Outcome and Assessment Information Set (OASIS-B1)

FOLLOW-UP VERSION

Items to be Used at this Time Point---------- **M0080-M0100, M0175, M0230-M0250, M0390, M0420, M0440, M0450, M0460, M0476, M0488, M0490, M0530-M0550, M0610, M0650-M0700, M0825**

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

(M0090) Date Assessment Completed: __ __ /__ __ /__ __ __ __
month day year

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

Follow-Up

☐ 4 – Recertification (follow-up) reassessment **[Go to *M0175*]**
☐ 5 – Other follow-up **[Go to *M0175*]**

DEMOGRAPHICS AND PATIENT HISTORY

(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) _____
☐ NA - Patient was not discharged from an inpatient facility

(M0230/M0240) Diagnoses and Severity Index: List each medical diagnosis or problem for which the patient is receiving home care and ICD-9-CM code category (three digits required; five digits optional – no surgical or V-codes) and rate them using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses.

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 diagnoses. 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-9-CM	Severity Rating
a.	_____	(__ __ __ . __ __)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
	(M0240) Other Diagnoses	ICD-9-CM	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

Effective 10/1/2003

(M0245) Payment Diagnosis (optional): If a V-code was reported in M0230 in place of a case mix diagnosis, list the primary diagnosis and ICD-9-CM code, determined in accordance with OASIS requirements in effect before October 1, 2003--no V-codes, E-codes, or surgical codes allowed. ICD-9-CM sequencing requirements must be followed. Complete both lines (a) and (b) if the case mix diagnosis is a manifestation code or in other situations where multiple coding is indicated for the primary diagnosis; otherwise, complete line (a) only.

	(M0245) Primary Diagnosis	ICD-9-CM
a.	_____	(__ __ __ . __ __)
	(M0245) First Secondary Diagnosis	ICD-9-CM
b.	_____	(__ __ __ . __ __)

(M0250) Therapies the patient receives at home: **(Mark all that apply.)**

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

SENSORY STATUS

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

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

(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

INTEGUMENTARY STATUS

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

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

(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					

(M0460) [Skip this item if patient has no pressure ulcers]

Stage of Most Problematic (Observable) Pressure Ulcer:

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

(M0476) [Skip this item if patient has no stasis ulcers]

Status of Most Problematic (Observable) Stasis Ulcer:

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

(M0488) [Skip this item if patient has no surgical wounds]

Status of Most Problematic (Observable) Surgical Wound:

☐ 1 - Fully granulating
☐ 2 - Early/partial granulation
☐ 3 - Not healing
☐ NA - No observable surgical wound

RESPIRATORY STATUS

(M0490) When is the patient dyspneic or noticeably **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)

ELIMINATION STATUS

(M0530) [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

(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

(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 inpatient facility stay, or b) necessitated a change in medical or treatment regimen?

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

NEURO/EMOTIONAL/BEHAVIORAL STATUS

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

- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (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

ADL/IADLs

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

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.

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

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.

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

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.

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

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.

(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.

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 or pivot when transferred by another person.
- ☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- ☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.

(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.

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.

THERAPY NEED

(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