- Wound with $\geq$ 25% avascular tissue OR signs/symptoms of infection OR clean but not granulating wound bed OR closed hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

M0482 Does this patient have a **Surgical Wound?**

☐ 0 – No ***[If No, go to M0490]***
☐ 1 – Yes

Item Clarification: Identifies the presence of any wound resulting from a surgical procedure.

Recommendations from Expert Design Forum

Optimal Question: How did you get this wound?

Optimal Technique: Visually inspect skin. Obtain wound history. Determine etiology of lesion.

Tips: Surgical wound:

- Result of a surgical procedure and surgical instrumentation.
- Orthopedic pin sites, central line sites, stapled or sutured incisions.
- Mediport sites and other implanted infusion devices or implanted venous access devices.
- Peritoneal dialysis catheter.
- Debrided graft sites.
- Wounds with drains.
- Surgical incision with well approximated edges and a scab (i.e., crust) from dried blood or tissue fluid.
- Muscle flap to surgically replace pressure ulcer.
- Gastrostomy closed by "take down".

Excludes:

- PICC lines (peripherally inserted).
- Gastrostomy allowed to close on its own (without surgical intervention).
- Surgical wounds resulting in scar or keloid formation.
- Pressure ulcers treated by surgical debridement.
- Recent healed surgical wounds with well approximated edges, complete epithelialization, no drainage, edema or signs of infection and healing ridge no longer palpable.
- Traumatic wounds that were surgically closed.
- Pressure ulcers treated with a skin graft.

M0484 Current Number of (Observable) Surgical Wounds: (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.)

- ☐ 0 – Zero
- ☐ 1 – One
- ☐ 2 – Two
- ☐ 3 – Three
- ☐ 4 – Four or more

Item Clarification: Identifies the number of observable surgical wounds.

Recommendations from Expert Design Forum

Optimal Technique: Inspect skin.

Tips Count as separate wounds:

- Number of visible wounds.
- Each opening in a single surgical wound.

Do not count as separate wounds:

- Suture or staple insertion sites.

Nonobservable surgical wounds not included in count:

- Covered by a dressing or cast not to be removed by physician's order.

M0484

M0486 Does this patient have at least one **Surgical Wound that Cannot be Observed** due to the presence of a nonremovable dressing?

☐ 0 – No
☐ 1 – Yes

Item Clarification: Identifies the presence of a surgical wound covered by a dressing which is not to be removed, per physician's orders.

Recommendations from Expert Design Forum

Optimal Technique: Inspect skin. Count visible openings.

Tips: Nonobservable surgical wound not covered:

- Covered by a dressing or cast not to be removed by physician's order.

Delay answering this item if dressing will be removed and visualized within 5 days of M0090.

M0486

M0488 [At follow-up, skip this item if patient has no surgical wounds] **Status of Most Problematic (Observable) Surgical Wound:**

- ☐ 1 – Full granulating
- ☐ 2 – Early/partial granulation
- ☐ 3 – Not healing
- ☐ NA – No observable stasis ulcer

Item Clarification: Identifies the degree of healing visible in the most problematic, observable surgical wound. "most problematic" may be complicated by the presence of infection, location, large size, difficult management of drainage, or slow healing, depending on the specific situation.

Recommendations from Expert Design Forum

Optimal Technique: Observe wound. Apply definitions fron WOCN's OASIS Guidance Document to select status**.**

Tips: Refer to OASIS Guidance Document (www.wocn.org).

Nonobservable surgical wound not to be counted:

- Covered by a dressing or cast not to be removed by physician's order.

Definitions:
Healing by **Primary Intention** (i.e., approximated edges).

Fully granulating/healing:

- Incision well approximated with complete epithelialization.
- No signs or symptoms of infection.
- Healing ridge is well defined.

Early/partial granulation:

- Incision well approximated but not completely epithelialized.
- No signs or symptoms of infection.
- Healing ridge palpable but poorly defined.

Non-healing:

- Incisional separation OR
- Incisional necrosis OR
- Signs or symptoms of infection OR
- No palpable healing ridge (may include first 4-5 days post wounding).

Healing by **Secondary Intention** (i.e. healing of dehisced wound by granulation, contraction and epithelialization).

Fully granulating:

- Wound bed filled with granulation tissue to the level of surrounding skin or new epithelium.
- No dead space, no avascular tissue (necrotic such as slough and eschar).
- No signs or symptoms of infection.
- Wound edges are open.

M0488

M0488 Continued

Early/partial granulation:

- ≥ 25% of the wound bed is covered with granulation tissue.
- There is minimal avascular tissue (i.e < 25% of the wound bed is covered with avascular tissue.
- May have dead space.
- No sign or symptoms of infection.
- Wound edges are open.

Non-healing:

- Wound with ≥ 25% avascular tissue (necrotic such as eschar or slough) OR
- Signs/symptoms of infection OR
- Clean but non-granulating wound bed OR
- Closed/hyperkeratotic wound edges OR
- Persistent failure to improve despite comprehensive appropriate wound management.

Delay answering this item if dressing will be removed and visualized within 5 days of M0090.

M0488

M0490 When is the patient dyspneic or noticeable **Short of Breath?**

- ☐ 0 – Never, patient is not short of breath
- ☐ 1 – When walking more than 20 feet, climbing stairs
- ☐ 2 – With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 – With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 – At rest (during day or night)

Item Clarification: Identifies the patient's level of shortness of breath.

Recommendations from Expert Design Forum

Optimal Question: What causes you to get SOB? Walking? Dressing? Feeling anxious? Talking?

Optimal Technique: Observe patient walk at least 20 feet (to bathroom). If unable to walk observe movement by transfer or within bed. Note level of exertion which causes a noticeable shortness of breath.

Tips: Patient must perform some activity and movement in order to assess appropriately.

If oxygen worn continuously, assess patient response while using oxygen.

If oxygen used intermittently, do not assess patient response while using oxygen.

Emotional states such as anxiety and agitation can produce shortness of breath.

M0490

M0500 Respiratory Treatments utilized at home: **(Mark all that apply.)**

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

Item Clarification: Identifies any of the listed respiratory treatments being used by the patient.

Recommendations from Expert Design Forum

Optimal Question: Do you ever use oxygen, a ventilator or c-pap device, something to make it better for you to breathe?

Optimal Technique: Observe environment for evidence of respiratory equipment.

Tips: Applies **only** to the treatments listed.

M0500

M0510 Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

- ☐ 0 – No
- ☐ 1 – Yes
- ☐ NA – Patient on prophylactic treatment
- ☐ UK – Unknown

Item Clarification: Identifies treatment of urinary tract infection during the past 14 days.

Recommendations from Expert Design Forum

Optimal Question: Have you been on medicine in the past 14 days for a urine infection or problems urinating?

Optimal Technique: Review current and past prescriptions. Check clinical documentation, referral information or ask physician if suspected.

Tips: Time period**:** Count back 14 days starting with the day prior to the assessment.

M0510

M0520 Urinary Tract Incontinence or Urinary Catheter Presence:

☐ 0 – No incontinence or catheter (includes anuria or ostomy for urinary drainage). ***[If No, go to M0540]***
☐ 1 – Patient is incontinent
☐ 2 – Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) ***[Go to M0540]***

Item Clarification: Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent. Etiology (cause) of incontinence is not addressed in this time.

Recommendations from Expert Design Forum

Optimal Question: Do you ever have trouble holding your urine? Do you ever leak urine or not make it to the bathroom in time? Do your pants ever get moist from urine?

Optimal Technique: Observe surroundings and note urine odors. Observe condition of undergarments when assessing skin condition. Observe for presence of blue pads, adult briefs, panty liners.

Tips: Identify:

- Presence of any type of urinary catheter for any reason
- Existence of incontinence of any kind for any reason regardless of how often it occurs

Incontinence includes:

- Any reason the patient leaks urine

Incontinence excludes:

- Leaking urinary appliance (catheter, ostomy, ileal conduit, etc).

M0520

M0530 [At follow-up, skip this item if patient has no urinary incontinence or does have a urinary catheter] **When** does **Urinary Incontinence** occur?

- ☐ 0 – Timed voiding defers incontinence
- ☐ 1 – During the night only
- ☐ 2 – During the day and night

Item Clarification: Identifies the time of day when the urinary incontinence occurs.

Recommendations from Expert Design Forum

Optimal Question: When (what time of day) do you have trouble holding your urine?

Optimal Technique: Check clinical record, history for information. Interview caregivers.

Tips: Timed voiding defers includes:

- Continence without accidents

Timed voiding defers excludes:

- Episodes of incontinence in spite of timed voiding (use of diapers at night, etc)
- Stress incontinence
- Timed voiding programs initiated with this visit

During day and night includes:

- Day only.
- Day and night.

M0530

M0540 Bowel Incontinence Frequency

- ☐ 0 – Very rarely or never has bowel incontinence
- ☐ 1 – Less than once weekly
- ☐ 2 – One to three times weekly
- ☐ 3 – Four to six times weekly
- ☐ 4 – On a daily basis
- ☐ 5 – More often than once daily
- ☐ NA – Patient has ostomy for bowel elimination
- ☐ UK – Unknown

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

Recommendations from Expert Design Forum

Optimal Question: Do you ever leak stool or not make it to the bathroom in time? How often?

Optimal Technique: Observe surroundings and note stool odors. Observe condition of undergarments when assessing skin condition. Interview caregivers.

Tips:

Includes:

- Episodes of incontinence in spite of bowel regimen
- Any reason the patient may not have control of his bowels, regardless of reason

Excludes:

- Bowel regimens that effectively control movements

M0540

M0550 Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days) a) was related to an ipatient facility stay, or b) necessitated a change in medical or treatment regimen?

☐ 0 – Patient does not have an ostomy for bowel elimination

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

☐ 2 – The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

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

Recommendations from Expert Design Forum

Optimal Question: Do you have a colostomy?

Optimal Technique: Inspect patient for presence of ostomy. Determine reason for inpatient stay from referral information.

Tips:

M0550

M0560 Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)

- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ☐ 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

Item Clarification: Identifies patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

Recommendations from Expert Design Forum

Optimal Question: Ask caregivers: Does patient need reminders about taking meds or getting dressed or bathing, etc? Does he ask same question or tell same story multiple times? Is he easily distracted?

Optimal Technique: Ask patient to carry out a series of two or three simple instructions and observe response. Observe how patient responds to questions regarding current health and past history, medications, names of family and friends, time of day, and ability to stay focused on conversation. Observe patient appearance.

Tips: Appropriate response selection should be apparent by end of visit. Note distractibility and need to repeat directions.

Do not obtain information by asking as a direct question.

Do not select "0" when patient uses/needs written reminders to remember events or perform tasks.

Draw a circle. Ask patient to draw numbers on a clock. Ask him to draw hands representing a time you pick.

Use mini mental status exam if needed.

M0560

M0570 When Confused (Reported or Observed):

- ☐ 0 – Never
- ☐ 1 – In new or complex situations only
- ☐ 2 – On awakening or at night only
- ☐ 3 – During the day and evening, but not constantly
- ☐ 4 – Constantly
- ☐ NA – Patient nonresponsive

Item Clarification: Identifies the time of day that patient is likely to be confused, if at all.

Recommendations from Expert Design Forum

Optimal Question: Do you ever find you don't know where you are or how you got there? Feel "mixed up"? What is today's date?

Optimal Technique: Ask patient to identify people in pictures that are displayed.
Determine if a medication has been prescribed to treat a problem.
Interview family/caretaker.

Tips: Focuses on when patient experiences a deficit in orientation to person, place, time or situation.

M0570

M0580 When Anxious (Reported or Observed):

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

Item Clarification: Identifies the frequency with which the patient feels anxious.

Recommendations from Expert Design Forum

Optimal Question: Do you find yourself worrying about things? Have feelings of nervousness? Wake up at night with things on your mind? If yes, how often.

Optimal Technique: Observe behavior during interview. Interview the family/caregiver.

Tips: Anxiety is defined as an apprehension about an uncertain future, real or imagined, situations where there is a threat to personal safety and security or anything that makes life less predictable or causes one to feel less in control over the direction of one's life.

M0580

M0590 Depressive Feelings Reported or Observed in the Patient:
(Mark all that apply)

- ☐ 1 – Depressed mood (e.g., feeling sad, tearful)
- ☐ 2 – Sense of failure or self reproach
- ☐ 3 – Hopelessness
- ☐ 4 – Recurrent thoughts of death
- ☐ 5 – Thoughts of suicide
- ☐ 6 – None of the above feelings observed or reported

Item Clarification: Identifies presence of symptoms of depression.

Recommendations from Expert Design Forum

Optimal Question: Tell me about your life/situation and how you feel now as compared to last year. Use symptoms listed above as a direct question for further clarification.

Optimal Technique: Observe and interview patient, family/caregiver. Observe mood, energy, affect. Check for antidepressant medications.

Tips: Response based on observations and other information collected during the assessment.

M0590

M0610 Behaviors Demonstrated <u>at Least Once a Week</u> (Reported or Observed): (Mark all that apply.)

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

Item Clarification: Identifies specific behaviors which may reflect alterations in a patient's cognitive or neuro/emotional status.

Recommendations from Expert Design Forum

Optimal Question: Interview caregivers and ask question directly.
Obtain information from interview and observation.

Optimal Technique: Observe for behaviors during assessment. Look at medications.
Determine if patient is on any medication to control any behaviors.

Tips: When evaluating, key in on the first two words used prior to the colon in items 1 thru 4 (i.e. memory deficit) when making a decision.

Include in response 1 those with memory deficits who:

- Require supervision of ADL/IADL for safe performance or completion of task.
- Require supervision or assistance with medication or equipment.

Include in response "2" those who:

- Demonstrate poor safety awareness (leave walker on other side of room and use furniture and walls for balance, smoke in bed or smoke in presence of oxygen, etc).

M0610

M0620 Frequency of Behavior Problems (Reported or Observed)

(e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.)

- ☐ 0 – Never
- ☐ 1 – Less than once a month
- ☐ 2 – Once a month
- ☐ 3 – Several times each month
- ☐ 4 – Several times a week
- ☐ 5 – At least daily

Item Clarification: Identifies frequency of behavior problems which may reflect an alteration in a patient's cognitive or emotional status. "Behavior problems" are not limited to only those identified in M0610. For example, "wandering" is included as an additional behavior problem. Any behavior of concern for the patient's safety or social environment can be regarded as a problem behavior.

Recommendations from Expert Design Forum

Optimal Technique: Interview caregivers using examples from response selections. Determine how often patient displays behaviors that would jeopardize their safety or social environment or their ability to achieve their care plan goals. If so how frequently?

Tips: If multiple problems are exhibited, respond based on the total frequency of all behaviors.

This item includes examples given in this question, behaviors identified in MO610 and any other behavior that would jeopardize the patient's safety, disrupt his social environment, including caregivers, or create barriers to achieving care plan goals.

M0620

M0630 Is patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

☐ 0 – No
☐ 1 – Yes

Item Clarification: Identifies whether the patient is receiving psychiatric nursing services at home as provided by a qualified psychiatric nurse. "Psychiatric Nursing Services" address mental/emotional needs; a "qualified psychiatric nurse: is so qualified through educational preparation or experience.

Recommendations from Expert Design Forum

Optimal Technique: Note physician order for psychiatric nurse services on Plan of Care.

Tips: Includes only psychiatric nursing services provided by the home health agency.

At discharge, select yes if psychiatric nursing services is performing discharge.

OASIS Items M0640-820

Complete OASIS items according to "ability" which may not be how they actually perform the activity on a routine basis. To determine "ability" requires interview strategies combined with patient demonstration of task and then making a clinical judgment to factor out patient “willingness” or "compliance". In addition, if the patient has varying levels of ability, clinician must decide which response reflects the patient’s ability to perform the task more than 50% of the time.

"Ability" encompasses patient performance that is **safe** considering the patient’s current physical condition, mental/emotional/cognitive status, activities permitted, medical restrictions, environment and location and access to rooms and facilities in home. Ability can be temporarily or permanently limited by:

- Physical impairments (e.g., limited range of motion, impaired balance, presence and location of wound, etc).
- Emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear, etc).
- Sensory impairments (e.g., pain, impaired vision or hearing).
- Environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry, lack of safety equipment like grab bars, etc).

The patient’s ability may change as the patient’s condition improves or declines, as medical restrictions are lifted or imposed or as the environment is modified.

Do not consider whether the patient becomes short of breath requiring tasks to be done in stages for any of these evaluations. Consider his level of independence.

After evaluating all these factors, choose the response that reflects what the patient is "ABLE" to do on the day of the assessment, regardless of what he is or is not actually doing.

In selecting the response, ask yourself the question, "What kind and how much assistance is required for the patient to perform this task safely, effectively and efficiently?"

M0640 Grooming: Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

Prior	Current		
☐	☐	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.
☐	UK -Unknown		

Item Clarification: Identifies the patient's ability to tend to personal hygiene needs, excluding bathing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Technique: Note location of grooming items and ease of access to them**.** Observe washing hands and/or face/or demonstrate actions**.** Note the patient's coordination, flexibility, coordination, balance, strength, etc. Use all reported and observed information to make necessary inferences about patient's ability to perform grooming tasks listed.

Tips: Grooming includes several activities. Consider the frequency with which the selected tasks are necessary. Ability to do more frequently performed activities and inability to perform less frequently performed activities should be considered as having more grooming ability.

Assessment of "ability" includes consideration of:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, etc).
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions (sling and swath to immobilize arm, shoulder, etc).
- Activity limitations (bed rest, joint replacement patient with inability to climb multiple stairs to second floor where grooming items located, etc).
- Current clinical condition (limited ROM shoulder, elbow, edema, pain, paresis, paralysis, impaired balance, fall risk, etc.).
- Location of bathroom (restricted access for any reason, narrow doorways, etc.).
- Assessment of "ability" may be in conflict with reporting on how the task is actually performed on a routine basis. Document differences in clinical record.

Supervision:

- Verbal cues.
- Prompting.
- Reminders.
- Standby.

Assistance:

- Touching.
- Contact guarding.
- Participation in task.

On a scale of 0-3

0 Independent, no human intervention required for any part of task completion.
1 Dependent on another person for set up.
2 Dependent on another person for at least minimal assistance (standby) or supervision (reminders, cueing).
3 Totally dependent on another person to accomplish grooming.

Prior:

Ability on day #14 before this assessment day.

M0650 Ability to Dress Upper Body (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

Prior	Current		
☐	☐	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.
☐	UK		-Unknown

Item Clarification: Identifies the patient's ability to dress upper body, including the ability to obtain, put on and remove upper body clothing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: Have you changed what you wear to make it easier to get dressed?
What do you wear to the doctor's office?
Where are your clothes located?

Optimal Technique: Show me how you take your shirt off and put it back on.
Observe ability to reach above shoulder level to get clothes out of closet. Note the patient's flexibility, coordination, balance, strength, etc. Use all reported and observed information to make necessary inferences about patient's ability to obtain, put on, and take off upper body clothing that the patient routinely wears. Observe ability to safely carry any item. Note location of clothes and ability to safely carry any item.

Tips: Determine physical and cognitive ability to safely retrieve, dress and undress upper body in clothing routinely worn by obtaining patient demonstration.

If applicable, also include ability to apply upper extremity prosthesis or immobilizer.

Assessment of "ability" includes consideration of:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, inability to sequence task, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, coordination, etc).
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions (immobilization of shoulder, bulky dressings, etc).
- Activity limitations (inability to climb multiple stairs to second floor where clothing is located, bed rest, etc).
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc.).
- Location of bedroom (restricted access for any reason, narrow doorways, etc.).

Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

Supervision:

- Verbal cues.
- Prompting.
- Reminders.
- Standby.

Assistance:

- Touching.
- Contact guarding.
- Participation in task.

On a scale of 0-3

0- Independent, no human intervention required for any part of task completion.
1 Dependent on another person for set up, to obtain items for dressing.
2 Dependent on another person for at least minimal assistance (standby) or supervision (cueing, reminders).
3 Totally dependent on another person to accomplish upper body dressing.

Prior:
Ability on day #14 before this assessment day.

M0650

M0660 Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Prior	Current		
☐	☐	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.
☐		UK	- Unknown

Item Clarification: Identifies the patient's ability to dress lower body, including the ability to obtain, put on and remove lower body clothing. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: Have you changed what you wear to make it easier to get dressed?
What do you wear to the doctor's office?
Where are your clothes located?

Optimal Technique: Show me how you take your shoes and socks off and put them back on.
Observe the patient's flexibility, coordination, balance, strength, etc., and use all reported and observed information to make necessary inferences about patient's ability to obtain, put on, and take off lower body clothing that the patient routinely wears. Note location of clothes and ability to safely carry any item.

Tips: Determine physical and cognitive ability to safely retrieve clothing, dress and undress lower body in clothing routinely worn by obtaining patient demonstration.

If applicable, also include ability to apply TED hose, lower extremity prosthesis or immobilizer.

Assessment of "ability" includes consideration of:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, inability to sequence task, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, coordination, etc).
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions (immobilization of joint, bulky dressings, hip precautions, etc).
- Activity limitations (joint replacement with inability to climb multiple stairs to second floor where clothing located, bed rest, etc).
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc.).
- Location of bedroom (restricted access for any reason, narrow doorways, etc).

. Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

Supervision:

- Verbal cues.
- Prompting.
- Reminders.
- Standby.

Assistance:

- Touching.
- Contact guarding.
- Participation in task.

On a scale of 0-3

0 Independent, no human intervention required for any part of task completion
1 Dependent on another person for set up or minimal supervision
2 Dependent on another person for intermittent assistance or intermittent supervision
3 Totally dependent on another person to accomplish dressing of lower body

Prior:
Ability on day #14 before this assessment day.

M0660

M0670 Bathing: Ability to wash entire body. **Excludes grooming (washing face and hands only).**

Prior	Current		
☐	☐	0	-Able to bathe self in shower or tub independently.
☐	☐	1	-With the use of devices, is able to bathe self in shower or tub independently.
☐	☐	2	-Able to bathe in shower or tub with the 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	-Participates 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 and is bathed in bed or bedside chair.
☐	☐	5	-Unable to effectively participate in bathing and is totally bathed by another person.
☐	UK -Unknown		

Item Clarification: Identifies the patient's ability to bathe entire body and the assistance which may be required to safely bathe in shower or tub. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: Where is your tub/shower located? How do you bathe? What keeps you from bathing in the tub/shower? Does anyone help you to bathe?

Optimal Technique: Show me how you get in and out of tub or shower. Show me how you wash your feet or your back. Observe the patient's judgment, flexibility, coordination, balance, strength, etc., and use all reported and observed information to make necessary inferences about patient's ability to bathe. Note location of tub/shower and ability to safely carry any item.

Tips: Determine physical and cognitive ability to safely wash and dry entire body including transfer to bathing area by obtaining patient demonstration.

A patient may "choose" not to bathe by tub or shower but that is not an assessment of "ability".

Assessment of "ability" includes consideration of:

- cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, etc).
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions (no showering till staples removed, keep dressing dry, etc).
- Activity limitations (joint replacement patient with inability to climb multiple stairs to second floor where shower/tub located, bed rest, joint immobilization, etc).
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc).
- Location of bathroom, shower facilities (restricted access for any reason, narrow doorways, lack of grab bars, etc).

Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

Supervision
- Verbal cues.
- Prompting.
- Reminders.
- Standby.

Assistance:
- Touching.
- Contact guarding.
- Participation in task.

On a scale of 0-5

0 Independent, does not require human intervention or adaptive or safety equipment for bathing in tub or shower.

1 Independent, does not require human intervention but requires use of safety or adaptive equipment for bathing in tub or shower.

2 Dependent, requires set up and/or intermittent assistance or supervision of another person for bathing in tub or shower.

3 Dependent—requires constant supervision or assistance of another for bathing in shower or tub.

4 Dependent—unable to safely bathe in tub or shower due to a cognitive, emotional or physical deficit or location of tub or shower but can safely bathe at bedside or washstand or in bed, with or without human intervention

5 Dependent—totally dependent on another for bathing activity.

Select responses from 0-3 if patient has ability to bathe in tub or shower regardless of whether they routinely do it.
Select response 4 if patient able to bathe or participate in bathing other than shower/tub.
Prior: Ability on day #14 before this assessment day.

M0670

M0680 Toileting: Ability to get to and from the toilet or bedside commode.

Prior	Current		
☐	☐ 0	-	Able to get to and from the toilet independently with or without a device.
☐	☐ 1	-	When reminded, assisted, or supervised by another person, able to get to and from the toilet.
☐	☐ 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.
☐	UK -		Unknown

Item Clarification: Identifies the patient's ability to safely get to and from the toilet or bedside commode. Excludes personal hygiene and management of clothing when toileting. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: Do you use a toilet, bedside commode or bed pan/urinal to go to the bathroom? Where is your bathroom located? Describe how you get there?

Optimal Technique: Show me how you get to the toilet or bedside commode.
Note the patient's judgment, coordination, balance, strength, etc., and use all reported and observed information to make necessary inferences about patient's ability to safely get to and from the toilet or bedside commode. Note location of the toilet or bedside commode and any related environmental barriers.

Tips: Determine physical and cognitive ability to get to and from (mobility) toilet or bedside commode safely.

This is an access question. How does patient get to and use the device he uses for toileting?

Ignore the presence of a urinary catheter, urostomy, colostomy, etc when making this assessment and determine patient ability if urinary/fecal diversions did not exist.

Assessment excludes consideration of:

- Personal hygiene.
- Management of clothing.

Assessment of "ability" includes consideration of:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, coordination, etc).
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions (hip precautions, etc).
- Activity limitations (joint replacement patient with inability to climb multiple stairs to second floor where toilet is located, bed rest, etc).
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc.).
- Location of bathroom, (restricted access for any reason, narrow doorways, etc).

Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

M0680 Continued

Supervision:
- Verbal cues.
- Prompting.
- Reminders.
- Standby.

Assistance:
- Touching.
- Contact guarding.
- Participation in task.

On a scale of 0-4:

0 - Independent, able to get to toilet without any intervention of another, may use assistive device.

1 - Dependent, requires at least minimal assistance (standby) or supervision (cueing) of another to get to toilet.

2 - Cannot get to Toilet but can get to bedside commode with or without human intervention.

3 - Cannot get to toilet or bedside commode but can use urinal or bedpan without assistance from another.

4 - Totally dependent on another to use toilet, bedside commode or bedpan/urinal

Select response 0-1 when patient routinely using toilet.
Select response 2 when patient routinely using bedside commode
Select response 3 when routinely using urinal/ bedpan

Bedside commode exludes:
Raised or 3 in 1 toilet

Prior:
Ability on day #14 before this assessment day.

M0690 Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

Prior	Current		
☐	☐	0	Able to independently transfer.
☐	☐	1	Transfers with minimal human assistance or with use of an assistive device.
☐	☐	2	Unable to transfer self but is able to bear weight and pivot during the transfer process.
☐	☐	3	Unable to transfer self and is unable to bear weight and pivot during the transfer process.
☐	☐	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.
☐	UK -Unknown		

Item Clarification: Identifies the patient's ability to safely transfer in a variety of situations. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: Describe how you get out of bed, on and off the toilet, in and out of the shower/tub.

Optimal Technique: Show me how you get on and off a chair, move from bed to chair, get in and out of the tub or shower, get on and off toilet/commode. Note the patient's judgment, flexibility, coordination, balance, strength, etc., and use all reported and observed information to make necessary inferences about patient's ability to perform only these transfer tasks listed.

Tips: Determine physical and cognitive ability to perform only these 3 transfers safely by obtaining patient demonstration.

Assistive device includes:

- Equipment items (e.g., walker, cane, grab bars, hydraulic lift, etc.) that the patient would need to utilize in order to safely perform the transfer.

Assistive device excludes:

- Chair arms or other furniture items.

Assessment of "ability" includes:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, etc).
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions (presence of bulky dressings or immobilizers, etc)
- Activity limitations (bed rest, hip precautions, etc).
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc).
- Location of bathroom, shower facilities, bedroom (restricted access for any reason, narrow doorways, lack of grab bars, etc).

Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

Continued

M0690 Continued

Supervision:
- Verbal cues.
- Prompting.
- Reminders.
- Standby.

Assistance:
- Touching.
- Contact guarding.
- Participation in task.

On a scale of 0-5:
0 - Able to perform these three transfers without human intervention or assistive device.
1 - Able to perform these 3 transfer when using assistive device or with minimal human intervention.
2 - Able to participate in these 3 transfers by weight bearing and pivoting.
3 - Unable to participate in these 3 transfers by weight bearing and/or pivoting.
4 - If bedfast (confined to bed), can turn and position self in bed.
5 - If bedfast (confined to bed), can not turn and position self in bed.

Select response 1:
- If able to safely perform the transfers with an assistive device
- If stand by assistance (from another person) is necessary to achieve the safe transfer
- If needs a steadying hand of another person (as opposed to the other person actually providing the lifting power).

Select response 2-3 when able to move from one surface to another but another person fully participates in the transfer.
Select 3 if transfers occur by hoyer lift.
Select response 4-5 if patient does not get out of bed.

Prior:
Ability on day #14 before this assessment day.

M0690

M0700 Ambulation/Locomotion: Ability to safely walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Prior	Current		
☐	☐	0	- Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
☐	☐	1	- Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
☐	☐	2	- Able to walk only with the supervision or assistance of another person at all times.
☐	☐	3	- Chairfast, unable to ambulate but is able to wheel self independently.
☐	☐	4	- Chairfast, unable to ambulate and is unable to wheel self.
☐	☐	5	- Bedfast, unable to ambulate or be up in a chair.
☐		UK	- Unknown

Item Clarification: Identifies the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: Describe how you walk around the house, get up and down steps.

Optimal Technique: "Walk with me." If non-ambulatory, "show me how you can get around in your wheelchair". Go over most difficult surface maintaining patient safety.
Observe the patient's judgment, coordination, balance, strength, etc., and use all reported and observed information to make necessary inferences about patient's ability to ambulate or propel wheelchair.

Tips: Determine physical and cognitive ability to safely walk (excluding coming to a standing position) on a variety of surfaces, even and uneven including stairs.

If unable to walk, determine physical and cognitive ability to safely use a wheelchair (powered or manual) once seated, on a variety of surfaces. Include even and uneven surfaces, curbs, w/c parts management in assessment.

Assessment of "ability" includes:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, etc).
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions (joint immobilization, etc)
- Activity limitations (joint replacement patient with inability to climb multiple stairs, bed rest, hip precautions, etc).
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc).
- Floor plan of home and access to areas routinely used.

Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

Continued

M0700 Continued

Supervision:
- Verbal cues.
- Prompting.
- Reminders.
- Standby.

Assistance:
- Touching.
- Contact guarding.
- Participation in task.

On a scale of 0-5

0 - Independent on all surfaces without human intervention or assistive device.
1 - Able to safely walk on all surfaces using assistive device OR requires at least intermittent minimal human intervention for cueing or guarding on stairs, steps or uneven surfaces.
2 - Requires at least minimal human intervention for safety at all times
3 - Able to propel their own wheelchair without human intervention.
4 - Unable to propel wheelchair independently, unable to walk and is bedfast.
5 - Confined to bed.

Select 0-2 when able to walk.
Select 3-4 when unable to walk and uses wheelchair for mobility.
Select 5 when unable to get out of bed.

Prior:
Ability on day #14 before this assessment day.

M0700

M0710 Feeding or Eating: Ability to feed self meals and snacks. **Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.**

Prior	Current		
☐	☐	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.
☐		UK	Unknown

Item Clarification: Identifies the patient's ability to feed self meals, including the process of eating, chewing and swallowing food. This item excludes evaluation of preparation of food items. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: How much help do you need to cut up your food or feeding yourself?
How much of a problem do you have with chewing or swallowing your food?
Do you ever choke on your food?

Optimal Technique: Observe patient eat.

Tips: Determine physical and cognitive ability to safely perform activities associated with eating once food is placed in front of him. When patient no longer receiving nutrition from feeding tube, response 0, 1, or 2 applies.

Assessment of "ability" includes:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
- Physical function (vision, ROM, strength, dexterity, endurance, etc).
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions (presence of feeding tube).
- Activity limitations.
- Current clinical condition (pain, paresis, paralysis, condition of teeth, etc).

Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

Supervision:

- Verbal cues
- Prompting
- Reminders
- Standby

Assistance:

- Touching.
- Contact guarding.
- Participation in task.

If able to feed self select:

0 - No equipment or human intervention required.
1 - Requires setup, intermittent assistance or supervision or special food preparation,

If unable to feed self select:

2 - Requires at least minimal human intervention for eating
3 - Takes food orally **and** uses NG tube or gastrostomy for nutrition.
4 - Uses NG or gastrostomy **and** has no oral intake.
5 - Receives no nutrients by mouth or tube feeding.

Prior:

Ability on day #14 before this assessment day.

M0710

M0720 Planning and Preparing Light Meals (e.g., cereal, sandwich) or reheat delivered meals:

Prior Current

☐ ☐ 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b)Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).

☐ ☐ 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.

☐ ☐ 2 - Unable to prepare any light meals or reheat any delivered meals.

☐ UK - Unknown

Item Clarification: Identifies the patient's physical, cognitive and mental ability to plan and prepare meals, even if the patient does not routinely perform this task. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: If you had to prepare your next meal what could you make and how would you do it? What do you eat when you have no one to prepare a meal for you?

Optimal Technique: Observe patient make a sandwich.

Tips: Determine physical and cognitive ability to safely perform all activities associated with planning and preparing a light meal; know what to do to retrieve items, carry them, prepare them, get them to table.

Assessment of "ability" includes:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, etc).
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, uses walker and can't carry food items, etc).
- Medical restrictions (hip precautions, etc)
- Activity limitations (joint replacement patient with inability to negotiate steps where kitchen is located, bed rest, etc).
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc.).
- Location of kitchen (restricted access for any reason, narrow doorways, steps, etc.).

Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

Supervision

- Verbal cues.
- Prompting.
- Reminders.
- Standby.

Assistance:

- Touching.
- Contact guarding.
- Participation in task.

On scale of 0-2

0 - Independent, does not require any human intervention OR although able, may not perform routinely.

1 - Can sometimes prepare light meals.

2 - Cannot prepare light meals.

Prior:

Ability on day #14 before this assessment day.

M0720

M0730 Transportation: Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway).

Prior	Current		
☐	☐	0-	Able to independently drive a regular or adapted car; OR uses a regular or handicap accessible public bus.
☐	☐	1-	Able to ride in a car only when driven by another person; OR able to use a bus or handicap van only when assisted or accompanied by another person.
☐	☐	2-	Unable to ride in a car, taxi, bus, or van, and requires transportation by ambulance.
☐		UK-	Unknown

Item Clarification: Identifies the patient's physical and mental ability to safely use a car, taxi or public transportation. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: When you need to go to the doctor, how do you get there? How did you get home from the hospital**?**

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Tips: Determine physical and cognitive ability to safely perform all activities associated with use of car or public transportation.

Assessment of "ability" includes:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, etc).
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions (do not drive)
- Activity limitations (bed rest, hip precautions, no driving, limit activities to home, etc).
- Current clinical condition (impaired vision, pain, paresis, paralysis, impaired balance, etc.).

Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

Supervision:

- Verbal cues.
- Prompting.
- Reminders.
- Standby.

Assistance:

- Touching.
- Contact guarding.
- Participation in task.

On scale of 0-2

0 - Can drive requiring no human intervention regardless of whether vehicle or equipment is adapted.
1 - Cannot drive and requires at least minimal human intervention for transportation.
2 - Can only be transported by ambulance.

Prior:

Ability on day #14 before this assessment day.

M0730

M0740 Laundry: Ability to do own laundry – to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand.

Prior	Current		
☐	☐	0	- (a) Able to independently take care of all laundry tasks; OR (b) Is physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this home care admission.)
☐	☐	1	- Able to do only light laundry, such as minor handwash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry.
☐	☐	2	- Unable to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.
☐		UK	- Unknown

Item Clarification: Identifies the patient's physical, cognitive and mental ability to do laundry, even if the patient does not routinely perform this task. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: Describe how you would do laundry today.

Optimal Technique: Observe the patient's comprehension, judgment, coordination, balance, strength, lifting restrictions, weight bearing status, etc., and use all reported and observed information to make necessary inferences about patient's ability to do laundry. Note location of washer and dryer or laundry facilities.

Tips: Determine physical and cognitive ability to safely manage all activities associated with completing laundry including carrying laundry to and from the washing machine, use of washer and dryer, washing small items by hand.

Assessment of "ability" includes:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, ability to carry clothes and laundry basket, etc).
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions (do not lift more than 5 lbs, etc).
- Activity limitations (joint replacement with inability to climb multiple stairs to another floor where washer/dryer located, bed rest, etc).
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc).
- Location of laundry facilities (restricted access for any reason, steps, etc).

Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

Supervision:

- Verbal cues.
- Prompting.
- Reminders.
- Standby.

Assistance:

- Touching.
- Contact guarding.
- Participation in task.

On scale 0-2

0 - Independent- no human intervention or assistance required OR although able, may not perform routinely.
1 - Independent performing minor laundry tasks only
2 - Unable to do any laundry or requires continuous human intervention to do

Prior:

Ability on day #14 before this assessment day.

M0740

M0750 Housekeeping: Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.

Prior	Current		
☐	☐	0	- (a) Able to independently take care of all housekeeping tasks; OR (b) Is physically, cognitively, and mentally able to perform all housekeeping tasks, but has not routinely performed housekeeping tasks in the past (i.e., prior to this home care admission.)
☐	☐	1	- Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently.
☐	☐	2	- Able to perform housekeeping tasks with intermittent assistance or supervision from another person.
☐	☐	3	- Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process.
☐	☐	4	- Unable to effectively participate in any housekeeping tasks.
☐		UK	- Unknown

Item Clarification: Identifies the patient's physical, cognitive and mental ability to perform both heavier and lighter housekeeping tasks, even if the patient does not routinely carry out these activities. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: During this period of recovery, how will your housekeeping get done? Considering how you feel, tell me what cleaning and housekeeping tasks you can do.

Optimal Technique: Observe the patient's comprehension, judgment, coordination, balance, strength, lifting restrictions, weight bearing status, etc., and use all reported and observed information to make necessary inferences about patient's ability to do housekeeping tasks. Note floor plan of home.

Tips: Determine the patient's physical and cognitive ability to safely perform all tasks associated with light housekeeping and heavier cleaning tasks; dusting, bed making, sweeping floors, doing dishes, cleaning bathrooms, etc.

Assessment of "ability" includes:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, ability to push sweeper
- etc).
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions (do not lift more than 5 lbs, etc).
- Activity limitations (joint replacement with inability to climb multiple stairs to another floors, bed rest, etc).
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc).

Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

Supervision:

- Verbal cues.
- Prompting.
- Reminders.
- Standby.

Assistance:

- Touching.
- Contact guarding.
- Participation in task.

On scale of 0-4

0 - Independent- no human intervention or assistance needed.
1 - Independent with **light** housekeeping tasks only.
2 - Requires at least minimal human intervention for any housekeeping tasks.
3 - Requires constant human intervention to accomplish tasks.
4 - Cannot perform tasks.

M0750

M0760 Shopping: Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.

Prior Current

☐ ☐ 0 - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; OR
(b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission).

☐ ☐ 1 - Able to go shopping, but needs some assistance:
(a) By self is able to do only light shopping or carry small packages, but needs someone to do occasional major shopping; OR
(b) Unable to go shopping alone, but can go with someone to assist.

☐ ☐ 2 - Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery.

☐ ☐ 3 - Needs someone to do all shopping and errands.

☐ UK - Unknown

Item Clarification: Identifies the physical, cognitive and mental ability of the patient to plan for, select, and purchase items from a store, even if the patient does not routinely go shopping. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: How do you get your groceries or medication?

Optimal Technique: Observe the patient's comprehension, judgment, coordination, balance, strength, lifting restrictions, weight bearing status, etc., and use all reported and observed information to make necessary inferences about patient's ability to shop and acquire at least basic necessities. Assess shopping and transportation together.

Tips: Consider the patient's physical and cognitive ability to safely complete all tasks associated with shopping including planning, selecting, purchasing and carrying items home from the store or arranging delivery.

Assessment of "ability" includes:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc).
- Physical function (ROM, strength, dexterity, ambulation, endurance, ability to lift and carry groceries, etc.)
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions (do not lift more than 5 lbs, etc).
- Activity limitations (bed rest, etc).
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc).

Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

Supervision:

- Verbal cues.
- Prompting.
- Reminders.
- Standby.

Assistance:

- Touching.
- Contact guarding.
- Participation in task.

On scale of 0-3

0 - Independent to perform all tasks associated with shopping OR although able, does not do shopping
1 - Requires at least minimal human intervention in some aspect of shopping.
2 - Cannot go shopping but can develop list and get items into home.
3 - Dependent on another for all aspects of shopping.

Prior: Ability on day #14 before this assessment day.

M0770 Ability to Use Telephone: Ability to answer the phone, dial numbers, and effectively use the telephone to communicate.

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

Item Clarification: Identifies the ability of the patient to answer the phone, dial number, and effectively use the telephone to communicate. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: Where is your phone? Describe how you would call our office on the phone you normally use?

Optimal Technique: Show me how you use the phone. Ask patient to call the agency. Note presence and location of phone.

Tips: Consider the patient's physical and cognitive ability to safely complete all tasks associated with telephone use including answering, dialing and effectively using the telephone to communicate if available.

Assessment of "ability" includes:

- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc). Physical function (ROM, strength, dexterity, ambulation, endurance, ability to get to phone, etc)
- Safe, effective and efficient completion of tasks (availability of safety/adaptive equipment, level of function, etc).
- Medical restrictions
- Activity limitations (bed rest, etc).
- Current clinical condition (SOB limiting ability to talk, pain, paresis, paralysis, impaired balance, fall risk, etc)
- Location of phone (stationary or portable?).

Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

On scale of 0-5

0 - Independent making and receiving phone calls without adaptations to phone
1 - Independent making and receiving at phone calls with adaptations to phone
2 - can not place calls but can answer phone and converse
3 - Intermittently able to answer phone and conversation is limited
4 - Cannot answer phone but Can listen with special equipment
5 - Cannot use phone

Prior:

Ability to perform on day #14 before this assessment day.

M0780 Management of Oral Medications: Patient's ability to prepare and take all prescribed 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.)**

Prior	Current		
☐	☐	0	- Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
☐	☐	1	- Able to take medications at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) given daily reminders; OR (c) someone develops a drug diary or chart.
☐	☐	2	- Unable to take medication unless administered by someone else.
☐	☐	NA	- No oral medications prescribed.
☐		UK	- Unknown

Item Clarification: Identifies the patient's ability to prepare and take oral medications reliably and safely and the type of assistance required to administer the correct dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: Does anyone help you with your medications by reminding you to take them, creating a list, filling a pill box, etc?

Optimal Technique: Show me how and tell me when you take your medicines.

Tips: Consider the patient's physical and cognitive ability to safely complete all tasks associated with taking oral medication; preparing it (opening bottles, pouring), taking correct dose at proper time.

- **Select 0** when requires no human intervention for any aspect of taking oral medications. May use own reminder system.
- **Select 1** when patient requires at least minimal human intervention in any aspect of taking oral medications.
- **Select 2** when patient totally dependent on another for taking oral medications.

M0780

M0790 Management of Inhalant/Mist Medications: Patient's ability to prepare and take all prescribed inhalant/mist medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes all other forms of medication (oral tablets, injectable and IV medications).**

Prior	Current		
☐	☐	0	- Able to independently take the correct medication and proper dosage at the correct times.
☐	☐	1	- Able to take medications at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) given daily reminders.
☐	☐	2	- Unable to take medication unless administered by someone else.
☐	☐	NA	- No inhalant/mist medications prescribed.
☐		UK	- Unknown

Item Clarification: Identifies the patient's ability to prepare and take inhalant/mist medications reliably and safely and the type of assistance required to administer the correct dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: Does anyone help you with your inhalant/mist medications by reminding you to take them, creating a list, preparing them, etc?

Optimal Technique: Show me how and tell me when you take your inhalant/mist medicines.

Tips: Consider the patient's physical and cognitive ability to safely complete all tasks associated with taking inhalant/mist medication; preparing it (opening bottles, pouring), taking correct dose at proper time.

Select 0 when requires no human intervention for any aspect of taking inhalant/mist medications. May use own reminder system.

Select 1 when patient requires at least minimal human intervention in any aspect of taking inhalant/mist medications.

Select 2 when patient totally dependent on another for taking inhalant/mist medications.

M0790

M0800 Management of Injectable Medications: Patient's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes IV medications.**

Prior Current

- ☐ ☐ 0 - Able to independently take the correct medication and proper dosage at the correct times.
- ☐ ☐ 1 - Able to take injectable medication at the correct times if:
  (a) individual dosages are prepared in advance by another person; OR
  (b) given daily reminders.
- ☐ ☐ 2 - Unable to take injectable medication unless administered by someone else.
- ☐ ☐ NA - No injectable medications prescribed.
- ☐ UK - Unknown

Item Clarification: Identifies the patient's ability to prepare and take all injectable medications reliably and safely and the type of assistance required to administer the correct dosage at the appropriate times/intervals. The focus is on what the patient is able to do, not on the patient's compliance or willingness. The prior column should describe the patient's ability 14 days prior to the start (or resumption) of care visit. The focus for today's assessment – the "current" column – is on what the patient is able to do today.

Recommendations from Expert Design Forum

Optimal Question: Does anyone help you with your injectable medications by reminding you to take them, preparing them or giving them, etc?

Optimal Technique: Show me how and tell me when you take your injectable medicines.

Tips: Consider the patient's physical and cognitive ability to safely complete all tasks associated with taking injectable medication; preparing it (opening bottles, drawing up), taking correct dose at proper time.

Select 0 when requires no human intervention for any aspect of taking injectable medications. May use own reminder system.

Select 1 when patient requires at least minimal human intervention in any aspect of taking injectable medications.

Select 2 when patient totally dependent on another for taking injectable medications.

M0800

M0810 Patient Management of Equipment (includes ONLY oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies): Patient's ability to set up, monitor, and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**

- ☐ 0 - Patient manages all tasks related to equipment completely independently.
- ☐ 1 - If someone else sets up equipment, patient is able to manage all other aspects of equipment.
- ☐ 2 - Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task.
- ☐ 3 - Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.
- ☐ 4 - Patient is completely dependent on someone else to manage all the equipment.
- ☐ NA - No equipment of this type used in care ***[If NA, go to M0825]***
- ☐ UK - Unknown

Item Clarification: Identifies the patient's ability to set up, monitor and change equipment reliably and safely. The focus is on what the caregiver is able to do, not on compliance or willingness.

Recommendations from Expert Design Forum

Optimal Question: Describe how you set, clean and use your oxygen? Equipment related to infusion therapy? Equipment related to enteral/parenteral nutrition? Or Ventilator?

Optimal Technique: Show me how you set, clean and use your oxygen? Equipment related to infusion therapy? Equipment related to enteral/parenteral nutrition? Or Ventilator?

Tips: Consider the **patient's** physical *and* cognitive ability to safely complete all tasks associated with managing the equipment used to perform therapies identified only in MO250 and MO500.

Equipment management includes:

- Adding fluids and medications.
- Cleaning.
- Storing.
- Disposing of equipment and supplies by the patient**.**

Excludes:

- Delivery devices or equipment associated with other treatments

Include equipment types related to the following therapies:

- Subcutaneous, epidural, intrathecal infusions, and insulin pumps
- intermittent medications, fluids or flushes via VAD
- enteral/parenteral nutrition or hydration
- intermittent or continuous oxygen
- ventilators used continuously or at night
- continuous positive airway pressure (C-PAP)

Exclude equipment related to the following:

- Nebulizers, inhalers
- IM or SQ injections
- Other equipment not listed above

M0810

M0820 Caregiver Management of Equipment (includes ONLY oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies): Caregiver's ability to set up, monitor, and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**

- ☐ 0 - Caregiver manages all tasks related to equipment completely independently.
- ☐ 1 - If someone else sets up equipment, caregiver is able to manage all other aspects of equipment.
- ☐ 2 - Caregiver requires considerable assistance from another person to manage equipment, but independently completes portions of the task.
- ☐ 3 - Caregiver is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.
- ☐ 4 - Caregiver is completely dependent on someone else to manage all the equipment.
- ☐ NA - No equipment of this type used in care ***[If NA, go to M0825]***
- ☐ UK - Unknown

Item Clarification: Identifies the caregiver's ability to set up, monitor and change equipment reliably and safely. The focus is on what the caregiver is able to do, not on compliance or willingness. "Caregiver" is defined in M0360.

Recommendations from Expert Design Forum

Optimal Question: Describe how you set, clean and use your oxygen? Equipment related to infusion therapy? Equipment related to enteral/parenteral nutrition? Or Ventilator?

Optimal Technique: Show me how you set, clean and use your oxygen? Equipment related to infusion therapy? Equipment related to enteral/parenteral nutrition? Or Ventilator?

Tips: Consider the **caregiver's** physical *and* cognitive ability to safely complete all tasks associated with managing the equipment used to perform therapies identified only in MO250 and MO500.

Equipment management includes:
- Adding fluids and medications.
- Cleaning.
- Storing.
- Disposing of equipment and supplies by the patient**.**

Excludes:
- Delivery devices or equipment associated with other treatments

Include equipment types related to the following therapies:
- Subcutaneous, epidural, intrathecal infusions, and insulin pumps
- intermittent medications, fluids or flushes via VAD
- enteral/parenteral nutrition or hydration
- intermittent or continuous oxygen
- ventilators used continuously or at night
- continuous positive airway pressure (C-PAP)

Exclude equipment related to the following:
- Nebulizers, inhalers
- IM or SQ injections
- Other equipment not listed above

M0820

M0825 Therapy Need: Does the care plan of the Medicare payment period for which this assessment will define a case mix group indicate a need for therapy (physical, occupational, or speech therapy) that meets the threshold for a Medicare high-therapy case mix group?

☐ 0 - No
☐ 1 - Yes
☐ NA - Not applicable

Item Clarification: Identifies whether the patient's care plan indicates need for high-therapy use..

Recommendations from Expert Design Forum

Optimal Technique: Determine therapy need **after** completion of assessment and formulation of home health plan of care.

Tips: Collaborate with rehab services to determine their plan after their evaluation is performed. Answer after the physician orders are received for therapy within 5 days of M0090.

The current therapy threshold is 10 visits – which include PT, ST, OT alone or combined**.**

Choose Yes or No when Medicare is a payer.
Not applicable is the only answer to choose when Medicare is not the payer.

At resumption of care, consider the number of therapy visits already made in the episode and the number anticipated to be made before the end of the episode.

At recertification, consider the number of therapy visits that will be made in the new episode.

Note: If the therapy need was underestimated at the beginning of the episode and there is no clinical change in the patient's health status, the agency may cancel the RAP and resubmit it. Make a note in the patient's record as to the difference between therapy originally submitted and therapy actually delivered and correct the original assessment at MO825 which will update the HHRG. Retransmit the corrected assessment. (http://www.cms.hhs.gov/oasis/datasubm.asp)

M0830 Emergent Care: Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? **(Mark all that apply)**

- ☐ 0 - No emergent care services ***[If no emergent care, go to M0 855]***
- ☐ 1 - Hospital emergency room (includes 23 hour holding).
- ☐ 2 - Doctor's office emergency visit/house call.
- ☐ 3 - Outpatient department/clinic emergency (includes urgicenter sites.)
- ☐ UK - Unknown

Item Clarification: Identifies whether the patient received an unscheduled visit to any (emergent) medical services other than home care services. Emergent care includes all unscheduled visits to such medical services. A "pm" agency visit is not considered emergent care.

Recommendations from Expert Design Forum

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Optimal Question: Have you made unscheduled visits to the doctor or the emergency room?

Optimal Technique: Read medical record.

Tips: Determine emergent care since the last time an OASIS assessment was completed. Check the medical record to determine applicable time period.

Emergent care includes:

- All unscheduled visits to providers listed in the OASIS item
- ER visits regardless of whether the patient is admitted to the hospital as an inpatient**.**

M0830

M0840 **Emergent Care Reason:** For what reason(s) did the patient/family seek emergent care? **(Mark all that apply.)**

- ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Nausea, dehydration, malnutrition, constipation, impaction
- ☐ 3 - Injury caused by fall or accident at home
- ☐ 4 - Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)
- ☐ 5 - Wound infection, deteriorating wound status, new lesion/ulcer
- ☐ 6 - Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain)
- ☐ 7 - Hypo/hyperglycemia, diabetes out of control
- ☐ 8 - GI bleeding, obstruction
- ☐ 9 - Other than above
- ☐ UK - Unknown reason

Item Clarification: Identifies the reasons for which the patient/family sought emergent care.

Recommendations from Expert Design Forum

Optimal Question: What caused you to seek emergent care? What was wrong?

Optimal Technique: Interview patient, family or, physician office for reasons why emergent care was sought. Read patient discharge instructions.

Tips: All reasons must be marked.

M0840

M0855 To which **Inpatient Facility** has the patient been admitted?

- ☐ 1 - Hospital ***[Go to M0890]***
- ☐ 2 - Rehabilitation Facility ***[Go to M0903]***
- ☐ 3 - Nursing Home ***[Go to M0900]***
- ☐ 4 - Hospice [***Go to M0903]***
- ☐ NA - No inpatient facility admission

Item Clarification: Identifies the type of inpatient facility to which the patient was admitted. Any impatient admission of 24 hours or more (for reasons other than diagnostic tests), which occurs while the patient is o service with the home health agency is reported. When the patient is transferred to an inpatient facility, the agency may or may not discharge the patient depending upon agency policy.

Recommendations from Expert Design Forum

Optimal Technique: Contact family or physician office for information.

Tips: If in doubt, contact facility to inquire how it is licensed.

Confirm that patient had qualifying inpatient stay and was not an outpatient or "held for observation" even for multiple days. (Medicare Part A is payer.)

M0855

M0870 Discharge Disposition: Where is the patient after discharge from your agency? **(Choose only one answer)**

- ☐ 1 - Patient remained in community (not in hospital, nursing home or rehab facility).
- ☐ 2 - Patient transferred to a noninstitutional hospice ***[Go to M0903]***
- ☐ 3 - Unknown because patient moved to a geographic location not served by this agency. ***[Go to M0903]***
- ☐ UK - Unknown

Item Clarification: Identifies where the patient resides after discharge from the home health agency.

Recommendations from Expert Design Forum

Optimal Technique: Read medical record. Determine discharge plan and confirm with patient/family.

Tips: Patient in ALFs and board and care housing are considered to be living in the community.

M0870

M0880 After discharge, does the patient receive health, personal, or support **Services or Assistance? (Mark all that apply)**

☐ 1 - No assistance or services received
☐ 2 - Yes, assistance or services provided by family or friends
☐ 3 - Yes, assistance or services provided by other community resources (e.g., meals-on-wheels, home health services, homemaker assistance, transportation assistance, assisted living, board and care)

Go to M0903

Item Clarification: Identifies services or assistance a patient receives after discharge from the home health agency.

Recommendations from Expert Design Forum

Optimal Technique: Read medical record. Determine discharge plan and confirm with patient and family.

Tips: Assistance may be paid or unpaid.

Item 3 also includes assistance in the form of outpatient therapy.

M0880

M0890 If the patient was admitted to an acute care **Hospital**, for what **reason** was he/she admitted?

☐ 1 - Hospitalization for emergent (unscheduled) care
☐ 2 - Hospitalization for urgent (scheduled within 24 hours of admission) care
☐ 3 - Hospitalization for elective (scheduled more than 24 hours before admission) care
☐ UK - Unknown

Item Clarification: Identifies the urgency of the hospitalization.

Recommendations from Expert Design Forum

Optimal Technique: Call family, physician or admitting facility for information.

Tips: Select response "1" for all unscheduled hospital admissions.
Select "2" or "3" based on how much time elapsed between the scheduling and the actual admission.

M0890

M0895 Reason for Hospitalization: (Mark all that apply)

- ☐ 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Injury caused by fall or accident at home
- ☐ 3 - Respiratory problems (SOB, infection, obstruction)
- ☐ 4 - Wound or tube site infection, deteriorating wound status, new lesion/ulcer
- ☐ 5 - Hypo/hyperglycemia, diabetes out of control
- ☐ 6 - GI bleeding, obstruction
- ☐ 7 - Exacerbation of CHF, fluid overload, heart failure
- ☐ 8 - Myocardial infarction, stroke
- ☐ 9 - Chemotherapy
- ☐ 10 - Scheduled surgical procedure
- ☐ 11 - Urinary tract infection
- ☐ 12 - IV catheter-related infection
- ☐ 13 - Deep vein thrombosis, pulmonary embolus
- ☐ 14 - Uncontrolled pain
- ☐ 15 - Psychotic episode
- ☐ 16 - Other than above reasons

Go to M0903

Item Clarification: Identifies the specific condition(s) necessitating hospitalization.

Recommendations from Expert Design Forum

Optimal Technique: Interview patient, family or physician for reason.

Tips: All reasons must be marked.

M0895

M0900 For what **Reason(s)** was the patient **admitted** to a **Nursing Home?** **(Mark all that apply)**

- ☐ 1 - Therapy services
- ☐ 2 - Respite care
- ☐ 3 - Hospice care
- ☐ 4 - Permanent placement
- ☐ 5 - Unsafe for care at home
- ☐ 6 - Other
- ☐ UK - Unknown reason

Item Clarification: Identifies the reason(s) the patient was admitted to a nursing home.

Recommendations from Expert Design Forum

Optimal Technique: Interview family, caregiver or physician for reason.

Tips: If nursing home placement was planned – medical record must reflect the plan**.**

M0900

M0903 Date of Last (Most Recent) Home Visit:

		/			/				
Month			day			year			

Item Clarification: Identifies the last or most recent home visit of any agency provider, including skilled providers or home health aides.

Recommendations from Expert Design Forum

Optimal Technique: Determine which service made last visit from billing records and record date. Read medical record.

Tips: Collaborate with designated office based staff to determine.

M0903

M0906 Discharge/Transfer/Death Date:

		/			/				
Month			day			year			

Item Clarification: Identifies the actual date of discharge, transfer, or death (at home).

Recommendations from Expert Design Forum

Tips: Record actual date of the occurrence for:

- transfer to inpatient facility
- death.

Date of discharge is determined by agency policy.

"Death at home" includes death in transit to or in an ER.

M0906