OASIS-C2: REVIEW OF DATA COLLECTION CONVENTIONS AND GUIDANCE

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WHY –C2?

It's all about standardization!

Improving
Medicare
Post-
Acute
Care
Transformation
Act of 2014

PAC settings:
HHA, SNF, LTCH, IRF

- Report **standardized** patient assessment data re: quality measures, resource use and other measures
- Use assessment questions and response options that are identical and to which identical standards and definitions apply
- Identify cross setting quality comparisons capturing patient preferences and goals, enabling high quality care, outcomes and care coordination

OASIS CONVENTIONS - CHAPTER ONE

~ TIME PERIOD OR VISIT UNDER CONSIDERATION

- What is true on day of assessment unless different time period is indicated in item or related guidance
  - **Day of assessment** = 24 hours immediately preceding the visit **and** the time spent in the home
- Examples of **other time periods**:
  - "At the time of or any time since the **most recent SOC/ROC** OASIS assessment"
  - Within the last 14 days
  - Day of assessment & recent pertinent past
  - Prior to this current illness, exacerbation or injury
  - This payment episode (60 day)

OASIS CONVENTIONS

~ USUAL STATUS

- What is true greater than 50% of assessment time frame if patient's ability or status varies during the assessment timeframe
- Report usual status unless item directs differently

  - Example: **Pressure ulcers – assess as close to actual time of the SOC/ROC as possible**
- Does not apply to all items!
  - Example: M1860 Ambulation – "at all times"

~ QUALITY EPISODE = "Care episode"

- **Begins** with a SOC or ROC assessment, and **ends** with a Transfer or Discharge

OASIS CONVENTIONS

~ MINIMIZE THE USE OF NA/UNKNOWN

- Only use when no other response is possible or appropriate

~ OASIS USES SPECIFIC DEFINITIONS

- Understand definitions of words used in OASIS

~ UNDERSTAND WHAT IS INCLUDED AND EXCLUDED IN EACH ITEM

- Score item based ONLY on what's included
  - Example: Transferring includes just one transfer

~ COMPLETE OASIS items accurately and comprehensively

- Adhere to skip patterns

OASIS CONVENTIONS

~ DIRECT OBSERVATION PREFERRED

- When assessing physiologic or functional status
- Combine observation with interview, and other relevant strategies to complete items as needed

~ AVOID REFERRING BACK TO PRIOR OASIS ASSESSMENTS

- **UNLESS** collection of item data includes review of care notes
  - "At the time of or since the SOC/ROC…"
- Document current status based on an independent observation of condition and ability **at the time of the assessment**

OASIS CONVENTIONS

For ADL/IADL items:

~ REPORT COGNITIVE AND PHYSICAL ***ABILITY*** to perform included tasks; n**ot** willingness or preference

~ LEVEL OF ABILITY = level of assistance (if any) required to safely complete a specified task

~ MEDICAL RESTRICTIONS

- Physician ordered restrictions are considered when determining ability
  - Examples: activity restrictions, order for RN to administer medication

OASIS CONVENTIONS

~ ASSISTANCE

- Assistance (helper) refers to another person(s) unless otherwise specified in the item
  - Hands-on, standby, verbal cues or reminders

~ CAREGIVER IMPACT

- Presence/absence of a caregiver may impact the way a patient carries out an activity, but does not impact the patient's ability

~ ASSISTIVE DEVICES

- No formal list; see devices included in M items or guidance
  - Example: M1860 Ambulation/Locomotion – cane, crutches, hemi-walker, walker, wheelchair, stairlift, etc.
- Service animal = assistive device if required for safe function
- Use clinical judgment

OASIS CONVENTIONS

~ MAJORITY OF TASKS

- Applies to M1800 Grooming and M1810/20 Dressing
- When ability varies between tasks:
  - Enter response that describes patient's ability to independently complete a **majority of the more frequently** performed tasks

~ ONE CLINICIAN CONVENTION

- Only one clinician takes responsibility for completing a comprehensive assessment – although collaboration allowed for select items (for example, M2001-M2005; M2200) through Dec. 31, 2017
- One Clinician Convention expanded effective Jan. 1, **2018**.
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQISpotlight.html

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OASIS CONVENTIONS - DASH (–) RESPONSE

The following C2 items allow the use of a dash:

- GG0170C – Lying to sitting on side of bed
- M1028 Active Diagnoses
- M1060 Height and Weight
- M1313 Worsening in Pressure Ulcer Status
- M2001 Drug Regimen Review
- M2003 Medication Follow-up
- M2005 Medication Intervention

A **dash (–)** value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. CMS expects dash use to be a rare occurrence.

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?	
Enter Code [–]	0 No - No issues found during review **[*Go to M2010*]** 1 Yes - Issues found during review 9 NA - Patient is not taking any medications **[*Go to M2040*]**

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M1028 ACTIVE DIAGNOSES (SOC/ROC)

(M1028) Active Diagnoses- Comorbidities and Co-existing Conditions – Check all that apply See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.		
☐	1 -	Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐	2 -	Diabetes Mellitus (DM)

- Identify physician or physician-designee confirmed diagnoses that are **active** and associated with the patient's home health episode of care.
- **Active diagnoses** are diagnoses that have a **direct relationship** to the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at time of assessment.
- Do not include diagnoses that have been **resolved** or do not affect the patient's current functional, cognitive, mood or behavior status; medical treatments; nurse monitoring; or risk of death at time of assessment.
- Chapter 3 Guidance lists relevant ICD-10 codes for identifying these diagnoses

M1028 ACTIVE DIAGNOSES (SOC/ROC)

- Select **Response 1 -** if the patient has an active diagnosis of Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- Select **Response 2 -** if an active diagnosis of Diabetes Mellitus (DM)
- Select **Response 1 and 2** – if a diabetic patient has either PAD or PVD - (HHQRP Q&A 02/17, Q. 35)
- If assessment is completed and the patient does not have a confirmed diagnosis of PVD, PAD or DM both boxes should be left **unchecked**.
- A **dash (–)** value is a valid response for this item indicating that no information is available and /or an item could not be assessed.

M1060 HEIGHT AND WEIGHT (SOC/ROC)

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

- Measure height and weight in accordance with the **agency's policies and procedures**, which should reflect current standards of practice (shoes off, etc.)
- Measure and record **height in inches and weight in pounds**
- Use mathematical **rounding** to the nearest whole inch

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M1060 HEIGHT AND WEIGHT (SOC/ROC)

- Assessing clinician is expected to weigh and measure the patient directly
  - Self reported values and paperwork from another provider are **not** acceptable
- At ROC, attempt to weigh the patient. If unsuccessful, a previous weight obtained **by the agency** within the 30 day window can be used

  - (HHQRP Q&A 02/17, Q. 37)
- A **dash (–)** value is a valid response for this item indicating that no information is available and /or an item could not be assessed.
  - Example: A patient cannot be weighed because of extreme pain, immobility, or risk of pathological fractures. Enter the dash value and document the rationale on the patient's medical record.

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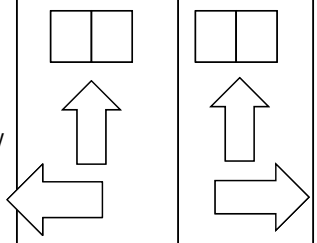
GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC			
(GG0170C) Mobility			
Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.			
Coding: **Safety** and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activity may be completed with or without assistive devices.* 06 Independent – Patient completes the activity by him/herself with no assistance from a helper. 05 Setup or clean-up assistance – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. 04 Supervision or touching assistance – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03 Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02 Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01 Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. If activity was not attempted, code reason: 07 Patient refused 09 Not applicable 88 Not attempted due to medical condition or safety concerns	**1. SOC/ROC Performance** ↓Enter Codes in Boxes	**2. Discharge Goal**	 Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

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GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

- Assess functional status based on **direct observation and/or report by patient/ caregiver.**
- Patients should be allowed to perform activities as independently as possible, as long as they are safe.
- Activities may be completed **with or without assistive device(s).** Use of assistive device(s) to complete an activity should not affect the scoring of the activity.
- May be assessed in preferred or necessary sleeping surface (recliner, sofa or mattress on the floor).
- If the patient's **performance varies** during the assessment time frame, report the **patient's usual status**.

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GG0170C LYING TO SITTING ON SIDE OF BED (SOC/ROC)

- If feet don't touch the floor may be:
  - **06 Independent** if safe dangling or
  - **05 Set Up Assist** if bed needs to be lowered or stool placed prior to the transfer.
- Use clinical judgement.

For GG0170C1 – SOC/ROC Performance

- Report the patient's usual status at SOC/ROC using the 6-point scale or
- Using one of the three "activity was not attempted" codes, report the reason the activity was not attempted.

Enter 06 – Independent	The patient completes the activity by him/herself with no human assistance.
Enter 05 – Setup or clean-up assistance	The caregiver SETS UP or CLEANS UP; patient completes activity. Caregiver assists only prior to or following the activity, but not during the activity. **For example**, the patient requires assistance putting on a shoulder sling prior to the transfer, or requires assistance removing the bedding from off his/her lower body to get out of bed.

- (Ch. 3, CMS Q&A Cat 4b Q 151.20, 151.21)

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GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

04 – Supervision or touching assistance	The caregiver must provide VERBAL CUES or TOUCHING/ STEADYING assistance as patient completes activity. Assistance may be required throughout the activity or intermittently. **For example**, the patient requires verbal cueing, coaxing, or general supervision for safety to complete activity; or patient may require only incidental help such as contact guard or steadying assist during the activity.
03 – Partial/moderate assistance	The caregiver must provide LESS THAN HALF the effort. Caregiver lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02 – Substantial/maximal assistance	The caregiver must provide MORE THAN HALF the effort. Caregiver lifts or holds trunk or limbs and provides more than half the effort.
01 – Dependent	The caregiver must provide ALL of the effort. Patient is unable to contribute any of the effort to complete the activity; or the assistance of **two or more** caregivers is required for the patient to complete the activity.

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GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

If the patient **does not attempt** the activity **and** a caregiver **does not complete** the activity for the patient, report the reason the activity was not attempted.

⚠ However, you may have sufficient information by *report from the patient, caregiver/family or your assessment* of other activities to allow you to select a 06 - 01 response.

"Activity Not Attempted" Codes

07 – Patient refused	The patient refused to complete the activity.
09 – Not Applicable	The patient did not perform this activity prior to the current illness, exacerbation, or injury.
88 – Not attempted due to medical condition or safety concerns	The activity was not attempted due to medical condition or safety concerns.
Dash ("–")	No information is available or assessment is not possible for reason other than above.

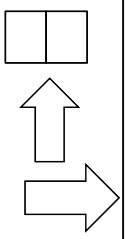
GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC

(GG0170C) Mobility

Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.

Coding:
Safety and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activity may be completed with or without assistive devices.
06 Independent – Patient completes the activity by him/herself with no assistance from a helper.
05 Setup or clean-up assistance – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.
04 Supervision or touching assistance – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03 Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02 Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01 Dependent – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.
If activity was not attempted, code reason:
07 Patient refused
09 Not applicable
88 Not attempted due to medical condition or safety concerns

1. SOC/ROC Performance	2. Discharge Goal
↓Enter Codes in Boxes	
	

Lying to Sitting on Side of Bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

GG0170C Lying to Sitting on Side of Bed (SOC/ROC)

For GG0170C – Discharge Goal

- The assessing clinician, in conjunction with patient and family input, can establish the discharge goal.
- **Use the 6-point scale; Do not enter 07, 09, or 88 to report a discharge goal**

Expected Patient Progress	Discharge Goal
Expected to **make functional progress** by discharge	Report a Discharge Goal **higher (more independent)** than the SOC/ROC Performance response
Not expected to make progress during the home health episode, but is expected to **maintain his/her SOC functional level** - A medically complex patient	Report a Discharge Goal **the same as** the patient's SOC Performance response
Expected to **rapidly decline** and skilled therapy services may slow the decline of function - A patient with a progressive neurological condition	Report a Discharge Goal **lower (more dependent)** than the SOC/ROC Performance response
Discharge Goal not established by assessing clinician	Enter a **dash (–)** for the Discharge Goal
If scored 07, 09, 88 at SOC/ROC	▪ Report a discharge goal of 01 through 06 if expected to gain function by DC ▪ Enter a dash **(–)** if not expected to regain function by discharge

LOOK BACK PERIOD (TRANSFER/DC)

…"at the time of or since the most recent SOC/ROC"

- **(M1501) Symptoms in Heart Failure Patients**: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) **at the time of or at any time since the most recent SOC/ROC assessment?**

- **(M1511) Heart Failure Follow-up**
- **(M2005) Medication Intervention**
- **(M2016) Patient/Caregiver Drug Education Intervention**
- **(M2301) Emergent Care**
- **(M2401) Intervention Synopsis**

M2001/M2003 (SOC/ROC) /M2005 (TRF, DC, DAH)

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?	
Enter Code ☐	0 No - No issues found during review 1 Yes - Issues found during review 9 NA - Patient is not taking any medications
Composite Quality Measure	
(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?	
Enter Code ☐	0 - No 1 - Yes
(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?	
Enter Code ☐	0 No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

M2003 & M2005 - **"By midnight the next calendar day"**

"Yes" response requires identifying, contacting, and **completing** the prescribed/recommended actions.

M2005- Added to **Death at Home** (DAH) assessment

M2001(SOC/ROC)

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?	
Enter Code ☐	0 No - No issues found during review 1 Yes - Issues found during review 9 NA - Patient is not taking any medications

- The drug regimen review includes medication reconciliation and a review of all medications a patient is currently using to identify potential clinically significant medication issues.
- Consider all meds, prescribed and OTC, administered by any route
- Definition of a **potential** or **existing** clinically significant medication issue:
  - An issue that in the **care provider's clinical judgment**, requires physician/physician-designee notification **by midnight of the next calendar day (at the latest).**
  - Any circumstance that **does not require this immediate attention is not considered** a potential or actual clinically significant medication issue.

M2001 (SOC/ROC)

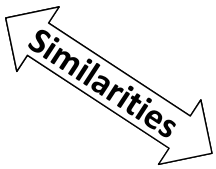
(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?	
Enter Code ☐	0 No - No issues found during review 1 Yes - Issues found during review 9 NA - Patient is not taking any medications

- **Potential** or **actual** clinically significant medication issues may include:
  - Adverse reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, nonadherence

- Enter **"0" No, no issues found during review** if, drug review was completed and in **clinician's judgment**, there were no clinically significant problems
- Enter **"1" Yes- Issues found during review** if, drug review was completed and in **clinician's judgment**, at least one potential clinically significant problem is identified
- Enter **"9" NA -** if not taking any medications
- A **Dash (-)** is a valid response if drug regimen review not done; do **not** use if patient is not on any meds or has no med problems

M2003 (SOC/ROC) & M2005 (TRF, DC, DEATH)

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



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

- Identifies if potential clinically significant medication issues identified through a medication review were addressed with the physician (or physician-designee) **and** prescribed/recommended actions completed as possible by midnight of the next calendar day following their identification.

M2003(SOC/ROC)

	SUN	MON	TUE	WED	THUR	FRI	SAT
12:01							
			Problem identified 10:15 am				
12:00 midnight							

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	M2003 Medication Follow-up	M2005 Medication Intervention
Time points	**SOC/ROC**	**TRN, DC, DAH**
Time Period	SOC/ROC assessment time period	**Look back** to the most recent **SOC/ROC** (at the time of or any time since the beginning of the quality episode)
Definition	**Actual or "Potential Clinically Significant Medication Issue"**: ▪ In the care provider's clinical judgment ▪ Warrants **notification** of physician for orders or recommendations **by midnight of the next calendar day**	
Best Practice Being Measured	**Notification of physician and completion of whatever prescribed/recommended actions possible by midnight of the next calendar day for all identified potential clinically significant medication issues**	
Examples	May include but are not limited to: ▪ Adverse reactions to medications (such as a rash) ▪ Ineffective drug therapy (analgesic that does not reduce pain) ▪ Side effects (potential bleeding from an anticoagulant) ▪ Drug interactions (serious drug-drug, drug-food and drug-disease interactions)	

- (Ch. 3)

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<table>
<tr><th></th><th>M2003 Medication Follow-up</th><th>M2005 Medication Intervention</th></tr>
<tr><td>More Examples</td><td colspan="2">▪ Duplicate therapy (generic name and brand name equivalent drugs are both prescribed)
▪ Omissions (missing drugs from an ordered regimen)
▪ Dosage errors (either too high or too low)
▪ Nonadherence (regardless of whether the nonadherence is purposeful or accidental)</td></tr>
<tr><td>Definition</td><td colspan="2">“Contact with Physician”:
▪ Communication with the physician or physician-designee:
▪ By telephone, voicemail, electronic means, fax
▪ Directly to/from the physician or physician-designee, or
▪ Indirectly through physician’s office staff on behalf of the physician or physician-designee, in accordance with the legal scope of practice.</td></tr>
<tr><td rowspan="2">Response 0-No</td><td colspan="2">When more than one potential clinically significant medication issues is identified, all prescribed/recommended actions possible for all identified issues were not completed by midnight of the next calendar day</td></tr>
<tr><td>AND
▪ Within the SOC/ROC assessment time period</td><td>AND
▪ At or since the most recent SOC/ROC</td></tr>
</table>

<table>
<tr><th></th><th>M2003 Medication Follow-up</th><th>M2005 Medication Intervention</th></tr>
<tr><td rowspan="2">Response 1-Yes</td><td colspan="2">▪ Identification of one or more clinically significant medication issue,
▪ Notification of the physician and
▪ Completion of whatever actions possible for each issue by midnight of the next calendar day</td></tr>
<tr><td>AND
▪ Within SOC/ROC assessment time period</td><td>AND
▪ At or since the most recent SOC/ROC</td></tr>
<tr><td>Examples</td><td colspan="2">▪ Physician instructs agency staff to continue to monitor the issue over the weekend and call if problem persists
▪ Physician instructs the patient to address the concern with his PCP on a visit that is scheduled in two days</td></tr>
<tr><td>Response 9-NA</td><td>Not a response option</td><td>▪ No clinically significant medications issues at or since the most recent SOC/ROC
OR
▪ Not taking any meds</td></tr>
<tr><td>Response Dash (-)</td><td colspan="2">Valid response indicating no information available – should be rare</td></tr>
<tr><td>Collaboration</td><td colspan="2">Collaboration with other agency staff to contact the physician and follow-up on clinically significant issues does not violate the “one clinician rule.”</td></tr>
</table>

PRESSURE ULCERS – NEW IN C2

- In April 2016, NPUAP announced updated terminology for the staging system (pressure "ulcer" changed to pressure "injury", removed "suspected" from sDTI, etc.)
- In OASIS-C2, CMS uses terminology ***adapted*** from NPUAP Pressure Ulcer Staging guidelines, which do not perfectly align with new 2016 NPUAP terminology.
- When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&As, providers should rely on the CMS OASIS instructions to complete OASIS.
- PRESSURE ULCER DEFINITION - Localized injury to skin and/or underlying tissue usually over a bony prominence, as a result of pressure.

Everyone Agrees!

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PRESSURE ULCERS

Standardization!

- Patient assessments should be completed as close to the actual time of the SOC/ROC as possible.
  - Do not change assessment for an ulcer that increases in numerical stage (worsens) within the assessment time period
  - **"Present on Admission" and "Present at SOC/ROC"** have equivalent meanings.

- Once a **Stage 2, 3, or 4** pressure ulcer is completely covered with new epithelial tissue, it is considered **healed** and **no longer reported** as a pressure ulcer.

- A previously **closed** Stage 3 or Stage 4 pressure ulcer that is currently **open** again should be reported at its **worst stage**.

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PRESSURE ULCERS

Standardization!

- A pressure ulcer that has been **surgically debrided remains a pressure ulcer**

- A pressure ulcer treated with a **skin graft** is a **surgical wound** until the graft edges completely heal

- A pressure ulcer treated with a **muscle flap, skin advancement flap, or rotational flap** procedure should no longer be reported as pressure ulcer on M1311, but would be **reported as a surgical wound**

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M1311 CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE (SOC, ROC, FU, DC)

SOC ROC FU DC

- Row 1: Identifies the pressure ulcers present at the time of the comprehensive assessment

FU & DC only

- Row 2: Identifies if the pressure ulcer present today was present **at the same stage** at the time of the most recent SOC/ROC

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	☐
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	☐
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 at FU/DC Go to M1311D1]	☐
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 at FU/DC Go to M1311E1	☐
D2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar [If 0 at FU/DC Go to M1311F1] **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)]	☐
F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
[Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC]	

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M1311 Current Number of Unhealed Pressure Ulcers at Each Stage (SOC, ROC)

Inventory

- At **SOC/ROC**, enter a response for each row.
- Enter a "0" if not present.

Pressure ulcers should be assessed as close to the admission (SOC/ROC) as possible.

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

M1311 CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE ("PRESENT ON ADMISSION")

If a pressure ulcer that is identified on the SOC date increases in numerical stage (worsens) within the **assessment time frame**, report the initial stage of the pressure ulcer at the SOC.

Example: On the Monday **SOC** visit, Your patient is observed to have a stage 2 pressure ulcer on his R buttock. You visit again on Wednesday and observe the pressure ulcer has worsened and is a now a full thickness Stage 3. You have not completed your SOC assessment. The patient has no other pressure ulcers.

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	1
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	0

SOC

…C1, D1, E1, F1

M1311 Current Number of Unhealed Pressure Ulcers at Each Stage (FU/DC)

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	☐
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	☐
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 at FU/DC Go to M1311D1]	☐
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 at FU/DC Go to M1311E1	☐
D2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar [If 0 at FU/DC Go to M1311F1] **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar**	☐
E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)]	☐
F2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
[Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC]	

- At **Follow-Up and Discharge**, enter a response for each row (unless directed to skip)
  - If a **"0"** is entered for Row 1, Row 2 will be **skipped**.
    - Do not enter a dash (-) or "0" .
- **Row 1**. Identify **unhealed** pressure ulcer(s) present at FU/DC
- **Row 2**. Compare pressure ulcer(s) in row 1 to determine if it was present on admission and stage at SOC/ROC.

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M1311 CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE ("PRESENT ON ADMISSION")

At Follow-Up and Discharge, enter a response in each row for each section.

Exception: If a "0" in Row 1, leave Row 2 blank (skip).

Example: At Discharge, Your patient has one Stage 3 pressure ulcer on his hip. It is smaller since the SOC when it was also identified as a Stage 3 pressure ulcer. He has no other pressure ulcers.

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	0
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	blank
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	1
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	1

At DC

…C1, C2, D1, D2, E1, E2, F1, F2

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M1311 - CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE ("PRESENT ON ADMISSION")

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	☐
A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

"Present at SOC/ROC" = "Present on Admission"

For each of the 6 stageable/unstageable sections:

<u>Row A1</u>. Determine whether an unhealed pressure ulcer is present at the time of the assessment.

FU & DC

<u>Row A2</u>. Report the number of current **unhealed** pressure ulcer(s) reported in Row A1 that were "present at the most recent SOC/ROC" **<u>at the same stage</u>.**

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M1311 - PRESSURE ULCERS

Row 2 consideration:
If the pressure ulcer was **unstageable at SOC/ROC**, but becomes **numerically stageable later,** its **"Present on Admission"** stage should be considered the **stage at which it first becomes numerically stageable**.

In other words

- If a pressure ulcer **stageable at discharge** was **stageable at SOC/ROC** (present on admission), compare and determine if it was the **same stage** at SOC/ROC.

and

- If the pressure ulcer **at discharge** was **unstageable at the SOC/ROC** (present on admission), compare to **when it first became numerically stageable** to determine if it was the **same stage**.

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M1311 CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE ("PRESENT ON ADMISSION")

If the pressure ulcer was unstageable at SOC/ROC, but becomes numerically stageable later, its "**Present on Admission"** stage should be considered the stage at which it first becomes numerically stageable.

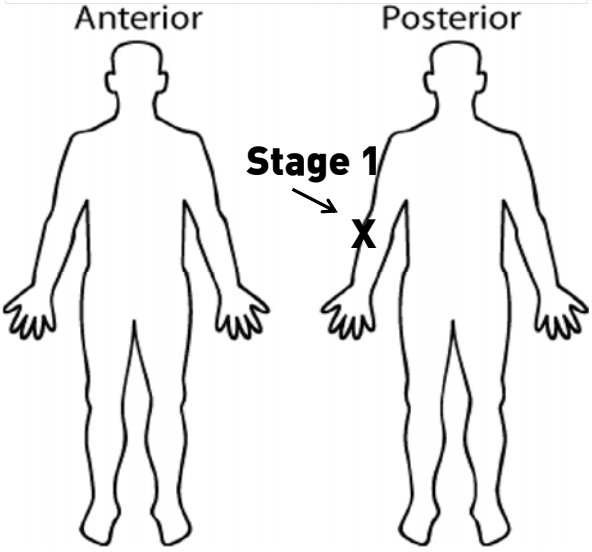
Example: At SOC, Your patient had a pressure ulcer completely covered with eschar. Two weeks later, it was debrided and assessed to be a Stage 3 pressure ulcer. It remained observable as a Stage 3 pressure ulcer until **discharge**.

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	0
A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	blank
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	1
B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	1

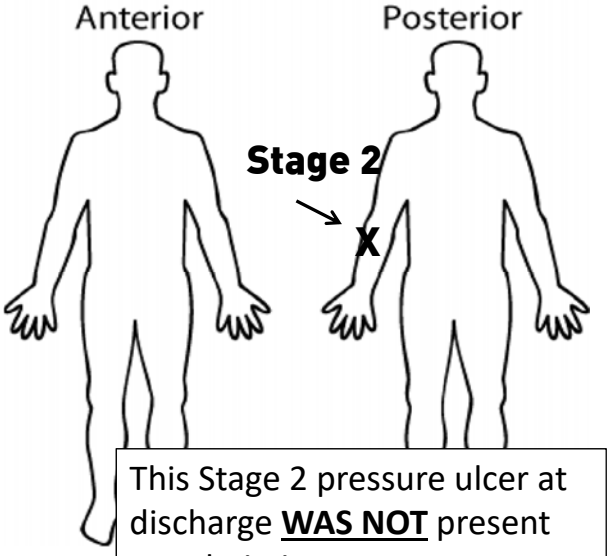
At DC

M1311 CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE ("PRESENT ON ADMISSION")

Present at SOC/ROC Assessment



Today's Assessment at Follow-up or Discharge



This Stage 2 pressure ulcer at discharge **<u>WAS NOT</u>** present on admission

M1313 WORSENING IN PRESSURE ULCER STATUS SINCE SOC/ROC (DC)

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:	
Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.	
	Enter Number
a. Stage 2	☐
b. Stage 3	☐
c. Stage 4	☐
Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.	
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	☐
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	☐
f. Unstageable – Suspected deep tissue injury in evolution.	☐

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M1313 WORSENING IN PRESSURE ULCER STATUS SINCE SOC/ROC (DC)

- Report the number of pressure ulcers present at Discharge that **were not present** (are new) or have **"worsened"** (increased in numerical stage) since the most recent SOC/ROC.
- Worsening means the pressure ulcer increased in numerical stage.
- If the pressure ulcer was **unstageable at SOC/ROC**, but becomes numerically stageable later, its "**Present on Admission**" stage should be considered the stage at which it first becomes numerically stageable.

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M1313 WORSENING IN PRESSURE ULCER STATUS SINCE SOC/ROC (DC)

- If the pressure ulcer was **unstageable for any reason at the most recent SOC/ROC**, do not consider it new or worsened **if at some point between SOC/ROC and Discharge it became stageable and remained at that same stage at Discharge.**

SOC/ROC	Another visit	DC	New or worse
Unstageable	Stageable	Same stage	No

- If the pressure ulcer was unstageable at SOC/ROC, then was stageable on a routine visit and/or Follow-Up assessment, and by Discharge the pressure ulcer had increased in numerical stage since the routine visit and/or Follow-Up assessment, is should be considered worsened at Discharge.

SOC/ROC	Another visit	DC	New or worse
Unstageable	Stageable	↑ in stage	Yes

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M1313 WORSENING IN PRESSURE ULCER STATUS SINCE SOC/ROC (DC)

- If a previously stageable pressure ulcer becomes unstageable, then was debrided sufficiently to be restaged by Discharge, **compare its stage before and after it was deemed unstageable.** If the pressure ulcer's stage has increased in numerical staging, it has worsened.

SOC/ROC	Another visit	DC	New or worse
Stageable	Unstageable	Compare stage before & after unstageable	Worse if ↑ in stage

- Pressure ulcers that are Unstageable at Discharge due to a dressing/device, such as a cast that cannot be removed to assess the skin underneath **cannot be reported as new or worsened unless no pressure ulcer existed at that site** at the most recent SOC/ROC.

SOC/ROC	Another visit	DC	New or worse
No ulcer		Unstageable under dressing/device	No

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M1313 REPORTING ALGORITHM

OASIS ITEM
Reporting algorithm for M1313

CURRENT STAGE at Discharge	Look back to most recent SOC/ROC	PRIOR STAGE at most recent SOC/ROC	REPORT AS NEW OR WORSENED?
a. Stage 2 at Discharge	If same pressure ulcer at most recent SOC/ROC was:	• Not present • Stage 1 • Covered with a non-removable dressing/device, then documented as a Stage 1 at any home visit or Follow-Up assessment(s)	YES
		• Stage 2	NO
		• Stage 3 • Stage 4	NA (Stage 3 or 4 could not become a Stage 2)
		• Covered with a non-removable dressing/device and remains Unstageable until assessed as a Stage 2 at Discharge	NO
b. Stage 3 at Discharge	If same pressure ulcer at most recent SOC/ROC was:	• Not present • Stage 1 • Stage 2 • Unstageable with documented Stage 1 and/or 2 at any home visit or Follow-Up assessment(s)	YES
		• Stage 3	NO
		• Stage 4	NA (Stage 4 could not become a Stage 3)
		• Unstageable until assessed as a Stage 3 at Discharge	NO
c. Stage 4 at Discharge	If same pressure ulcer at most recent SOC/ROC was:	• Not present • Stage 1 • Stage 2 • Stage 3 • Unstageable with documented Stage 1, 2, and/or 3 at any home visit or Follow-Up assessment(s)	YES
		• Stage 4 • Unstageable until assessed as a Stage 4 at Discharge	NO
d. Unstageable due to non-removable dressing at Discharge	If same pressure ulcer at most recent SOC/ROC was:	• Not present	YES
		• Stage 1 • Stage 2 • Stage 3 • Stage 4 • Unstageable	NO

Helpful resource from Ch. 3

CURRENT STAGE at Discharge	Look back to most recent SOC/ROC	PRIOR STAGE at most recent SOC/ROC	REPORT AS NEW OR WORSENED?
e. Unstageable due to slough and/or eschar at Discharge	If same pressure ulcer at most recent SOC/ROC was:	• Not present • Stage 1 • Stage 2	YES
		• Stage 3 • Stage 4 • Unstageable	NO
f. Unstageable – suspected deep tissue injury at Discharge	If same pressure ulcer at most recent SOC/ROC was:	• Not present • Stage 1 • Stage 2	YES
		• Stage 3 • Stage 4 • Unstageable due to slough and/or eschar	NA (Full thickness pressure ulcer could not become a sDTI)
		• Unstageable – Suspected DTI or due to a non-removable dressing/device	NO

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Home Health Patient Tracking Sheet

(M0010) CMS Certification Number:

(M0014) Branch State:

(M0016) Branch ID Number:

(M0018) National Provider Identifier (NPI) for the attending physician who has signed the plan of care**:**

☐ **UK – Unknown or Not Available**

(M0020) Patient ID Number:

(M0030) Start of Care Date: / /
month day year

(M0032) Resumption of Care Date: / / ☐ **NA - Not Applicable**
month day year

(M0040) Patient Name:
(First) (M I) (Last) (Suffix)

(M0050) Patient State of Residence:

(M0060) Patient ZIP Code: –

(M0063) Medicare Number: ☐ NA – No Medicare
(including suffix)

(M0064) Social Security Number: - - ☐ **UK – Unknown or Not Available**

(M0065) Medicaid Number: ☐ **NA – No Medicaid**

(M0066) Birth Date: / /
month day year

(M0069) Gender	
Enter Code ☐	1 Male 2 Female

(M0140) Race/Ethnicity: (Mark all that apply.)

- ☐ 1 - American Indian or Alaska Native
- ☐ 2 - Asian
- ☐ 3 - Black or African-American
- ☐ 4 - Hispanic or Latino
- ☐ 5 - Native Hawaiian or Pacific Islander
- ☐ 6 - White

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

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

Outcome and Assessment Information Set
Items to be Used at Specific Time Points

Time Point	Items Used
Start of Care ----------	M0010-M0030, M0040-M0150, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Start of care—further visits planned	
Resumption of Care ----------	M0032, M0080-M0110, M1000-M1036, M1060-M1306, M1311, M1320-M1410, M1600-M2003, M2010, M2020-M2250, GG0170
Resumption of care (after inpatient stay)	
Follow-Up ----------	M0080-M0100, M0110, M1011, M1021-M1025, M1030, M1200, M1242, M1306, M1311, M1322-M1342, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
Recertification (follow-up) assessment	
Other follow-up assessment	
Transfer to an Inpatient Facility ----------	M0080-M0100, M1041-M1056, M1501, M1511, M2005, M2016, M2301-M2410, M2430, M0903, M0906
Transferred to an inpatient facility—patient not discharged from an agency	
Transferred to an inpatient facility—patient discharged from agency	
Discharge from Agency — Not to an Inpatient Facility	
Death at home ----------	M0080-M0100, M2005, M0903, M0906
Discharge from agency ----------	M0080-M0100, M1041-M1056, M1230, M1242, M1306-M1342, M1400, M1501-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2005, M2016-M2030, M2102, M2301-M2420, M0903, M0906

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment

Enter Code ☐

1 RN
2 PT
3 SLP/ST
4 OT

(M0090) Date Assessment Completed:

☐☐ / ☐☐ / ☐☐☐☐
month day year

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

Enter Code ☐

Start/Resumption of Care
1 Start of care—further visits planned
3 Resumption of care (after inpatient stay)

Follow-Up
4 Recertification (follow-up) reassessment **[*Go to M0110*]**
5 Other follow-up **[*Go to M0110*]**

Transfer to an Inpatient Facility
6 Transferred to an inpatient facility–patient not discharged from agency **[*Go to M1041*]**
7 Transferred to an inpatient facility—patient discharged from agency **[*Go to M1041*]**

Discharge from Agency — Not to an Inpatient Facility
8 Death at home **[*Go to M2005*]**
9 Discharge from agency **[*Go to M1041*]**

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

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

☐ NA - No specific SOC date ordered by physician

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

☐☐ / ☐☐ / ☐☐☐☐
month day year

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

PATIENT HISTORY AND DIAGNOSES

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

☐ 1 - Long-term nursing facility (NF)
☐ 2 - Skilled nursing facility (SNF/TCU)
☐ 3 - Short-stay acute hospital (IPPS)
☐ 4 - Long-term care hospital (LTCH)
☐ 5 - Inpatient rehabilitation hospital or unit (IRF)
☐ 6 - Psychiatric hospital or unit
☐ 7 - Other (specify) _____
☐ NA - Patient was not discharged from an inpatient facility **[*Go to M1017*]**

(M1005) Inpatient Discharge Date (most recent):

☐☐ / ☐☐ / ☐☐☐☐
month day year

☐ UK - Unknown

(M1011) List each **Inpatient Diagnosis** and ICD-10-CM code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Inpatient Facility Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (patient was not discharged from an inpatient facility) ***[Omit "NA" option on SOC, ROC]***

(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-10-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):

	Changed Medical Regimen Diagnosis	ICD-10-CM Code
a.	_____	☐☐☐ ☐☐☐☐
b.	_____	☐☐☐ ☐☐☐☐
c.	_____	☐☐☐ ☐☐☐☐
d.	_____	☐☐☐ ☐☐☐☐
e.	_____	☐☐☐ ☐☐☐☐
f.	_____	☐☐☐ ☐☐☐☐

☐ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

(M1018) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions that existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

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

(M1021/1023/1025) **Diagnoses, Symptom Control, and Optional Diagnoses**: List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-CM code at the level of highest specificity in Column 2 (diagnosis codes only - no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a Z-code is reported in Column 2 in place of a diagnosis that is no longer active (a resolved condition), then optional item M1025 (Optional Diagnoses - Columns 3 and 4) may be completed. Diagnoses reported in M1025 will not impact payment.

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

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

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

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

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

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

Column 3: (OPTIONAL) There is no requirement that HHAs enter a diagnosis code in M1025 (Columns 3 and 4). Diagnoses reported in M1025 will not impact payment.

Agencies may choose to report an underlying condition in M1025 (Columns 3 and 4) when:

- a Z-code is reported in Column 2 AND
- the underlying condition for the Z-code in Column 2 is a resolved condition . An example of a resolved condition is uterine cancer that is no longer being treated following a hysterectomy.

Column 4: (OPTIONAL) If a Z-code is reported in M1021/M1023 (Column 2) and the agency chooses to report a resolved underlying condition that requires multiple diagnosis codes under ICD-10-CM coding guidelines, enter the diagnosis descriptions and the ICD-10-CM codes in the same row in Columns 3 and 4. For example, if the resolved condition is a manifestation code, record the diagnosis description and ICD-10-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-10-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1021) Primary Diagnosis & (M1023) Other Diagnoses		(M1025) Optional Diagnoses (OPTIONAL) (not used for payment)	
Column 1	**Column 2**	**Column 3**	**Column 4**
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	May be completed if a Z-code is assigned to Column 2 and the underlying diagnosis is resolved	Complete only if the Optional Diagnosis is a multiple coding situation (for example: a manifestation code)
Description	ICD-10-CM / Symptom Control Rating	Description/ ICD-10-CM	Description/ ICD-10-CM
(M1021) Primary Diagnosis a. _____	**V, W, X, Y codes NOT allowed** a. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** a. _____ (☐☐☐ ☐☐☐☐)	**V, W, X, Y, Z codes NOT allowed** a. _____ (☐☐☐.☐☐☐☐)
(M1023) Other Diagnoses b. _____	**All ICD-10–C M codes allowed** b. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	**V, W, X, Y, Z codes NOT allowed** b. _____ (☐☐☐.☐☐☐☐)	**V, W, X, Y, Z codes NOT allowed** b. _____ (☐☐☐.☐☐☐☐)
c. _____	c. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	c. _____ (☐☐☐.☐☐☐☐)	c. _____ (☐☐☐.☐☐☐☐)
d. _____	d. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	d. _____ (☐☐☐.☐☐☐☐)	d. _____ (☐☐☐.☐☐☐☐)
e. _____	e. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	e. _____ (☐☐☐.☐☐☐☐)	e. _____ (☐☐☐.☐☐☐☐)
f. _____	f. ☐☐☐ ☐☐☐☐ ☐0 ☐1 ☐2 ☐3 ☐4	f. _____ (☐☐☐.☐☐☐☐)	f. _____ (☐☐☐.☐☐☐☐)

(M1028) Active Diagnoses- Comorbidities and Co-existing Conditions – Check all that apply
See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.

☐ 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)

☐ 2 - Diabetes Mellitus (DM)

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

☐ 1 - Intravenous or infusion therapy (excludes TPN)

☐ 2 - Parenteral nutrition (TPN or lipids)

☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)

☐ 4 - None of the above

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

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

(M1034) Overall Status: Which description best fits the patient's overall status?	
Enter Code ☐	0 The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 1 The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 2 The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death. 3 The patient has serious progressive conditions that could lead to death within a year. UK The patient's situation is unknown or unclear.

(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome: **(Mark all that apply.)**

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

(M1041) Influenza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?	
Enter Code ☐	0 No *[Go to M1051]* 1 Yes
(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year's flu season?	
Enter Code ☐	1 Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge) 2 Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge) 3 Yes; received from another health care provider (for example, physician, pharmacist) 4 No; patient offered and declined 5 No; patient assessed and determined to have medical contraindication(s) 6 No; not indicated - patient does not meet age/condition guidelines for influenza vaccine 7 No; inability to obtain vaccine due to declared shortage 8 No; patient did not receive the vaccine due to reasons other than those listed in responses 4 – 7.

(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (for example, pneumovax)?	
Enter Code ☐	0 No 1 Yes **[*Go to M1501 at TRN; Go to M1230 at DC*]**
(M1056) Reason Pneumococcal Vaccine not received: If patient has never received the pneumococcal vaccination (for example, pneumovax), state reason:	
Enter Code ☐	1 Offered and declined 2 Assessed and determined to have medical contraindication(s) 3 Not indicated; patient does not meet age/condition guidelines for Pneumococcal Vaccine 4 None of the above

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

☐☐ inches — a. Height (in inches). Record most recent height measure since the most recent SOC/ROC

☐☐☐ pounds — b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)

LIVING ARRANGEMENTS

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

	Availability of Assistance				
Living Arrangement	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

SENSORY STATUS

(M1200) Vision (with corrective lenses if the patient usually wears them):	
Enter Code ☐	0 Normal vision: sees adequately in most situations; can see medication labels, newsprint. 1 Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length. 2 Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.

(M1210) Ability to Hear (with hearing aid or hearing appliance if normally used):	
Enter Code ☐	0 Adequate: hears normal conversation without difficulty. 1 Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly. 2 Severely Impaired: absence of useful hearing. UK Unable to assess hearing.
(M1220) Understanding of Verbal Content in patient's own language (with hearing aid or device if used):	
Enter Code ☐	0 Understands: clear comprehension without cues or repetitions. 1 Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand. 2 Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand. 3 Rarely/Never Understands. UK Unable to assess understanding.
(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):	
Enter Code ☐	0 Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. 1 Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance). 2 Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences. 3 Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases. 4 Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (for example, speech is nonsensical or unintelligible). 5 Patient nonresponsive or unable to speak.
(M1240) Has this patient had a formal **Pain Assessment** using a standardized, validated pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?	
Enter Code ☐	0 No standardized, validated assessment conducted 1 Yes, and it does not indicate severe pain 2 Yes, and it indicates severe pain
(M1242) Frequency of Pain Interfering with patient's activity or movement:	
Enter Code ☐	0 Patient has no pain 1 Patient has pain that does not interfere with activity or movement 2 Less often than daily 3 Daily, but not constantly 4 All of the time

INTEGUMENTARY STATUS

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers**?	
Enter Code ☐	0 No assessment conducted **[*Go to M1306*]** 1 Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool 2 Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)
(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?	
Enter Code ☐	0 No 1 Yes

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)	
Enter Code ☐	0 No **[*Go to M1322*]** 1 Yes
(M1307) The **Oldest Stage 2 Pressure Ulcer** that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers)	
Enter Code ☐	1 Was present at the most recent SOC/ROC assessment 2 Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: ☐☐ / ☐☐ / ☐☐☐☐ month day year NA No Stage 2 pressure ulcers are present at discharge

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 at FU/DC Go to M1311B1]	☐
A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 at FU/DC Go to M1311C1]	☐
B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 at FU/DC Go to M1311D1]	☐
C2. Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers due to non-removable dressing/device** [If 0 at FU/DC Go to M1311E1	☐
D2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 at FU/DC Go to M1311F1]	☐
E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)]	☐
F2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
[*Omit "A2, B2, C2, D2, E2 and F2" on SOC/ROC*]	

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:

Instructions for a-c: Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.	
	Enter Number
a. Stage 2	☐
b. Stage 3	☐
c. Stage 4	☐
Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.	
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	☐
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	☐
f. Unstageable – Suspected deep tissue injury in evolution.	☐

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

Enter Code ☐

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

(M1322) Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Enter Code ☐

0
1
2
3
4 or more

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

Enter Code ☐

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

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

Enter Code ☐

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

(M1332) Current Number of Stasis Ulcer(s) that are Observable:	
Enter Code ☐	1 One 2 Two 3 Three 4 Four or more
(M1334) Status of Most Problematic Stasis Ulcer that is Observable:	
Enter Code ☐	1 Fully granulating 2 Early/partial granulation 3 Not healing
(M1340) Does this patient have a **Surgical Wound?**	
Enter Code ☐	0 No **[*At SOC/ROC, go to M1350 ; At FU//DC, go to M1400*]** 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device **[*At SOC/ROC, go to M1350 ; At FU/DC, go to M1400*]**
(M1342) Status of Most Problematic Surgical Wound that is Observable	
Enter Code ☐	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing
(M1350) Does this patient have a **Skin Lesion** or **Open Wound** (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency?	
Enter Code ☐	0 No 1 Yes

RESPIRATORY STATUS

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

(M1410) Respiratory Treatments utilized at home: **(Mark all that apply.)**

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

CARDIAC STATUS

(M1501) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the most recent SOC/ROC assessment?	
Enter Code ☐	0 No **[*Go to M2005 at TRN; Go to M1600 at DC*]** 1 Yes 2 Not assessed **[*Go to M2005 at TRN; Go to M1600 at DC*]** NA Patient does not have diagnosis of heart failure **[*Go to M2005 at TRN; Go to M1600 at DC*]**

(M1511) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure at the time of or at any time since the most recent SOC/ROC assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

- ☐ 0 - No action taken
- ☐ 1 - Patient's physician (or other primary care practitioner) contacted the same day
- ☐ 2 - Patient advised to get emergency treatment (for example, call 911 or go to emergency room)
- ☐ 3 - Implemented physician-ordered patient-specific established parameters for treatment
- ☐ 4 - Patient education or other clinical interventions
- ☐ 5 - Obtained change in care plan orders (for example, increased monitoring by agency, change in visit frequency, telehealth)

ELIMINATION STATUS

(M1600) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?	
Enter Code ☐	0 No 1 Yes NA Patient on prophylactic treatment UK Unknown **[*Omit "UK" option on DC*]**
(M1610) Urinary Incontinence or Urinary Catheter Presence:	
Enter Code ☐	0 No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[*Go to M1620*]** 1 Patient is incontinent 2 Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic) **[*Go to M1620*]**
(M1615) When does **Urinary Incontinence** occur?	
Enter Code ☐	0 Timed-voiding defers incontinence 1 Occasional stress incontinence 2 During the night only 3 During the day only 4 During the day and night
(M1620) Bowel Incontinence Frequency:	
Enter Code ☐	0 Very rarely or never has bowel incontinence 1 Less than once weekly 2 One to three times weekly 3 Four to six times weekly 4 On a daily basis 5 More often than once daily NA Patient has ostomy for bowel elimination UK Unknown **[*Omit "UK" option on FU, DC*]**

(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?

Enter Code ☐

0 Patient does not have an ostomy for bowel elimination.

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

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

NEURO/EMOTIONAL/BEHAVIORAL STATUS

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

Enter Code ☐

0 Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.

1 Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.

2 Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.

3 Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.

4 Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

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

Enter Code ☐

0 Never

1 In new or complex situations only

2 On awakening or at night only

3 During the day and evening, but not constantly

4 Constantly

NA Patient nonresponsive

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

Enter Code ☐

0 None of the time

1 Less often than daily

2 Daily, but not constantly

3 All of the time

NA Patient nonresponsive

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized, validated depression screening tool?

Enter Code ☐

0 No

1 Yes, patient was screened using the PHQ-2©* scale.

Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2©*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	NA Unable to respond
a) Little interest or pleasure in doing things	☐0	☐1	☐2	☐3	☐NA
b) Feeling down, depressed, or hopeless?	☐0	☐1	☐2	☐3	☐NA

2 Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.

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

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week **(Reported or Observed): (Mark all that apply.)**

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

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed): Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.	
Enter Code ☐	0 Never 1 Less than once a month 2 Once a month 3 Several times each month 4 Several times a week 5 At least daily
(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?	
Enter Code ☐	0 No 1 Yes

ADL/IADLs

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

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Enter Code ☐

0 Able to obtain, put on, and remove clothing and shoes without assistance.
1 Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
2 Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
3 Patient depends entirely upon another person to dress lower body.

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

Enter Code ☐

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

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

Enter Code ☐

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

(M1845) **Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

Enter Code ☐

0 Able to manage toileting hygiene and clothing management without assistance.
1 Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.
2 Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
3 Patient depends entirely upon another person to maintain toileting hygiene.

(M1850) **Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

Enter Code ☐

0 Able to independently transfer.
1 Able to transfer with minimal human assistance or with use of an assistive device.
2 Able to bear weight and pivot during the transfer process but unable to transfer self.
3 Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
4 Bedfast, unable to transfer but is able to turn and position self in bed.
5 Bedfast, unable to transfer and is unable to turn and position self.

Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC

(GG0170C) Mobility

Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason.
Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.

Coding: **Safety** and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activity may be completed with or without assistive devices.* 06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper. 05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. 04 **Supervision or touching assistance –** Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01 **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. **If activity was not attempted, code reason:** 07 **Patient refused** 09 **Not applicable** 88 Not attempted due to **medical condition or safety concerns**	**1. SOC/ROC Performance**	**2. Discharge Goal**	
	↓Enter Codes in Boxes↓		
	☐☐	☐☐	**Lying to Sitting on Side of Bed**: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

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

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.	
Enter Code ☐	0 Able to independently feed self. 1 Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet. 2 Unable to feed self and must be assisted or supervised throughout the meal/snack. 3 Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. 4 Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. 5 Unable to take in nutrients orally or by tube feeding.
(M1880) Current **Ability to Plan and Prepare Light Meals** (for example, cereal, sandwich) or reheat delivered meals safely:	
Enter Code ☐	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 (specifically: 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.
(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.	
Enter Code ☐	0 Able to dial numbers and answer calls appropriately and as desired. 1 Able to use a specially adapted telephone (for example, 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.
(M1900) Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to his/her most recent illness, exacerbation, or injury.	
Enter Code ☐	a. Self-Care (specifically: grooming, dressing, bathing, and toileting hygiene) 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	b. Ambulation 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	c. Transfer 0 Independent 1 Needed Some Help 2 Dependent
Enter Code ☐	d. Household tasks (specifically: light meal preparation, laundry, shopping, and phone use) 0 Independent 1 Needed Some Help 2 Dependent

(M1910) Has this patient had a multi-factor **Falls Risk Assessment** using a standardized, validated assessment tool?	
Enter Code ☐	0 No. 1 Yes, and it does not indicate a risk for falls. 2 Yes, and it does indicate a risk for falls.

MEDICATIONS

(M2001) **Drug Regimen Review:** Did a complete drug regimen review identify potential clinically significant medication issues?	
Enter Code ☐	0 No - No issues found during review **[*Go to M2010*]** 1 Yes - Issues found during review 9 NA - Patient is not taking any medications **[*Go to M2040*]**
(M2003) Medication Follow-up: Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?	
Enter Code ☐	0 No 1 Yes
(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?	
Enter Code ☐	0 No 1 Yes 9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications
(M2010) Patient/Caregiver High-Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?	
Enter Code ☐	0 No 1 Yes NA Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications
(M2016) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?	
Enter Code ☐	0 No 1 Yes NA Patient not taking any drugs

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**	
Enter Code ☐	0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. 1 Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times 3 Unable to take medication unless administered by another person. NA No oral medications prescribed.
M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**	
Enter Code ☐	0 Able to independently take the correct medication(s) and proper dosage(s) at the correct times. 1 Able to take injectable medication(s) at the correct times if: (a) individual syringes are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection 3 Unable to take injectable medication unless administered by another person. NA No injectable medications prescribed.
(M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation or injury.	
Enter Code ☐	a. Oral medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable
Enter Code ☐	b. Injectable medications 0 Independent 1 Needed Some Help 2 Dependent NA Not Applicable

CARE MANAGEMENT

(M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.	
Enter Code ☐	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	b. **IADL assistance** (for example, meals, housekeeping, laundry, telephone, shopping, finances) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	c. **Medication administration** (for example, oral, inhaled or injectable) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	d. **Medical procedures/ treatments** (for example, changing wound dressing, home exercise program) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	e. **Management of Equipment** (for example, oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	g. **Advocacy or facilitation** of patient's participation in appropriate medical care (for example, transportation to or from appointments) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

(M2110) **How Often** does the patient receive **ADL or IADL assistance** from any caregiver(s) (other than home health agency staff)?	
Enter Code ☐	1 At least daily 2 Three or more times per week 3 One to two times per week 4 Received, but less often than weekly 5 No assistance received UK Unknown

THERAPY NEED AND PLAN OF CARE

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

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

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

(M2250) **Plan of Care Synopsis:** (Check only **one** box in each row.) Does the physician-ordered plan of care include the following:

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐0	☐1	☐NA	Physician has chosen not to establish patient-specific parameters for this patient. Agency will use standardized clinical guidelines accessible for all care providers to reference.
b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care	☐0	☐1	☐NA	Patient is not diabetic or is missing lower legs due to congenital or acquired condition (bilateral amputee).
c. Falls prevention interventions	☐0	☐1	☐NA	Falls risk assessment indicates patient has no risk for falls.
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment and/or physician notified that patient screened positive for depression	☐0	☐1	☐NA	Patient has no diagnosis of depression AND depression screening indicates patient has: 1) no symptoms of depression; or 2) has some symptoms of depression but does not meet criteria for further evaluation of depression based on screening tool used.
e. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐NA	Pain assessment indicates patient has no pain.
f. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐NA	Pressure ulcer risk assessment (clinical or formal) indicates patient is not at risk of developing pressure ulcers.
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐0	☐1	☐NA	Patient has no pressure ulcers OR has no pressure ulcers for which moist wound healing is indicated.

EMERGENT CARE

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

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

- ☐ 1 - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- ☐ 2 - Injury caused by fall
- ☐ 3 - Respiratory infection (for example, pneumonia, bronchitis)
- ☐ 4 - Other respiratory problem
- ☐ 5 - Heart failure (for example, fluid overload)
- ☐ 6 - Cardiac dysrhythmia (irregular heartbeat)
- ☐ 7 - Myocardial infarction or chest pain
- ☐ 8 - Other heart disease
- ☐ 9 - Stroke (CVA) or TIA
- ☐ 10 - Hypo/Hyperglycemia, diabetes out of control
- ☐ 11 - GI bleeding, obstruction, constipation, impaction
- ☐ 12 - Dehydration, malnutrition
- ☐ 13 - Urinary tract infection
- ☐ 14 - IV catheter-related infection or complication
- ☐ 15 - Wound infection or deterioration
- ☐ 16 - Uncontrolled pain
- ☐ 17 - Acute mental/behavioral health problem
- ☐ 18 - Deep vein thrombosis, pulmonary embolus
- ☐ 19 - Other than above reasons
- ☐ UK - Reason unknown

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

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

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

(M2410) To which **Inpatient Facility** has the patient been admitted?

Enter Code ☐

1 Hospital **[*Go to M2430*]**
2 Rehabilitation facility **[*Go to M0903*]**
3 Nursing home **[*Go to M0903*]**
4 Hospice **[*Go to M0903*]**
NA No inpatient facility admission **[*Omit "NA" option on TRN*]**

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

Enter Code ☐

1 Patient remained in the community (without formal assistive services)
2 Patient remained in the community (with formal assistive services)
3 Patient transferred to a non-institutional hospice
4 Unknown because patient moved to a geographic location not served by this agency
UK Other unknown **[*Go to M0903*]**

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

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

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

☐☐ / ☐☐ / ☐☐☐☐
month day year

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

☐☐ / ☐☐ / ☐☐☐☐
month day year

General OASIS Item Conventions

1. Understand the time period under consideration for each item. Report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance. Day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home.

2. For OASIS purposes, a quality episode must have a beginning (that is, an SOC or ROC assessment) and a conclusion (that is, a Transfer or Discharge assessment) to be considered a complete care episode.

3. If the patient's ability or status varies on the day of the assessment, report the patient's "usual status" or what is true greater than 50% of the assessment time frame, unless the item specifies differently.

4. Minimize the use of NA and Unknown responses.

5. Some items allow a dash response. A dash (–) value indicates that no information is available, and/or an item could not be assessed. This most often occurs when the patient is unexpectedly transferred, discharged or dies before assessment of the item could be completed. CMS expects dash use to be a rare occurrence.

6. Responses to items documenting a patient's current status should be based on independent observation of the patient's condition and ability at the time of the assessment without referring back to prior assessments. Several process items require documentation of prior care, at the time of or since the time of the most recent SOC or ROC OASIS assessment. These instructions are included in item guidance for the relevant OASIS questions.

7. Combine observation, interview, and other relevant strategies to complete OASIS data items as needed (for example, it is acceptable to review the hospital discharge summary to identify inpatient procedures and diagnoses at Start of Care, or to examine the care notes to determine if a physician-ordered intervention was implemented at Transfer or Discharge). However, when assessing physiologic or functional health status, direct observation is the preferred strategy.

8. When an OASIS item refers to assistance, this means assistance from another person. Assistance is not limited to physical contact and can include verbal cues and/or supervision.

9. Complete OASIS items accurately and comprehensively, and adhere to skip patterns.

10. Understand the definitions of words as used in the OASIS.

11. Follow rules included in the Item Specific Guidance (Chapter 3 of this manual).

12. Stay current with evolving CMS OASIS guidance updates. CMS may post updates to the guidance manual up to twice per year, and releases OASIS Q&As quarterly.

13. Only one clinician may take responsibility for accurately completing a comprehensive assessment. However, for selected items, collaboration is appropriate. These exceptions are noted in the item specific guidance.

14. The use of the term "specifically," means scoring of the item should be limited to only the circumstances listed. The use of "for example," means the clinician may consider other relevant circumstances or attributes when scoring the item.

Conventions Specific to ADL/IADL Items

1. Report the patient's physical and cognitive ability to perform a task. Do not report on the patient's preference or willingness to perform a specified task.

2. The level of ability refers to the level of assistance (if any) that the patient requires to safely complete a specified task.

3. While the presence or absence of a caregiver may impact the way a patient carries out an activity, it does not impact the assessing clinician's ability to assess the patient in order to determine and report the level of assistance that the patient requires to safely complete a task.

4. Understand what tasks are included and excluded in each item and select the OASIS response based only on included tasks.

5. If the patient's ability varies between the different tasks included in a multi-task item, report what is true in a majority of the included tasks, giving more weight to tasks that are more frequently performed.

6. Consider medical restrictions when determining ability. For example, if the physician has ordered activity restrictions, consider this when selecting the best response to functional items related to ambulation, transferring, bathing, etc.

OASIS ITEM - Reporting algorithm for M1313

CURRENT STAGE *at Discharge*	*Look back to most recent SOC/ROC*	PRIOR STAGE *at most recent SOC/ROC*	REPORT AS *NEW* OR *WORSENED*?
a. Stage 2 *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	• Not present • Stage 1 • Covered with a non-removable dressing/device, then documented as a Stage 1 at any home visit or Follow-Up assessment(s)	**YES**
		• Stage 2	NO
		• Stage 3 • Stage 4	NA (Stage 3 or 4 could not become a Stage 2)
		• Covered with a non-removable dressing/device and remains Unstageable until assessed as a Stage 2 at Discharge	NO
b. Stage 3 *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	• Not present • Stage 1 • Stage 2 • Unstageable with documented Stage 1 and/or 2 at any home visit or Follow-Up assessment(s)	**YES**
		• Stage 3	NO
		• Stage 4	NA (Stage 4 could not become a Stage 3)
		• Unstageable until assessed as a Stage 3 at Discharge	NO
c. Stage 4 *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	• Not present • Stage 1 • Stage 2 • Stage 3 • Unstageable with documented Stage 1, 2, and/or 3 at any home visit or Follow-Up assessment(s)	**YES**
		• Stage 4 • Unstageable until assessed as a Stage 4 at Discharge	NO
d. Unstageable due to non-removable dressing *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	• Not present	**YES**
		• Stage 1 • Stage 2 • Stage 3 • Stage 4 • Unstageable	NO
e. Unstageable due to slough and/or eschar *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	• Not present • Stage 1 • Stage 2	**YES**
		• Stage3 • Stage 4 • Unstageable	NO
f. Unstageable – suspected deep tissue injury *at Discharge*	*If same pressure ulcer at most recent SOC/ROC was:*	• Not present • Stage 1 • Stage 2	**YES**
		• Stage 3 • Stage 4 • Unstageable due to slough and/or eschar	NA (Full thickness pressure ulcer could not become a sDTI)
		• Unstageable – Suspected DTI or due to a non-removable dressing/device	NO