Outcome and ASsessment Information Set

OASIS-C Guidance Manual

September 2009

Centers for Medicare & Medicaid Services

CHAPTER 1 – INTRODUCTION

The Outcome and ASsessment Information Set (OASIS) is a group of standard data elements developed, tested, and refined over the past two decades through a research and demonstration program funded primarily by the Centers for Medicare & Medicaid Services (CMS), with additional funding from the Robert Wood Johnson Foundation and the New York State Department of Health. OASIS data elements are designed to enable systematic comparative measurement of home health care patient outcomes at two points in time. Outcome measures are the basis for outcome-based quality improvement (OBQI) efforts that home health agencies (HHAs) can employ to assess and improve the quality of care they provide to patients. Under OBQI, CMS provides HHAs with agency-patient related characteristic (case mix), risk-adjusted outcome, potential avoidable event (adverse event outcome), and patient tally reports for their patients for a 12-month period. The agency also is provided with comparison data from the HHA's prior 12-month period and national reference data.

Comparisons are risk adjusted for patient differences (both over time for the agency and between the agency and the reference group). OBQI requires uniform measures that are calculated from standardized data elements. Further details on OASIS and OBQI are included in Appendix F of this manual, and a full description of OBQI is available in the Outcome-Based Quality Improvement Manual, which can be found at OASIS OBQI Home Health Quality Initiatives.[1] OASIS-C allows for the computation and reporting of measures of clinical processes to supplement currently reported outcome measures. In addition to quality measurement, a subset of OASIS items is used to calculate payment algorithms under the Medicare Prospective Payment System (PPS).

In 1999, Medicare-certified HHAs began collecting and submitting OASIS data related to all adult (18 years or older) nonmaternity patients receiving skilled services with Medicare or Medicaid as a payer source. The OASIS items have been revised several times since 1999 to address the burden of data collection, refine items for payment algorithms, and enhance outcome reporting. In 2008, CMS began a large-scale effort to revise OASIS for three reasons:

a) To address issues raised by the HHA provider community for specific OASIS items;

b) To incorporate the measurement of selected processes of care to supplement the measurement of outcomes, and

c) To align OASIS measures and items with other instruments being developed to measure care across post-acute care settings (i.e., the nursing home Minimum Data Set [MDS] and the Continuity Assessment Record Evaluation [CARE]).

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

[1] http://www.cms.hhs.gov/HomeHealthQualityInits/16_HHQIOASISOBQI.asp#TopOfPage

the NQF endorsement process. More information about OASIS-C can be found on the CMS web page (OASIS-C Home Health Quality Initiatives).[2]

A. Manual Overview

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

This revised manual, the OASIS Guidance Manual, is a streamlined version of the original manual that contains content most relevant for HHAs experienced with OASIS requirements, with an emphasis on OASIS item guidance. Selected content from the OASIS Implementation Manual has been incorporated into the appendix to provide additional context for OASIS data collection requirements. Sections relevant to first-time implementation of OASIS data have been deleted. HHAs new to OASIS collection, or those interested in reviewing sections of the retired OASIS Implementation Manual, may access it at the following link: Archives Home Health Quality Initiatives.[3] However, please note that the OASIS Implementation Manual has **not** been updated to reflect the most recent revisions to OASIS.

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

Chapter 1 – The Introduction, which provides contextual information and other general information relevant to OASIS data collection.

Chapter 2 – Includes versions of the OASIS-C data set for each time point.

Chapter 3 – Contains item-specific guidance, subdivided into sections.

Chapter 4 – Contains sample clinical record forms for OASIS data collection time points.

Chapter 5 – Includes relevant resources for HHAs, with hyperlinks when available.

Appendices – Includes additional contextual information, including sections on OBQI, home health care regulations related to OASIS data collection, and recommendations for ensuring accuracy of OASIS data. Appendix D, formerly Attachment D, addresses the OASIS diagnosis items that pertain to the home health episode (i.e., M1020, M1022, and M1024).

[2] http://www.cms.hhs.gov/HomeHealthQualityInits/06_OASISC.asp#TopOfPage
[3] http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage

B. Why is OASIS Being Revised Now?

HHAs began collecting and transmitting OASIS data for adult skilled Medicare and Medicaid patients (with the exception of maternity patients) in 1999. During the past 10 years, numerous changes have occurred within the health care system, including specific recommendations for changes in the area of home health care quality measurement:

- 2001 – Institute of Medicine (IOM) identified six focus areas for improving health care quality (safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity).

- 2005 – National Quality Forum (NQF) endorsed the initial set of home health quality measures for public reporting along with recommendations for future changes to the measures.

- 2006 – Medicare Payment Advisory Commission (MedPAC) Report to Congress included recommendations for expanding home health quality measures to a) broaden the patient population covered by the OASIS, b) capture safety as an aspect of quality, c) capture an aspect of care directly under providers' influence, d) reduce variation in practice, and e) provide incentives to improve information technology.

- 2008 – NQF developed a new set of guidelines/frameworks for measures and priorities.

Current efforts are underway to create a system for assessing patients using consistent terminology and measuring quality across post-acute care settings. The instrument being developed for this program is the Continuity Assessment Record Evaluation (CARE), which will harmonize data elements across three well-known CMS clinical assessment instruments: the Minimum Data Set (MDS) for nursing homes, the Uniform Data Set for Medical Rehabilitation (FIM™) for rehabilitation facilities, and the OASIS for home care. In addition, the National Quality Forum has called for harmonization of influenza and pneumonia immunization assessment items and is working to develop a framework for measuring pressure ulcers across provider settings.

At the time OASIS was initially implemented, it was anticipated that the data set would evolve to reflect changes in quality priorities, health research, health care policy, payment, and care practices. To oversee this evolution of OASIS, CMS convened several technical expert panels to consider provider feedback on OASIS — along with the IOM aims and MedPAC recommendations — and recommend potential revisions. These recommendations, along with efforts to align OASIS-C elements with other data collection instruments where possible, were the basis for OASIS revisions being made for 2010. Because revisions to OASIS-B1 were extensive, this current version has been renamed OASIS-C.

C. What's New About OASIS-C

The OASIS-C represents the most comprehensive revision to OASIS since its original release. A summary of the types of revisions made to OASIS is provided below. A crosswalk of OASIS-B1 and OASIS-C items is provided in Appendix G. In the discussion below, examples are given to highlight the types of changes incorporated into OASIS-C.

Please note that, with the exception of the tracking items and M0903/M0906, the OASIS-C items have been renumbered; thus the OASIS-B1 M0 item numbers do not correspond to the

new OASIS-C numbering scheme. This was necessary because new OASIS items were placed within the existing sequence of items and other OASIS items were resequenced. Attempting to align the new items with the previous numbering system proved impossible for some sections. Instead, each section has been assigned to a range of numbers (e.g., Integumentary Status items are numbered M1300-M1350). This was determined to be a better long-term solution and one that mirrors systems being used by the data sets in other settings and the CARE instrument. See Table 1 for a list of OASIS items and their numbering sequence.

TABLE 1: OASIS-C Numbering System.

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

✓Revisions to OASIS-B1 Items

Many OASIS items were revised to reflect comments from the provider community. Some items (e.g., bathing, transferring) have been expanded to include additional scale levels, which will allow agencies to document changes in patient status with greater accuracy. Other items reflect wording changes designed to improve item clarity. For example, the Management of Oral Medications (M2020) now specifies that the item refers to the patient's ability to correctly manage all medications safely and reliably, in contrast to OASIS B-1 wording: "all *prescribed* oral medications." Because patient ability to take medications is so important to patient safety, CMS has determined that medication management warrants its own domain, outside of the ADL/IADL section. The OASIS data items for pressure ulcers (M1300 - M1324) were revised to reflect current National Pressure Ulcer Advisory Panel (NPUAP) and Wound, Ostomy, and Continence Nurses Society (WOCN) guidance on pressure ulcer assessment and to harmonize with other measures of pressure ulcers (based on the National Quality Forum framework for pressure ulcer measurement).

✓Elimination of OASIS-B1 Items

OASIS-B1 items not used for payment, quality measures (including those used in the survey process), case mix, or risk adjustment purposes (e.g., Transportation and Shopping), were eliminated. In some cases, eliminated items were replaced with items intended to capture the assessment parameter in a more efficient way. For example, the "prior status" items for all the ADLs/IADLs have been eliminated. Two new OASIS-C items were developed to capture the patient's prior level of dependence with ADLs/IADLs (M1900) and medication management (M2040).

✓New OASIS Items

OASIS-C items were created to a) increase clarity in measurement; b) replace OASIS-B1 items being eliminated; or c) measure processes of care in home health agencies.

a. New items to increase clarity in measurement: An example of such an item is (M1845), Toileting Hygiene, which was created to supplement measurement of toilet transferring (M1840). Together, these items are intended to more accurately capture toileting ability. Similarly, an item for understanding of verbal content (M1220) supplements the item for ability to hear (M1210) to provide a more comprehensive understanding of the patient's receptive communication ability.

b. New items to replace OASIS-B1 items: As noted above, two new OASIS-C items were developed to capture patient prior level of dependence with ADLs/IADLs (M1900) and medication management (M2040). As another example, (M1730) Depression Screening replaces the OASIS-B1 data item that assessed the presence of depressive feelings. M1730 includes a two-item screening tool (the PHQ-2©) for agencies choosing to use this standardized screening instrument.

c. New items to measure processes of care: Care processes refer to the use of assessment tools (included in a comprehensive assessment) or the planning and delivery of specific clinical interventions. Several evidence-based screening tools and interventions that can be considered "best practices" In home health care were identified through literature review and expert panel input. OASIS-C includes data items to measure the use of these "best practice" care processes. To reflect Institute of Medicine (IOM) aims and MedPAC recommendations, and to focus on high-risk, high-volume, problem-prone conditions in home health care, data items were created to measure processes of care in the following domains:

- Date of referral and physician-ordered start of care (timeliness)
- Patient-specific parameters for physician notification (care coordination)
- Influenza and pneumococcal vaccines (population health and prevention)
- Formal pain assessment, pain interventions, and pain management steps (effectiveness of care)
- Pressure ulcer risk assessment, prevention measures, and use of moist healing principles (effective care and prevention)

- Diabetic foot care plan, education and monitoring (disease specific: high risk, high volume, problem prone)
- Heart failure symptoms of volume overload and follow-up (disease specific: high risk, high volume, problem prone)
- Depressive symptom screening and intervention/referral (influences self-management abilities)
- Falls risk assessment, planning and interventions (safety)
- Medication adverse events/reaction, reconciliation and follow up; drug education (high priority for safety – care coordination)

It is anticipated that processes of care implemented according to evidence-based guidelines will ultimately lead to better clinical outcomes. The process items are a logical follow-up to the Quality Improvement Organizations (QIOs) 8th Scope of Work on Best Practices (MedQIC - HHQI Campaign).[4] Agencies participating in reliability testing of OASIS-C felt process items gave them "credit" for excellent patient care practices already in place.

The care processes documented in the OASIS-C **are not mandated** under the current Conditions of Participation. Clinicians may find that these processes of care have no application for a particular patient and therefore no related assessment or intervention is needed. Clinicians may document in the clinical record any appropriate additional information. With the exception of the OASIS-C items, CMS does not prescribe the content of agency clinical assessment forms nor mandate specific processes of care.

However, some of the OASIS-C process items will support publicly-reported measures and agencies choosing not to adopt those processes of care will see their decisions reflected in Home Health Compare scores. It should also be noted that it is possible that the process measures **may be** incorporated in a future quality-based purchasing (pay for performance) system for home health care. While the OASIS-C process items will be used for quality reporting, CMS understands that the evidence-based practices being measured are not appropriate for every patient, and a rate of 100% is not expected for any agency or any measure.

OASIS-C process data items address use of screening assessments (e.g., for falls or depression), inclusion of specific evidence-based care processes in the plan of care (M2250), and whether clinical interventions were provided to the patient during the care episode. For example, M2400 asks if pain management steps to monitor and mitigate pain were implemented during the care episode. Many of the process items are skipped at certain time points if patients do not exhibit these problems. It should be noted that some of the process data items require review of care provided since the most recent OASIS assessment to determine if assessment and interventions for certain conditions occurred during that specified time period. This will require some new data collection strategies as discussed in detail in Section D below.

[4] http://www.qualitynet.org/dcs/ContentServer?c=MQParents&pagename=Medqic%2FContent%2FParentShellTemplate&cid= 1196689997847&parentName=Topic

✓Number of items

Overall, agencies pilot testing OASIS-C noted that the new version of OASIS required little additional time to complete when compared to OASIS-B1 assessment time, regardless of the overall item increase. The net changes are shown in Table 2.

The time point with the largest increase in data items is Transfer. This increase was needed to (a) calculate additional quality measures related to reasons for hospitalization, and (b) assess care processes that potentially can reduce the rate of acute care hospitalization. Many process items, like other OASIS items, are simple yes/no responses or are skipped if the patient does not have the relevant condition. For example, (M1510) Heart Failure Follow-Up is skipped for patients who do not have a diagnosis of heart failure.

TABLE 2: Change in Number of OASIS Items.

Time Point	Total Number of OASIS-C Items	Net Change in Number of Items from OASIS-B1
Patient Tracking	17	-1
SOC	79	+2
ROC	79	+2
Follow-up	32	+1
Transfer	19	+8
Discharge	61	-11
Death at home	5	+1

D. Collecting OASIS-C Data

Techniques for collecting OASIS-C data are the same used for OASIS-B1, with the exception of the process items. This section will provide a basic overview for collecting OASIS-C data. For more detail on clinical strategies for collecting OASIS data as part of a comprehensive assessment, refer to Appendix A of this manual.

Eligible Patients

OASIS data are collected for Medicare and Medicaid patients, 18 years and older, receiving skilled services, with the exception of patients receiving services for pre- or postnatal conditions. Patients receiving only personal care, homemaker, or chore services exclusively are excluded since these are not considered skilled services. Note, OASIS data collection and submission are not required for patients who have a single visit in a quality episode. See OASIS Management for Single Visit at SOC or ROC[5] on the OASIS link of the QIES Technical Support Office web page.

[5] https://www.qtso.com/download/hha/OASIS_Mgmnt_of_Single_Visit_SOC_ROC_11_05_07.pdf

Time Points

OASIS-C data are collected at the following time points:

- Start of Care
- Resumption of Care following inpatient facility stay
- Recertification within the last five days of each 60-day recertification period
- Other Follow-Up
- Transfer to inpatient facility
- Discharge from home care
- Death at Home

All of these assessments, with the exception of transfer to inpatient facility and death at home, must be conducted during a home visit because all require the clinician to have an in-person encounter with the patient. The transfer to an inpatient facility requires collection of limited OASIS data (most of which may be obtained through a telephone call).

Not all OASIS items are completed at every assessment time point. Some items are completed only at start of care, some only at discharge, and still others only when a patient is admitted to a specific type of inpatient facility (e.g., M2400 - Reason for Nursing Home Admission). The table of "Items to be Used at Specific Time Points" included at the beginning of the OASIS data set allows the clinician conducting the assessment to identify the necessary OASIS items at each time point.

Hospitalization rates are a CMS priority across settings and an important quality measure; therefore, admission to an inpatient facility during the home care episode is a significant event that must be considered in the computation of home care outcomes. Thus, the transfer of a patient to an inpatient facility for a period of 24 hours (or more) for any reason other than diagnostic testing **and** the resumption of care after this inpatient facility stay (which necessitates a comprehensive assessment during a home visit) also require the reporting of assessment data. Understanding the reasons for these potentially avoidable events will help agencies improve care.

At the start of care time point, the comprehensive assessment should be completed within five days of the start of care date. At the resumption of care, the comprehensive assessment must be completed within 48 hours of inpatient facility discharge. For the transfer to inpatient facility, discharge from home care, death at home, and other follow-up, the assessments must be completed within 48 hours of becoming aware of the transfer, discharge, death, or significant change in condition.

Who Completes OASIS-C

As identified in (M0080) Discipline of Person Completing Assessment, the comprehensive assessment and OASIS data collection should be conducted by a registered nurse (RN) or any of the therapies (PT, SLP/ST, OT). An LPN/LVN, PTA, OTA, MSW, or Aide may not complete OASIS assessments,

In cases involving nursing, the RN completes the comprehensive assessment at SOC. Any discipline qualified to perform assessments – RN, PT, SLP, OT – may complete subsequent assessments. For a therapy-only case, the therapist usually conducts the comprehensive

assessment. It is acceptable for a PT or SLP to conduct and complete the comprehensive assessment at SOC. An OT may conduct and complete the assessment when the need for occupational therapy establishes program eligibility. Note: Occupational therapy alone does not establish eligibility for the Medicare home health benefit at the start of care; however, occupational therapy may establish eligibility under other programs, such as Medicaid. The Medicare home health patient who is receiving services from multiple disciplines (i.e., skilled nursing, physical therapy, and occupational therapy) during the episode of care, can retain eligibility if, over time, occupational therapy is the only remaining skilled discipline providing care. At that time, an OT can conduct OASIS assessments.

Multidisciplinary cases may have multiple points of discipline-specific discharge, though only one is the agency discharge, which must include OASIS data collection and completion of the OASIS discharge comprehensive assessment**.** Other non-OASIS required documentation for recertification and discharge are specified in the Home Health Services Conditions for Coverage (CfCs) & Conditions of Participations (CoPs).[6] OASIS items were designed to be discipline-neutral and have been tested and validated with clinicians from various disciplines.

Comprehensive Assessment and Plan of Care

OASIS-C data are collected as part of the comprehensive assessment required by the Medicare Conditions of Participation (see Appendix A of this manual). As with OASIS-B1, OASIS-C is not intended to represent a comprehensive assessment in and of itself. Each agency is expected to incorporate the OASIS items into its own comprehensive assessment documentation and follow its own assessment policies and procedures. Agencies are free to rearrange OASIS-C item sequence in a way that permits logical ordering within their own forms, as long as the actual item content, skip patterns, and OASIS number remain the same. OASIS data, like the rest of the comprehensive assessment, are collected using a variety of strategies, including observation, interview, review of pertinent documentation (e.g., hospital discharge summaries to obtain information on inpatient facility procedures and diagnoses), discussions with other care team members where relevant (e.g., phone calls to the physician to verify diagnoses), and measurement (e.g., wound length/width, intensity of pain). As with OASIS-B1, OASIS-C data should be collected at each time point based on a unique patient assessment, not simply carried over from a previous assessment. Comprehensive assessment data form the basis of the physician-ordered plan of care. Thus, there should be congruency between documentation of findings from the comprehensive assessment and the plan of care. As specified in the Medicare Conditions of Participation for Home Health (see link to the Conditions of Participation in Chapter 5 of this manual), the plan of care should be updated to reflect revised care orders and current diagnoses throughout the period the patient is receiving home health care services.

Process of Care Data Items

Process of care data items collected at transfer and discharge time points may require the clinician completing the assessment to review the entire care episode, defined as the time since the most recent OASIS assessment. The purpose of this review is to determine if a condition (e.g., pain, symptoms of heart failure) was present during the episode and whether interventions to address the condition were a) incorporated into the plan of care and b) implemented as part of patient care (see example in Table 3).

[6] http://www.cms.hhs.gov/CFCsAndCoPs/12_homehealth.asp#TopOfPage

This review must consider care provided by all disciplines during the episode, not limited to care provided by the discipline of the clinician completing the OASIS assessment. This evaluation of the care episode can be accomplished in several different ways. The care provider may find it necessary to review clinical records, including the plan of care, updated orders, and visit notes. Alternatively, the agency may elect to create a flowsheet with the appropriate parameters that are checked off on each visit. Review of the flowsheet may provide the needed information, such that a review of the clinical record would be unnecessary. Another strategy for agencies using electronic health records is to create a report template that could pull the needed information from data fields incorporated into visit notes. Regardless of the technique that an agency chooses, the process data items completed at transfer and discharge will require knowledge of patient symptoms, initial and subsequent physician's orders, and clinical interventions performed to address patient symptoms across the episode of care.

TABLE 3: Illustrative Process Items.

Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

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

Conventions for Completing OASIS-C

Table 4 lists conventions, or general rules, that should be observed when completing OASIS-C. Item-specific guidance is provided in Chapter 3. The OASIS-C Guidance provides clarification of item intent based on "Frequently Asked Questions" posted to CMS since OASIS was initially implemented. We do, however, anticipate that we will not clarify all of the situations that are unique and the exceptions that may be encountered in clinical practice.

Each patient scenario, clinical status, social and environmental situation is unique, requiring professional/clinical judgment and care coordination. In the event you cannot resolve your understanding of the OASIS questions, CMS will continue to provide avenues to accept and respond to questions.

TABLE 4: Conventions for Completing OASIS-C Items.

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. 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 (e.g., for M2020 Management of Oral Medications, M2030 Management of Injectable Medications, and M2100e Management of Equipment, instead of "usual status" or "greater than 50% of the time," consider the medication or equipment for which the most assistance is needed).
3. Minimize the use of NA and Unknown responses.
4. Responses to items documenting a patient's current status should be based on independent observation of the patient's condition and ability at the time of the assessment without referring back to prior assessments unless collection of the item includes review of the care episode (e.g., process items). For OASIS items that require review of the episode, the phrase "since the previous OASIS assessment" should be interpreted to mean "at or since the time of the last OASIS assessment." These instructions are included in item guidance for the relevant OASIS questions.
5. Combine observation, interview, and other relevant strategies to complete OASIS data items as needed (e.g., it is acceptable to review the hospital discharge summary to identify inpatient procedures and diagnoses at Start of Care, or to examine the care notes to determine if a physician-ordered intervention was implemented at Transfer or Discharge). However, when assessing physiologic or functional health status, direct observation is the preferred strategy.
6. When an OASIS item refers to assistance, this means assistance from another person unless otherwise specified within the item. Assistance is not limited to physical contact and includes both verbal cues and supervision.
7. Complete OASIS items accurately and comprehensively, and adhere to skip patterns.
8. Understand what tasks are included and excluded in each item and score item based only on what is included.
9. Consider medical restrictions when determining ability. For example, if the physician has ordered activity restrictions, these should be considered when selecting the best response to functional items related to ambulation, transferring, etc.
10. Understand the definitions of words as used in the OASIS.
11. Follow rules included in the Item Specific Guidance.
12. Stay current with evolving CMS OASIS guidance updates.
13. Only one clinician takes responsibility for accurately completing a comprehensive assessment, although for selected items, collaboration is appropriate (e.g., Medication items M2000 – M2004). These exceptions are noted in the Item Specific Guidance.
14. When the OASIS item includes language specifying "one calendar day" (e.g., M2002 Medication Follow-up), this means until the end of the next calendar day.
15. The use of i.e., means "only in these circumstances" or "that is" and scoring of the item should be limited to the examples listed. The use of e.g., means "for example" and the clinician may consider other relevant examples when scoring this item.

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TABLE 4: Conventions for Completing OASIS-C Items. (cont'd)

ADL/IADL item-specific conventions

1. Report the patient's ability, not actual performance or willingness, to perform a task. While the presence or absence of a caregiver may impact actual performance of activities, it does not impact the patient's ability to perform a task.
2. The level of ability refers to the patient's ability to safely complete specified activities.
3. If the patient's ability varies between the different tasks included in a multi-task item, report what is true in a majority of the included tasks, giving more weight to tasks that are more frequently performed.

E. OASIS Data Accuracy

In any data-driven system, the quality of the output is only as good as the quality of the data input. OASIS data are used to produce quality reports for agencies and for public reporting on the Medicare Home Health Compare website, as well as to determine payment. At some point in the future, OASIS data may be used to determine incentive payments under a quality-based purchasing program. Thus, it is imperative that the OASIS data that HHAs collect and submit be accurate and complete. Regulatory language specifying accuracy of OASIS data can be found in the Medicare Conditions of Participation §484.20(b) Standard: Accuracy of Encoded OASIS Data (2005 CFR Title 42, Volume 3).[7] (Also, see Appendix B of this manual.)[8]

CMS recommends that agencies develop internal systems for monitoring data accuracy in addition to data checking features incorporated into HAVEN and other data entry systems. These may include clinical record audits, data entry audits, and other activities that are explained in detail in Appendix B of this manual, which incorporates Chapter 12 of the OASIS Implementation Manual (Archives Home Health Quality Initiatives).[9]

HHAs can correct nearly all erroneous assessments themselves following professional standards for correcting documents. Inactivation procedures to correct assessments containing key field errors can be found at https://www.qtso.com/download/hha/HHAcorrectionpolicy.pdf. Additional information related to correction of erroneous OASIS data is provided in the April 20, 2001 Survey and Certification memorandum on this topic (https://www.qtso.com/download/hha/HHAcorrectionpolicy.pdf).[10] A copy of the memorandum is also provided in Appendix B of this manual.

[7] http://www.access.gpo.gov/nara/cfr/waisidx_05/42cfr484_05.html
[8] http://www.cms.hhs.gov/CFCsAndCoPs/12_homehealth.asp#TopOfPage
[9] http://www.cms.hhs.gov/HomeHealthQualityInits/20_HHQIArchives.asp#TopOfPage
[10] https://www.qtso.com/download/hha/HHAcorrectionpolicy.pdf

F. OASIS Data Encoding and Transmission

OASIS-C revisions do not change the requirements for OASIS data encoding within 30 days of assessment completion (M0090). The requirements are specified in the Medicare Conditions of Participation §484.20(a) Standard: Encoding OASIS Data, §484.20(c) Standard: Transmittal of OASIS Data, and §484.20(d) Standard: Data Format. (Available at Home Health Services Conditions of Participations (CoPs); and summarized in Appendix E of this manual. Detailed instructions on encoding and transmitting OASIS data are found in the HHA System User's Guide and the OASIS Validation Report Messages and Description Guide (both available at QIES Technical Support Office - OASIS Download)[11] and the HAVEN System Reference Manual (QIES Technical Support Office - HAVEN Download)[12] for those agencies using HAVEN to meet these requirements.

[11] https://www.qtso.com/hhadownload.html
[12] https://www.qtso.com/havendownload.html

PREFACE

This manual is an updated, streamlined version of the original OASIS-B1 Implementation Manual, originally published in 1999. It is the first in a four-manual series on the Outcome and Assessment Information Set (OASIS), interpretation of the OASIS-based quality reports that CMS provides, and use of the reports for performance improvement. This manual provides guidance for home health agencies (HHAs) on how to ensure the collection of high-quality (accurate) OASIS-C data. It includes both general data collection conventions and item-specific guidance, as well as links to quality-related resources for agencies. The original manual has been archived, and while it will still be accessible on the CMS web site (Archives Home Health Quality Initiatives), it will not be updated to reflect OASIS-C changes or other future changes.

The second manual, entitled "*Outcome-based Quality Improvement (OBQI) Manual*" is written for agencies wishing to implement activities to improve or maintain OASIS outcomes. The third manual, the "*Process Quality Measure Manual,*" provides information on the OASIS-derived process measure report and recommendations for using the process measures both as a starting place for increasing the use of best practices in home health care delivery, and in conjunction with OASIS outcomes to improve clinical outcomes. The "*Quality Monitoring Using Case Mix and Adverse Event Outcome Reports*" manual focuses on the measures on the Potentially Avoidable Event (adverse event outcome) reports, which can be helpful to agencies as part of a quality monitoring program. These manuals will be available to agencies in 2010.

Since OASIS collection was implemented in 1999, national interest in the area of home health care quality measurement and improvement has been ongoing. CMS received hundreds of comments about OASIS from a variety of sources: providers, professional organizations (e.g., American Nurses Association and the American Physical Therapy Association), home care provider organizations, accrediting organizations, researchers, etc. In addition, individuals and groups with expertise in health care quality measurement, such as the Medicare Payment Advisory Commission (MedPAC), the National Quality Forum (NQF), and several technical expert panels commissioned by CMS to guide OASIS evolution have offered suggestions for improving OASIS and expanding the domains of home health quality measurement to address the six aims (safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness) articulated by the Institute of Medicine in their 2001 report "Crossing the Quality Chasm."

Input from the NQF, a nonprofit organization that endorses national consensus standards for measuring and publicly reporting on performance, has been especially valuable in guiding the evolution of OASIS and associated performance reports. NQF-endorsed voluntary consensus standards are widely viewed as the gold standard for measurement of health care quality. Once a measure is NQF-endorsed, it can be used by government agencies like CMS for public reporting and quality improvement. In 2005, NQF endorsed the initial set of home health quality measures that now appear on Home Health Compare. At that time, they recommended that CMS augment the outcome measures by developing measures to examine care processes. The NQF recommendations were incorporated into the development of OASIS-C and associated quality measures. In Fall 2008, a new set of OASIS performance measures were submitted for NQF review, including existing measures that were scheduled for maintenance review and revised/new measures based on OASIS-C items. NQF reviewed the new home health measures and offered several suggestions for revisions to both data items and associated measures, which were addressed when finalizing OASIS-C. Ultimately, NQF endorsed 10 outcome measures and 13 process quality measures based on OASIS-C data. These measures will appear on the Home Health Compare website in 2010-2011, after sufficient OASIS-C data are reported.

Preface added 12/18/2009

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Eleven agencies from three states contributed significant staff time to participate in the OASIS-C time analysis and reliability testing, and their feedback on the draft data items and guidance has been indispensable. Many industry experts volunteered their time to offer feedback on data items and suggested measures, and reviewed the draft manuals and other materials. Many thanks to the following individuals: Mary St. Pierre, MGA, BSN, RN (NAHC); Joyce Rackers, BSN, OEC, COS-C (Missouri Department of Health And Human Services); Rhonda Will, RN, BS, COS-C, HCS-D (Fazzi Associates, Inc.); Tonya Miller, PT, DPT, COS-C, and Misty Kevech, RN, BS Ed, MS, COS-C (Celtic Healthcare); Cindy Kraft, PT, MS, COS-C (APTA); Mary Curry Narayan, MSN, RN, HHCNS-BC, CTN, COS-C; Ben Peirce, RN, BA, CWOCN, COS-C; Laurie McNichol, MSN, RN, GNP, CWOCN; and Dianne Mackey, BSN, RN, CWOCN (WOCN); Barbara Woodford, RN, and Margo Zink, RN, BSN, MN, EdD for their thorough review and excellent suggestions.

These contributions were extremely valuable in the refinement and finalization of OASIS-C and the manuals. The result is an improved OASIS that a) eliminates items not needed for quality measurement, payment or risk adjustment; b) reflects current terminology and concepts; c) contains new scale levels to more accurately measure patient status changes; d) includes items to support measurement of care processes and clinical domains not previously addressed; and e) is aligned (harmonized) with data sets being developed to measure care in other post-acute care settings.

Acknowledgements added 12/18/2009

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Appendices

CHAPTER 2 – OASIS-C: ALL ITEMS AND TIMEPOINT VERSIONS

Chapter 2 contains the full set of **all OASIS-C items** and the following individual timepoint versions:

- Patient Tracking Sheet of OASIS-C1
- Start of Care (SOC) (also used for Resumption of Care Following Inpatient Stay)
- Resumption of Care (ROC)
- Follow-Up (FU)
- Transfer (TRN) (used for Transfer to an Inpatient Facility)
- Discharge (DC) (also used for Transfer to an Inpatient Facility)
- Death at Home (Death)

Outcome and Assessment Information Set

Items to be Used at Specific Time Points

Start of Care	M0010-M0030, M0040-M0150, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Start of care—further visits planned	
Resumption of Care	M0032, M0080-M0110, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Resumption of care (after inpatient stay)	
Follow-Up	M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1324, M1330-M1350, 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, M1040-M1055, M1500, M1510, M2004, M2015, M2300-M2410, M2430-M2440, 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, M0903, M0906
Discharge from agency	M0080-M0100, M1040-M1055, M1230, M1242, M1306-M1350, M1400-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2100-M2110, M2300-M2420, M0903, M0906

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

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

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

Start/Resumption of Care

☐ 1 – Start of care—further visits planned
☐ 3 – Resumption of care (after inpatient stay)

Follow-Up

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

Transfer to an Inpatient Facility

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

Discharge from Agency — Not to an Inpatient Facility

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

(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?

☐ 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 during the past 14 days? **(Mark all that apply.)**

☐ 1 - Long-term nursing facility (NF)
☐ 2 - Skilled nursing facility (SNF / TCU)
☐ 3 - Short-stay acute hospital (IPP S)
☐ 4 - Long-term care hospital (LTCH)
☐ 5 - Inpatient rehabilitation hospital or unit (IRF)
☐ 6 - Psychiatric hospital or unit
☐ 7 - Other (specify) _____
☐ NA - Patient was not discharged from an inpatient facility **[***Go to M1016***]**

(M1005) Inpatient Discharge Date (most recent):

__ __ /__ __ /__ __ __ __
month / day / year

☐ UK - Unknown

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

	Inpatient Facility Diagnosis	ICD-9-C M Code
a.	_____	__ __ __ . __ __
b.	_____	__ __ __ . __ __
c.	_____	__ __ __ . __ __
d.	_____	__ __ __ . __ __
e.	_____	__ __ __ . __ __
f.	_____	__ __ __ . __ __

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

	Inpatient Procedure	Procedure Code
a.	_____	__ __ . __ __
b.	_____	__ __ . __ __
c.	_____	__ __ . __ __
d.	_____	__ __ . __ __

☐ NA - Not applicable

☐ UK - Unknown

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

	Changed Medical Regimen Diagnosis	ICD-9-C M 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 which existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

☐ 1 - Urinary incontinence

☐ 2 - Indwelling/suprapubic catheter

☐ 3 - Intractable pain

☐ 4 - Impaired decision-making

☐ 5 - Disruptive or socially inappropriate behavior

☐ 6 - Memory loss to the extent that supervision required

☐ 7 - None of the above

☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days

☐ UK - Unknown

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-C M code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-C M sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

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

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-C M code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 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 in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete **only if** the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. _____	**(V-codes are allowed)** a. (__ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)
(M1022) Other Diagnoses b. _____	**(V- or E-codes are allowed)** b. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** b._____ (__ __ __ . __ __)	**(V- or E-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._____ (__ __ __ . __ __)

(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

(M1032) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

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

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

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

(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

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.)**

Living Arrangement	Availability of Assistance				
	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 (e.g., assisted living)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

SENSORY STATUS

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

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

(M1210) Ability to hear (with hearing aid or hearing appliance if normally used):

- ☐ 0 - Adequate: hears normal conversation without difficulty.
- ☐ 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- ☐ 2 - Severely Impaired: absence of useful hearing.
- ☐ UK - Unable to assess hearing.

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

- ☐ 0 - Understands: clear comprehension without cues or repetitions.
- ☐ 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- ☐ 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- ☐ 3 - Rarely/Never Understands
- ☐ UK - Unable to assess understanding.

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):

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

(M1240) Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

- ☐ 0 - No standardized assessment conducted
- ☐ 1 - Yes, and it does not indicate severe pain
- ☐ 2 - Yes, and it indicates severe pain

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

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

INTEGUMENTARY STATUS

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers**?

- ☐ 0 - No assessment conducted **[** *Go to M1306* **]**
- ☐ 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
- ☐ 2 - Yes, using a standardized tool, e.g., Braden, Norton, other

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?

- ☐ 0 - No
- ☐ 1 - Yes

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as "unstageable"?

- ☐ 0 - No **[** *Go to M1322* **]**
- ☐ 1 - Yes

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

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

Directions for M1310, M1312, and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

(M1310) Pressure Ulcer Length: Longest length "head-to-toe" | ___ | ___ | . | ___ | (cm)

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

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

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area

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

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

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

(M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

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

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

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

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

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

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

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

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

(M1340) Does this patient have a **Surgical Wound?**

☐ 0 - No **[** *Go to M1350* **]**
☐ 1 - Yes, patient has at least one (observable) surgical wound
☐ 2 - Surgical wound known but not observable due to non-removable dressing **[** *Go to M1350* **]**

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

☐ 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?

☐ 0 - No
☐ 1 - Yes

RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?

- ☐ 0 - Patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

(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

ELIMINATION STATUS

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

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient on prophylactic treatment
- ☐ UK - Unknown **[Omit "UK" option on DC]**

(M1610) Urinary Incontinence or Urinary Catheter Presence:

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[** *Go to M1620* **]**
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[** *Go to M1620* **]**

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

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - Occasional stress incontinence
- ☐ 2 - During the night only
- ☐ 3 - During the day only
- ☐ 4 - During the day and night

(M1620) Bowel Incontinence Frequency:

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

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

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

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.

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

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

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

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

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

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

☐ 0 - No

☐ 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

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

☐ 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.

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

(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 (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)

☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)

☐ 6 - Delusional, hallucinatory, or paranoid behavior

☐ 7 - None of the above behaviors demonstrated

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

☐ 0 - Never

☐ 1 - Less than once a month

☐ 2 - Once a month

☐ 3 - Several times each month

☐ 4 - Several times a week

☐ 5 - At least daily

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

☐ 0 - No

☐ 1 - Yes

ADL/IADLs

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

- ☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- ☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- ☐ 2 - Someone must assist the patient to groom self.
- ☐ 3 - Patient depends entirely upon someone else for grooming needs.

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on upper body clothing.
- ☐ 3 - Patient depends entirely upon another person to dress the upper body.

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

- ☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- ☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on 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).**

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

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

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

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

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

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

- ☐ 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.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- ☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- ☐ 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- ☐ 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- ☐ 3 - Able to walk only with the supervision or assistance of another person at all times.
- ☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- ☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.
- ☐ 6 - Bedfast, unable to ambulate or be up in a chair.

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- ☐ 0 - Able to independently feed self.
- ☐ 1 - Able to feed self independently but requires:
  - (a) meal set-up; OR
  - (b) intermittent assistance or supervision from another person; OR
  - (c) a liquid, pureed or ground meat diet.
- ☐ 2 - Unable to feed self and must be assisted or supervised 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** (e.g., cereal, sandwich) or reheat delivered meals safely:

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

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

☐ 0 - Able to dial numbers and answer calls appropriately and as desired.

☐ 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.

☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.

☐ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.

☐ 4 - Unable to answer the telephone at all but can listen if assisted with equipment.

☐ 5 - Totally unable to use the telephone.

☐ NA - Patient does not have a telephone.

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

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

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

☐ 0 - No multi-factor falls risk assessment conducted.

☐ 1 - Yes, and it does not indicate a risk for falls.

☐ 2 - Yes, and it indicates a risk for falls.

MEDICATIONS

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

☐ 0 - Not assessed/reviewed **[** *Go to M2010* **]**

☐ 1 - No problems found during review **[** *Go to M2010* **]**

☐ 2 - Problems found during review

☐ NA - Patient is not taking any medications **[** *Go to M2040* **]**

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

☐ 0 - No

☐ 1 - Yes

(M2010) Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

☐ 0 - No

☐ 1 - Yes

☐ NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

☐ 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.

☐ 1 - Able to take medication(s) at the correct times if:
(a) individual dosages are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.

☐ 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times

☐ 3 - Unable to take medication unless administered by another person.

☐ NA - No oral medications prescribed.

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

☐ 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.

☐ 1 - Able to take injectable medication(s) at the correct times if:
(a) individual syringes are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.

☐ 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection

☐ 3 - Unable to take injectable medication unless administered by another person.

☐ NA - No injectable medications prescribed.

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

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	☐0	☐1	☐2	☐na
b. Injectable medications	☐0	☐1	☐2	☐na

CARE MANAGEMENT

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

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

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

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

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 bilateral amputee
c. Falls prevention interventions	☐0	☐1	☐na	Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐na	Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐na	No pain identified
f. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐na	Patient is not assessed to be at risk for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐0	☐1	☐na	Patient has no pressure ulcers with need for moist wound healing

Home Health Patient Tracking Sheet

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

Outcome and Assessment Information Set

Items to be Used at Specific Time Points

Start of Care ----------	M0010-M0030, M0040-M0150, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Start of care—further visits planned	
Resumption of Care ----------	M0032, M0080-M0110, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Resumption of care (after inpatient stay)	
Follow-Up ----------	M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1324, M1330-M1350, 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, M1040-M1055, M1500, M1510, M2004, M2015, M2300-M2410, M2430-M2440, 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, M0903, M0906
Discharge from agency ----------	M0080-M0100, M1040-M1055, M1230, M1242, M1306-M1350, M1400-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2100-M2110, M2300-M2420, M0903, M0906

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

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

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

Start/Resumption of Care

☐ 1 – Start of care—further visits planned

☐ 3 – Resumption of care (after inpatient stay)

Follow-Up

☐ 4 – Recertification (follow-up) reassessment **[** *Go to M0110* **]**

☐ 5 – Other follow-up **[** *Go to M0110* **]**

Transfer to an Inpatient Facility

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

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

Discharge from Agency — Not to an Inpatient Facility

☐ 8 – Death at home **[** *Go to M0903* **]**

☐ 9 – Discharge from agency **[** *Go to M1040* **]**

(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?

☐ 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 during the past 14 days? **(Mark all that apply.)**

☐ 1 - Long-term nursing facility (NF)

☐ 2 - Skilled nursing facility (SNF / TCU)

☐ 3 - Short-stay acute hospital (IPP S)

☐ 4 - Long-term care hospital (LTCH)

☐ 5 - Inpatient rehabilitation hospital or unit (IRF)

☐ 6 - Psychiatric hospital or unit

☐ 7 - Other (specify) _____

☐ NA - Patient was not discharged from an inpatient facility **[***Go to M1016* **]**

(M1005) Inpatient Discharge Date (most recent):

__ __ /__ __ /__ __ __ __
month / day / year

☐ UK - Unknown

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

	Inpatient Facility Diagnosis	ICD-9-C M Code
a.	_____	__ __ __ . __ __
b.	_____	__ __ __ . __ __
c.	_____	__ __ __ . __ __
d.	_____	__ __ __ . __ __
e.	_____	__ __ __ . __ __
f.	_____	__ __ __ . __ __

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

	Inpatient Procedure	Procedure Code
a.	_____	__ __ . __ __
b.	_____	__ __ . __ __
c.	_____	__ __ . __ __
d.	_____	__ __ . __ __

☐ NA - Not applicable

☐ UK - Unknown

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

	Changed Medical Regimen Diagnosis	ICD-9-C M 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 which existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

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

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-C M code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-C M sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

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

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-C M code for the diagnosis described in Column 1;
Rate the degree of symptom control for the condition listed in Column 1 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 in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		**(M1024) Payment Diagnoses (OPTIONAL)**	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete **only if** the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. _____	**(V-codes are allowed)** a. (__ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)
(M1022) Other Diagnoses b. _____	**(V- or E-codes are allowed)** b. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** b._____ (__ __ __ . __ __)	**(V- or E-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._____ (__ __ __ . __ __)

(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

(M1032) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

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

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

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

(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

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.)**

Living Arrangement	Availability of Assistance				
	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 (e.g., assisted living)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

SENSORY STATUS

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

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

(M1210) Ability to hear (with hearing aid or hearing appliance if normally used):

- ☐ 0 - Adequate: hears normal conversation without difficulty.
- ☐ 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- ☐ 2 - Severely Impaired: absence of useful hearing.
- ☐ UK - Unable to assess hearing.

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

- ☐ 0 - Understands: clear comprehension without cues or repetitions.
- ☐ 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- ☐ 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- ☐ 3 - Rarely/Never Understands
- ☐ UK - Unable to assess understanding.

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):

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

(M1240) Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

- ☐ 0 - No standardized assessment conducted
- ☐ 1 - Yes, and it does not indicate severe pain
- ☐ 2 - Yes, and it indicates severe pain

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

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

INTEGUMENTARY STATUS

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers**?

- ☐ 0 - No assessment conducted **[** *Go to M1306* **]**
- ☐ 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
- ☐ 2 - Yes, using a standardized tool, e.g., Braden, Norton, other

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?

- ☐ 0 - No
- ☐ 1 - Yes

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as "unstageable"?

- ☐ 0 - No **[** *Go to M1322* **]**
- ☐ 1 - Yes

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

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

Directions for M1310, M1312, and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

(M1310) Pressure Ulcer Length: Longest length "head-to-toe" | ___ | ___ | . | ___ | (cm)

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

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

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area

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

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

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

(M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

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

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

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

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

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

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

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

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

(M1340) Does this patient have a **Surgical Wound?**

☐ 0 - No **[** *Go to M1350* **]**
☐ 1 - Yes, patient has at least one (observable) surgical wound
☐ 2 - Surgical wound known but not observable due to non-removable dressing **[** *Go to M1350* **]**

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

☐ 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?

☐ 0 - No
☐ 1 - Yes

RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?

- ☐ 0 - Patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

(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

ELIMINATION STATUS

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

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient on prophylactic treatment
- ☐ UK - Unknown **[Omit "UK" option on DC]**

(M1610) Urinary Incontinence or Urinary Catheter Presence:

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[** *Go to M1620* **]**
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[** *Go to M1620* **]**

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

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - Occasional stress incontinence
- ☐ 2 - During the night only
- ☐ 3 - During the day only
- ☐ 4 - During the day and night

(M1620) Bowel Incontinence Frequency:

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

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

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

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.

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

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

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

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

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

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

☐ 0 - No

☐ 1 - Yes, patient was screened using the PHQ-2©***** scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

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

☐ 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.

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

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(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 (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)

☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)

☐ 6 - Delusional, hallucinatory, or paranoid behavior

☐ 7 - None of the above behaviors demonstrated

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

☐ 0 - Never

☐ 1 - Less than once a month

☐ 2 - Once a month

☐ 3 - Several times each month

☐ 4 - Several times a week

☐ 5 - At least daily

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

☐ 0 - No

☐ 1 - Yes

ADL/IADLs

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

- ☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- ☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- ☐ 2 - Someone must assist the patient to groom self.
- ☐ 3 - Patient depends entirely upon someone else for grooming needs.

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on upper body clothing.
- ☐ 3 - Patient depends entirely upon another person to dress the upper body.

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

- ☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- ☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on 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).**

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

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

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

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

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

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

- ☐ 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.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- ☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- ☐ 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- ☐ 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- ☐ 3 - Able to walk only with the supervision or assistance of another person at all times.
- ☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- ☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.
- ☐ 6 - Bedfast, unable to ambulate or be up in a chair.

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- ☐ 0 - Able to independently feed self.
- ☐ 1 - Able to feed self independently but requires:
  - (a) meal set-up; OR
  - (b) intermittent assistance or supervision from another person; OR
  - (c) a liquid, pureed or ground meat diet.
- ☐ 2 - Unable to feed self and must be assisted or supervised 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** (e.g., cereal, sandwich) or reheat delivered meals safely:

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

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

☐ 0 - Able to dial numbers and answer calls appropriately and as desired.

☐ 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.

☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.

☐ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.

☐ 4 - Unable to answer the telephone at all but can listen if assisted with equipment.

☐ 5 - Totally unable to use the telephone.

☐ NA - Patient does not have a telephone.

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

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

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

☐ 0 - No multi-factor falls risk assessment conducted.

☐ 1 - Yes, and it does not indicate a risk for falls.

☐ 2 - Yes, and it indicates a risk for falls.

MEDICATIONS

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

☐ 0 - Not assessed/reviewed **[** *Go to M2010* **]**

☐ 1 - No problems found during review **[** *Go to M2010* **]**

☐ 2 - Problems found during review

☐ NA - Patient is not taking any medications **[** *Go to M2040* **]**

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

☐ 0 - No

☐ 1 - Yes

(M2010) Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

☐ 0 - No

☐ 1 - Yes

☐ NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

☐ 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.

☐ 1 - Able to take medication(s) at the correct times if:
(a) individual dosages are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.

☐ 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times

☐ 3 - Unable to take medication unless administered by another person.

☐ NA - No oral medications prescribed.

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

☐ 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.

☐ 1 - Able to take injectable medication(s) at the correct times if:
(a) individual syringes are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.

☐ 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection

☐ 3 - Unable to take injectable medication unless administered by another person.

☐ NA - No injectable medications prescribed.

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

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	☐0	☐1	☐2	☐na
b. Injectable medications	☐0	☐1	☐2	☐na

CARE MANAGEMENT

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

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

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

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

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 bilateral amputee
c. Falls prevention interventions	☐0	☐1	☐na	Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐na	Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐na	No pain identified
f. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐na	Patient is not assessed to be at risk for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐0	☐1	☐na	Patient has no pressure ulcers with need for moist wound healing

Outcome and Assessment Information Set

Items to be Used at Specific Time Points

Start of Care ---------- Start of care—further visits planned	M0010-M0030, M0040-M0150, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Resumption of Care ---------- Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Follow-Up ---------- Recertification (follow-up) assessment Other follow-up assessment	M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1324, M1330-M1350, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
Transfer to an Inpatient Facility ---------- Transferred to an inpatient facility—patient not discharged from an agency Transferred to an inpatient facility—patient discharged from agency	M0080-M0100, M1040-M1055, M1500, M1510, M2004, M2015, M2300-M2410, M2430-M2440, M0903, M0906
Discharge from Agency — Not to an Inpatient Facility	
Death at home ----------	M0080-M0100, M0903, M0906
Discharge from agency ----------	M0080-M0100, M1040-M1055, M1230, M1242, M1306-M1350, M1400-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2100-M2110, M2300-M2420, M0903, M0906

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

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

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

Start/Resumption of Care

☐ 1 – Start of care—further visits planned
☐ 3 – Resumption of care (after inpatient stay)

Follow-Up

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

Transfer to an Inpatient Facility

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

Discharge from Agency — Not to an Inpatient Facility

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

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?

☐ 1 - Early

☐ 2 - Later

☐ UK - Unknown

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

PATIENT HISTORY AND DIAGNOSES

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-C M code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-C M sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

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

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-C M code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 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 in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete **only if** the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. _____	**(V-codes are allowed)** a. (__ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)
(M1022) Other Diagnoses b. _____	**(V- or E-codes are allowed)** b. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** b._____ (__ __ __ . __ __)	**(V- or E-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._____ (__ __ __ . __ __)

(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

SENSORY STATUS

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

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

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

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

INTEGUMENTARY STATUS

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as "unstageable"?

- ☐ 0 - No **[** *Go to M1322* **]**
- ☐ 1 - Yes

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

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

(M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

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

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

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

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

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

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

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

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

(M1340) Does this patient have a **Surgical Wound?**

- ☐ 0 - No **[** *Go to M1350* **]**
- ☐ 1 - Yes, patient has at least one (observable) surgical wound
- ☐ 2 - Surgical wound known but not observable due to non-removable dressing **[** *Go to M1350* **]**

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

- ☐ 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?

- ☐ 0 - No
- ☐ 1 - Yes

RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?

- ☐ 0 - Patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

ELIMINATION STATUS

(M1610) Urinary Incontinence or Urinary Catheter Presence:

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[** *Go to M1620* **]**
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[** *Go to M1620* **]**

(M1620) Bowel Incontinence Frequency:

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

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

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

ADL/IADLs

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on upper body clothing.
- ☐ 3 - Patient depends entirely upon another person to dress the upper body.

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

- ☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- ☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on 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).**

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

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

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

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

- ☐ 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.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- ☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- ☐ 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- ☐ 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- ☐ 3 - Able to walk only with the supervision or assistance of another person at all times.
- ☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- ☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.
- ☐ 6 - Bedfast, unable to ambulate or be up in a chair.

MEDICATIONS

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

☐ 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.

☐ 1 - Able to take injectable medication(s) at the correct times if:
(a) individual syringes are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.

☐ 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection

☐ 3 - Unable to take injectable medication unless administered by another person.

☐ NA - No injectable medications prescribed.

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.

Outcome and Assessment Information Set

Items to be Used at Specific Time Points

Start of Care ----------	M0010-M0030, M0040-M0150, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Start of care—further visits planned	
Resumption of Care ----------	M0032, M0080-M0110, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Resumption of care (after inpatient stay)	
Follow-Up ----------	M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1324, M1330-M1350, 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, M1040-M1055, M1500, M1510, M2004, M2015, M2300-M2410, M2430-M2440, 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, M0903, M0906
Discharge from agency ----------	M0080-M0100, M1040-M1055, M1230, M1242, M1306-M1350, M1400-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2100-M2110, M2300-M2420, M0903, M0906

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

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

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

Start/Resumption of Care

☐ 1 – Start of care—further visits planned
☐ 3 – Resumption of care (after inpatient stay)

Follow-Up

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

Transfer to an Inpatient Facility

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

Discharge from Agency — Not to an Inpatient Facility

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

PATIENT HISTORY AND DIAGNOSES

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?

- ☐ 0 - No
- ☐ 1 - Yes **[** *Go to M1050* **]**
- ☐ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. **[** *Go to M1050* **]**

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:

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

(M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?

- ☐ 0 - No
- ☐ 1 - Yes **[** *Go to M1500 at TRN*; *Go to M1230 at DC* **]**

(M1055) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:

- ☐ 1 - Patient has received PPV in the past
- ☐ 2 - Offered and declined
- ☐ 3 - Assessed and determined to have medical contraindication(s)
- ☐ 4 - Not indicated; patient does not meet age/condition guidelines for PPV
- ☐ 5 - None of the above

CARDIAC STATUS

(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

- ☐ 0 - No **[** *Go to M2004 at TRN; Go to M1600 at DC* **]**
- ☐ 1 - Yes
- ☐ 2 - Not assessed **[***Go to M2004 at TRN; Go to M1600 at DC* **]**
- ☐ NA - Patient does not have diagnosis of heart failure **[***Go to M2004 at TRN; Go to M1600 at DC* **]**

(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

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

MEDICATIONS

(M2004) Medication Intervention: If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - No clinically significant medication issues identified since the previous OASIS assessment

(M2015) Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient not taking any drugs

EMERGENT CARE

(M2300) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?

- ☐ 0 - No **[** *Go to M2400* **]**
- ☐ 1 - Yes, used hospital emergency department WITHOUT hospital admission
- ☐ 2 - Yes, used hospital emergency department WITH hospital admission
- ☐ UK - Unknown **[** *Go to M2400* **]**

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

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

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

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

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

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

☐ 1 - Hospital **[** ***Go to M2430*** **]**

☐ 2 - Rehabilitation facility **[** ***Go to M0903*** **]**

☐ 3 - Nursing home **[** ***Go to M2440*** **]**

☐ 4 - Hospice **[** ***Go to M0903*** **]**

☐ NA - No inpatient facility admission **[Omit "NA" option on TRN]**

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

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

[*Go to M0903* **]**

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

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

[*Go to M0903* **]**

(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

Outcome and Assessment Information Set

Items to be Used at Specific Time Points

Start of Care	M0010-M0030, M0040-M0150, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Start of care—further visits planned	
Resumption of Care	M0032, M0080-M0110, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Resumption of care (after inpatient stay)	
Follow-Up	M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1324, M1330-M1350, 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, M1040-M1055, M1500, M1510, M2004, M2015, M2300-M2410, M2430-M2440, 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, M0903, M0906
Discharge from agency	M0080-M0100, M1040-M1055, M1230, M1242, M1306-M1350, M1400-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2100-M2110, M2300-M2420, M0903, M0906

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

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

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

Start/Resumption of Care

☐ 1 – Start of care—further visits planned
☐ 3 – Resumption of care (after inpatient stay)

Follow-Up

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

Transfer to an Inpatient Facility

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

Discharge from Agency — Not to an Inpatient Facility

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

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?

- ☐ 0 - No
- ☐ 1 - Yes **[** *Go to M1050* **]**
- ☐ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. **[** *Go to M1050* **]**

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:

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

(M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?

- ☐ 0 - No
- ☐ 1 - Yes **[** *Go to M1500 at TRN*; *Go to M1230 at DC* **]**

(M1055) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:

- ☐ 1 - Patient has received PPV in the past
- ☐ 2 - Offered and declined
- ☐ 3 - Assessed and determined to have medical contraindication(s)
- ☐ 4 - Not indicated; patient does not meet age/condition guidelines for PPV
- ☐ 5 - None of the above

SENSORY STATUS

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):

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

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

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

INTEGUMENTARY STATUS

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as "unstageable"?

☐ 0 - No **[** ***Go to M1322*** **]**

☐ 1 - Yes

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

☐ 1 - Was present at the most recent SOC/ROC assessment

☐ 2 - Developed since the most recent SOC/ROC assessment: record date pressure ulcer first identified:
__ __ /__ __ /____ __ __
month / day / year

☐ NA - No non-epithelialized Stage II pressure ulcers are present at discharge

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

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

Directions for M1310, M1312, and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

(M1310) Pressure Ulcer Length: Longest length "head-to-toe" | ___ | ___ | . | ___ | (cm)

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

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

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area

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

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

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

(M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

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

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

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

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

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

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

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

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

(M1340) Does this patient have a **Surgical Wound?**

- ☐ 0 - No **[** *Go to M1350* **]**
- ☐ 1 - Yes, patient has at least one (observable) surgical wound
- ☐ 2 - Surgical wound known but not observable due to non-removable dressing **[** *Go to M1350* **]**

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

- ☐ 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?

- ☐ 0 - No
- ☐ 1 - Yes

RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?

- ☐ 0 - Patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

(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

(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

- ☐ 0 - No **[** *Go to M2004 at TRN; Go to M1600 at DC* **]**
- ☐ 1 - Yes
- ☐ 2 - Not assessed **[***Go to M2004 at TRN; Go to M1600 at DC* **]**
- ☐ NA - Patient does not have diagnosis of heart failure **[***Go to M2004 at TRN; Go to M1600 at DC* **]**

(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

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

ELIMINATION STATUS

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

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient on prophylactic treatment
- ☐ UK - Unknown **[Omit "UK" option on DC]**

(M1610) Urinary Incontinence or Urinary Catheter Presence:

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[** *Go to M1620* **]**
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[** *Go to M1620* **]**

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

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - Occasional stress incontinence
- ☐ 2 - During the night only
- ☐ 3 - During the day only
- ☐ 4 - During the day and night

(M1620) Bowel Incontinence Frequency:

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

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.

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

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

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

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

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

(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 (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

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

ADL/IADLs

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

- ☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- ☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- ☐ 2 - Someone must assist the patient to groom self.
- ☐ 3 - Patient depends entirely upon someone else for grooming needs.

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on upper body clothing.
- ☐ 3 - Patient depends entirely upon another person to dress the upper body.

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

- ☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- ☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on 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).**

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

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

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

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

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

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

- ☐ 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.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- ☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- ☐ 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- ☐ 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- ☐ 3 - Able to walk only with the supervision or assistance of another person at all times.
- ☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- ☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.
- ☐ 6 - Bedfast, unable to ambulate or be up in a chair.

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- ☐ 0 - Able to independently feed self.
- ☐ 1 - Able to feed self independently but requires:
  (a) meal set-up; OR
  (b) intermittent assistance or supervision from another person; OR
  (c) a liquid, pureed or ground meat diet.
- ☐ 2 - Unable to feed self and must be assisted or supervised 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** (e.g., cereal, sandwich) or reheat delivered meals safely:

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

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

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

MEDICATIONS

(M2004) Medication Intervention: If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?

☐ 0 - No

☐ 1 - Yes

☐ NA - No clinically significant medication issues identified since the previous OASIS assessment

(M2015) Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?

☐ 0 - No

☐ 1 - Yes

☐ NA - Patient not taking any drugs

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

☐ 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.

☐ 1 - Able to take medication(s) at the correct times if:
(a) individual dosages are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.

☐ 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times

☐ 3 - Unable to take medication unless administered by another person.

☐ NA - No oral medications prescribed.

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

☐ 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.

☐ 1 - Able to take injectable medication(s) at the correct times if:
(a) individual syringes are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.

☐ 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection

☐ 3 - Unable to take injectable medication unless administered by another person.

☐ NA - No injectable medications prescribed.

CARE MANAGEMENT

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

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

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

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

EMERGENT CARE

(M2300) **Emergent Care:** Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?

- ☐ 0 - No **[** ***Go to M2400*** **]**
- ☐ 1 - Yes, used hospital emergency department WITHOUT hospital admission
- ☐ 2 - Yes, used hospital emergency department WITH hospital admission
- ☐ UK - Unknown **[** ***Go to M2400*** **]**

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

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

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

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

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

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

☐ 1 - Hospital **[** ***Go to M2430*** **]**

☐ 2 - Rehabilitation facility **[** ***Go to M0903*** **]**

☐ 3 - Nursing home **[** ***Go to M2440*** **]**

☐ 4 - Hospice **[** ***Go to M0903*** **]**

☐ NA - No inpatient facility admission **[Omit "NA" option on TRN]**

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

☐ 1 - Patient remained in the community (without formal assistive services)

☐ 2 - Patient remained in the community (with formal assistive services)

☐ 3 - Patient transferred to a non-institutional hospice

☐ 4 - Unknown because patient moved to a geographic location not served by this agency

☐ UK - Other unknown

[***Go to M0903*** **]**

(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

Outcome and Assessment Information Set

Items to be Used at Specific Time Points

Start of Care ---------- Start of care—further visits planned	M0010-M0030, M0040-M0150, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Resumption of Care ---------- Resumption of care (after inpatient stay)	M0032, M0080-M0110, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Follow-Up ---------- Recertification (follow-up) assessment Other follow-up assessment	M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1324, M1330-M1350, M1400, M1610, M1620, M1630, M1810-M1840, M1850, M1860, M2030, M2200
Transfer to an Inpatient Facility ---------- Transferred to an inpatient facility—patient not discharged from an agency Transferred to an inpatient facility—patient discharged from agency	M0080-M0100, M1040-M1055, M1500, M1510, M2004, M2015, M2300-M2410, M2430-M2440, M0903, M0906
Discharge from Agency — Not to an Inpatient Facility	
Death at home ----------	M0080-M0100, M0903, M0906
Discharge from agency ----------	M0080-M0100, M1040-M1055, M1230, M1242, M1306-M1350, M1400-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2100-M2110, M2300-M2420, M0903, M0906

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

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

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

Start/Resumption of Care

☐ 1 – Start of care—further visits planned
☐ 3 – Resumption of care (after inpatient stay)

Follow-Up

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

Transfer to an Inpatient Facility

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

Discharge from Agency — Not to an Inpatient Facility

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

(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

Home Health Patient Tracking Sheet

(M0010) C M S Certification Number: __ __ __ __ __ __

(M0014) Branch State: __ __

(M0016) Branch I D Number: __ __ __ __ __ __ __ __ __ __

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

__ __ __ __ __ __ __ __ __ __ ☐ **UK – Unknown or Not Available**

(M0020) Patient I D 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:

☐ 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 (e.g., Title III, V, or XX)
- ☐ 7 - Other government (e.g., TriCare, VA, etc.)
- ☐ 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

Start of Care	M0010-M0030, M0040- M0150, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Start of care—further visits planned	
Resumption of Care	M0032, M0080-M0110, M1000-M1036, M1100-M1242, M1300-M1302, M1306, M1308-M1324, M1330-M1350, M1400, M1410, M1600-M1730, M1740-M1910, M2000, M2002, M2010, M2020-M2250
Resumption of care (after inpatient stay)	
Follow-Up	M0080-M0100, M0110, M1020-M1030, M1200, M1242, M1306, M1308, M1322-M1324, M1330-M1350, 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, M1040-M1055, M1500, M1510, M2004, M2015, M2300-M2410, M2430-M2440, 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, M0903, M0906
Discharge from agency	M0080-M0100, M1040-M1055, M1230, M1242, M1306-M1350, M1400-M1620, M1700-M1720, M1740, M1745, M1800-M1890, M2004, M2015-M2030, M2100-M2110, M2300-M2420, M0903, M0906

CLINICAL RECORD ITEMS

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

(M0090) Date Assessment Completed: __ __ /__ __ /__ __ __ __

month / day / year

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

Start/Resumption of Care

☐ 1 – Start of care—further visits planned

☐ 3 – Resumption of care (after inpatient stay)

Follow-Up

☐ 4 – Recertification (follow-up) reassessment **[** *Go to M0110* **]**

☐ 5 – Other follow-up **[** *Go to M0110* **]**

Transfer to an Inpatient Facility

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

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

Discharge from Agency — Not to an Inpatient Facility

☐ 8 – Death at home **[** *Go to M0903* **]**

☐ 9 – Discharge from agency **[** *Go to M1040* **]**

(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?

☐ 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 during the past 14 days? **(Mark all that apply.)**

☐ 1 - Long-term nursing facility (NF)
☐ 2 - Skilled nursing facility (SNF / TCU)
☐ 3 - Short-stay acute hospital (IPP S)
☐ 4 - Long-term care hospital (LTCH)
☐ 5 - Inpatient rehabilitation hospital or unit (IRF)
☐ 6 - Psychiatric hospital or unit
☐ 7 - Other (specify) _____
☐ NA - Patient was not discharged from an inpatient facility **[*Go to M1016*]**

(M1005) Inpatient Discharge Date (most recent):

__ __ /__ __ /__ __ __ __
month / day / year

☐ UK - Unknown

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

	Inpatient Facility Diagnosis	ICD-9-C M Code
a.	_____	__ __ __ . __ __
b.	_____	__ __ __ . __ __
c.	_____	__ __ __ . __ __
d.	_____	__ __ __ . __ __
e.	_____	__ __ __ . __ __
f.	_____	__ __ __ . __ __

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

	Inpatient Procedure	Procedure Code
a.	_____	__ __ . __ __
b.	_____	__ __ . __ __
c.	_____	__ __ . __ __
d.	_____	__ __ . __ __

☐ NA - Not applicable

☐ UK - Unknown

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

	Changed Medical Regimen Diagnosis	ICD-9-C M 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 which existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**

☐ 1 - Urinary incontinence

☐ 2 - Indwelling/suprapubic catheter

☐ 3 - Intractable pain

☐ 4 - Impaired decision-making

☐ 5 - Disruptive or socially inappropriate behavior

☐ 6 - Memory loss to the extent that supervision required

☐ 7 - None of the above

☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days

☐ UK - Unknown

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-C M code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-C M sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

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

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-C M code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 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 in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Form on next page)

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete **only if** the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. _____	**(V-codes are allowed)** a. (__ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)
(M1022) Other Diagnoses b. _____	**(V- or E-codes are allowed)** b. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** b._____ (__ __ __ . __ __)	**(V- or E-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._____ (__ __ __ . __ __)

(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

(M1032) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

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

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

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

(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

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?

- ☐ 0 - No
- ☐ 1 - Yes **[** *Go to M1050* **]**
- ☐ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. **[** *Go to M1050* **]**

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:

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

(M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?

- ☐ 0 - No
- ☐ 1 - Yes **[** *Go to M1500 at TRN*; *Go to M1230 at DC* **]**

(M1055) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:

- ☐ 1 - Patient has received PPV in the past
- ☐ 2 - Offered and declined
- ☐ 3 - Assessed and determined to have medical contraindication(s)
- ☐ 4 - Not indicated; patient does not meet age/condition guidelines for PPV
- ☐ 5 - None of the above

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.)**

Living Arrangement	Availability of Assistance				
	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 (e.g., assisted living)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

SENSORY STATUS

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

☐ 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.

☐ 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.

☐ 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

(M1210) Ability to hear (with hearing aid or hearing appliance if normally used):

☐ 0 - Adequate: hears normal conversation without difficulty.

☐ 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.

☐ 2 - Severely Impaired: absence of useful hearing.

☐ UK - Unable to assess hearing.

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

☐ 0 - Understands: clear comprehension without cues or repetitions.

☐ 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.

☐ 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.

☐ 3 - Rarely/Never Understands

☐ UK - Unable to assess understanding.

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):

☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.

☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).

☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.

☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.

☐ 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).

☐ 5 - Patient nonresponsive or unable to speak.

(M1240) Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

- ☐ 0 - No standardized assessment conducted
- ☐ 1 - Yes, and it does not indicate severe pain
- ☐ 2 - Yes, and it indicates severe pain

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

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

INTEGUMENTARY STATUS

(M1300) **Pressure Ulcer Assessment:** Was this patient assessed for **Risk of Developing Pressure Ulcers**?

- ☐ 0 - No assessment conducted **[** *Go to M1306* **]**
- ☐ 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
- ☐ 2 - Yes, using a standardized tool, e.g., Braden, Norton, other

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?

- ☐ 0 - No
- ☐ 1 - Yes

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as "unstageable"?

- ☐ 0 - No **[** *Go to M1322* **]**
- ☐ 1 - Yes

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

- ☐ 1 - Was present at the most recent SOC/ROC assessment
- ☐ 2 - Developed since the most recent SOC/ROC assessment: record date pressure ulcer first identified:
  __ __ /__ __ /____ __ __
  month / day / year
- ☐ NA - No non-epithelialized Stage II pressure ulcers are present at discharge

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

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

Directions for M1310, M1312, and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

(M1310) Pressure Ulcer Length: Longest length "head-to-toe" | ___ | ___ | . | ___ | (cm)

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

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

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area

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

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

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

(M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

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

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

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

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

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

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

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

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

(M1340) Does this patient have a **Surgical Wound?**

☐ 0 - No **[** *Go to M1350* **]**
☐ 1 - Yes, patient has at least one (observable) surgical wound
☐ 2 - Surgical wound known but not observable due to non-removable dressing **[** *Go to M1350* **]**

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

☐ 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?

☐ 0 - No
☐ 1 - Yes

RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?

- ☐ 0 - Patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

(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

(M1500) **Symptoms in Heart Failure Patients:** If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

- ☐ 0 - No **[** *Go to M2004 at TRN; Go to M1600 at DC* **]**
- ☐ 1 - Yes
- ☐ 2 - Not assessed **[***Go to M2004 at TRN; Go to M1600 at DC* **]**
- ☐ NA - Patient does not have diagnosis of heart failure **[***Go to M2004 at TRN; Go to M1600 at DC* **]**

(M1510) **Heart Failure Follow-up:** If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

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

ELIMINATION STATUS

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

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient on prophylactic treatment
- ☐ UK - Unknown **[Omit "UK" option on DC]**

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

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[** *Go to M1620* **]**
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[** *Go to M1620* **]**

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

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - Occasional stress incontinence
- ☐ 2 - During the night only
- ☐ 3 - During the day only
- ☐ 4 - During the day and night

(M1620) Bowel Incontinence Frequency:

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

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

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

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.

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

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

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

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

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

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

☐ 0 - No
☐ 1 - Yes, patient was screened using the PHQ-2©***** scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

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

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

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

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

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

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

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

- ☐ 0 - No
- ☐ 1 - Yes

ADL/IADLs

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

- ☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- ☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- ☐ 2 - Someone must assist the patient to groom self.
- ☐ 3 - Patient depends entirely upon someone else for grooming needs.

(M1810) Current **Ability to Dress Upper Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on upper body clothing.
- ☐ 3 - Patient depends entirely upon another person to dress the upper body.

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

- ☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- ☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- ☐ 2 - Someone must help the patient put on 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).**

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

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

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

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

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

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

- ☐ 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.

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- ☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- ☐ 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- ☐ 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- ☐ 3 - Able to walk only with the supervision or assistance of another person at all times.
- ☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- ☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.
- ☐ 6 - Bedfast, unable to ambulate or be up in a chair.

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- ☐ 0 - Able to independently feed self.
- ☐ 1 - Able to feed self independently but requires:
  (a) meal set-up; OR
  (b) intermittent assistance or supervision from another person; OR
  (c) a liquid, pureed or ground meat diet.
- ☐ 2 - Unable to feed self and must be assisted or supervised 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** (e.g., cereal, sandwich) or reheat delivered meals safely:

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

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

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

(M1890) **Ability to Use Telephone:** Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

☐ 0 - Able to dial numbers and answer calls appropriately and as desired.

☐ 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.

☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.

☐ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.

☐ 4 - Unable to answer the telephone at all but can listen if assisted with equipment.

☐ 5 - Totally unable to use the telephone.

☐ NA - Patient does not have a telephone.

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

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

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

☐ 0 - No multi-factor falls risk assessment conducted.

☐ 1 - Yes, and it does not indicate a risk for falls.

☐ 2 - Yes, and it indicates a risk for falls.

MEDICATIONS

(M2000) **Drug Regimen Review:** Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

☐ 0 - Not assessed/reviewed **[** *Go to M2010* **]**

☐ 1 - No problems found during review **[** *Go to M2010* **]**

☐ 2 - Problems found during review

☐ NA - Patient is not taking any medications **[** *Go to M2040* **]**

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

☐ 0 - No

☐ 1 - Yes

(M2004) Medication Intervention: If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?

☐ 0 - No

☐ 1 - Yes

☐ NA - No clinically significant medication issues identified since the previous OASIS assessment

(M2010) Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

☐ 0 - No

☐ 1 - Yes

☐ NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

(M2015) Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?

☐ 0 - No

☐ 1 - Yes

☐ NA - Patient not taking any drugs

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

☐ 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.

☐ 1 - Able to take medication(s) at the correct times if:
(a) individual dosages are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.

☐ 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times

☐ 3 - Unable to take medication unless administered by another person.

☐ NA - No oral medications prescribed.

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

☐ 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.

☐ 1 - Able to take injectable medication(s) at the correct times if:
(a) individual syringes are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.

☐ 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection

☐ 3 - Unable to take injectable medication unless administered by another person.

☐ NA - No injectable medications prescribed.

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

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	☐0	☐1	☐2	☐na
b. Injectable medications	☐0	☐1	☐2	☐na

CARE MANAGEMENT

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

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

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

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

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 bilateral amputee
c. Falls prevention interventions	☐0	☐1	☐na	Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐na	Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐na	No pain identified
f. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐na	Patient is not assessed to be at risk for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐0	☐1	☐na	Patient has no pressure ulcers with need for moist wound healing

EMERGENT CARE

(M2300) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?

- ☐ 0 - No **[** ***Go to M2400*** **]**
- ☐ 1 - Yes, used hospital emergency department WITHOUT hospital admission
- ☐ 2 - Yes, used hospital emergency department WITH hospital admission
- ☐ UK - Unknown **[** ***Go to M2400*** **]**

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

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

DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY DISCHARGE ONLY

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

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

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

☐ 1 - Hospital **[** ***Go to M2430*** **]**

☐ 2 - Rehabilitation facility **[** ***Go to M0903*** **]**

☐ 3 - Nursing home **[** ***Go to M2440*** **]**

☐ 4 - Hospice **[** ***Go to M0903*** **]**

☐ NA - No inpatient facility admission **[Omit "NA" option on TRN]**

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

☐ 1 - Patient remained in the community (without formal assistive services)

☐ 2 - Patient remained in the community (with formal assistive services)

☐ 3 - Patient transferred to a non-institutional hospice

☐ 4 - Unknown because patient moved to a geographic location not served by this agency

☐ UK - Other unknown

[***Go to M0903*** **]**

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

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

[*Go to M0903* **]**

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

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

[*Go to M0903* **]**

(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

CHAPTER 3 – OASIS ITEM GUIDANCE

Chapter 3 contains item-specific guidance for each OASIS item. Item-specific guidance is no longer contained in a single document, but has been divided into sections that can be accessed through individual links. The sections contained in this chapter are as follows:

A - Patient Tracking

B - Clinical Record Items

C - Patient History & Diagnoses

D - Living Arrangements

E - Sensory Status

F - Integumentary Status

G - Respiratory Status

H - Cardiac Status

I - Elimination Status

J - Neuro/Emotional/Behavioral Status

K - ADLs/IADLs

L - Medications

M - Care Management

N - Therapy Need and Plan of Care

O - Emergent Care

P - Discharge

OASIS ITEM
(M0010) CMS Certification Number: __ __ __ __ __ __
ITEM INTENT
Specifies the agency's Centers for Medicare and Medicaid Services (CMS) certification number (CCN/Medicare provider number).
TIME POINTS ITEM(S) COMPLETED
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS
• Enter the agency's CMS certification (Medicare provider) number, if applicable. If agency is not Medicare-certified, leave blank. • This is NOT the Provider's NPI number. • Preprinting this number on clinical documentation is allowed and recommended.
DATA SOURCES / RESOURCES
• Agency administrator and billing staff

OASIS ITEM
(M0014) Branch State: __ __
ITEM INTENT
Specifies the State where the agency branch office is located.
TIME POINTS ITEM(S) COMPLETED
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS
• Enter the two-letter postal service abbreviation of the State in which the branch office is located. Leave blank if your agency has no branches or all branches are located in the same State. • Preprinting this number on clinical documentation is allowed and recommended.
DATA SOURCES / RESOURCES
• Agency or branch administrator

OASIS ITEM
(M0016) Branch ID: __ __ __ __ __ __ __ __ __ __
ITEM INTENT
Specifies the branch identification code, as assigned by CMS. The identifier consists of 10 digits – the State code as the first two digits, followed by Q (upper case), followed by the last four digits of the current Medicare provider number, ending with the three-digit CMS-assigned branch number.
TIME POINTS ITEM(S) COMPLETED
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS
• Enter the Federal branch identification number specified for this branch as assigned by CMS. • If you are an HHA with no branches, enter "N" followed by 9 blank spaces. • If you are a parent HHA that has branches, enter "P" followed by 9 blank spaces. • Preprinting this number on clinical documentation is allowed and recommended.
DATA SOURCES / RESOURCES
• Agency or branch administrator

OASIS ITEM:
(M0018) National Provider Identifier (NPI) for the attending physician who has signed the plan of care**:** __ __ __ __ __ __ __ __ __ __ ☐ **UK – Unknown or Not Available**
ITEM INTENT
Identifies the physician who will sign the Plan of Care
TIME POINTS ITEM(S) COMPLETED
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS
• The NPI replaces UPIN of "Primary Referring Physician ID."
DATA SOURCES / RESOURCES
• Agency medical records department • For more information see the link for NPI registry in Chapter 5 of this manual.

OASIS ITEM
(M0020) Patient ID Number: _
ITEM INTENT
Specifies the agency-specific patient identifier. This is the identification code the **agency** assigns to the patient and uses for record keeping purposes for this episode of care. The patient ID number may stay the same from one admission to the next or may change with each subsequent admission, depending on agency policy. However, it should remain constant throughout a single episode of care (e.g., from admission to discharge).
TIME POINTS ITEM(S) COMPLETED
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS
• If there are fewer digits than spaces provided, leave spaces at the end blank.
DATA SOURCES / RESOURCES
• Agency medical records department

OASIS ITEM

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

ITEM INTENT

Specifies the start of care date, which is the date that the first reimbursable service is delivered.

TIME POINTS ITEM(S) COMPLETED

SOC (Patient Tracking Sheet)

RESPONSE—SPECIFIC INSTRUCTIONS

- In multidiscipline cases, regulatory requirements, coverage criteria (such as the Conditions of Participation), and agency policy establish which discipline's visit is considered the start of care. A reimbursable service must be delivered to be considered the start of care. For Medicare reimbursement, as explained in 42 CFR 409.46, a physician must specifically order that a particular covered service be furnished on the SOC date. All other coverage criteria must be met for this initial service to be billable and to establish the start of care.
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
- For skilled PT or SLP to perform the start of care visit for a Medicare patient:
  - the HHA is expected to have orders from the patient's physician indicating the need for physical therapy or SLP prior to the initial assessment visit;
  - no orders are present for nursing at the start of care;
  - a reimbursable service must be provided; and
  - the need for this service establishes program eligibility for the Medicare home health benefit (42 CFR 484.55(a)(2).
- Accuracy of this date is essential; many other aspects of data collection are based on this date.
- When the agency's policy/practice is for an RN to perform the SOC assessment in a therapy-only case, the nursing assessment visit must be made the same day or within five days after the therapist's first visit.
- If questions exist as to the start of care date, clarify the exact date with agency administrative personnel.

DATA SOURCES / RESOURCES

- Agency administrative staff

OASIS ITEM

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

ITEM INTENT

Specifies the date of the first visit following an inpatient stay by a patient receiving service from the home health agency.

TIME POINTS ITEM(S) COMPLETED

ROC

The resumption of care date must be updated on the Patient Tracking Sheet whenever a patient returns to service following an inpatient facility stay.

RESPONSE—SPECIFIC INSTRUCTIONS

- At start of care, mark "NA."
- The most recent resumption of care date should be entered.
- Agencies who always discharge patients when they are admitted to an inpatient facility will not have a resumption of care date.
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
- Assessment strategies: If question exists as to the resumption of care date, clarify with the agency administrative staff.

DATA SOURCES / RESOURCES

- Agency administrative staff

OASIS ITEM
(M0040) Patient Name: __ __ __ __ __ __ __ __ __ __ __ __ __   __   __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __   __ __ __ (First) (MI) (Last) Suffix)
ITEM INTENT
Specifies the full name of the patient: first name, middle initial, last name, and suffix (e.g., Jr., III, etc.).
TIME POINTS ITEM(S) COMPLETED
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS
• Enter all letters of the first and last names, the middle initial, and the abbreviated suffix. Correct spelling is important. • If no suffix, leave blank. If middle initial is not known, leave blank. • The name entered should be exactly as it appears on the patient's Medicare or other insurance card. • The name entered should be the patient's legal name, even if the patient consistently uses a nickname. • The sequence of the names may be reordered (i.e., last name, first name, etc.) in agency forms, if desired.
DATA SOURCES / RESOURCES
• Patient's Medicare card, private insurance card, HMO identification card, etc.

OASIS ITEM
(M0050) Patient State of Residence: __ __
ITEM INTENT
Specifies the State in which the patient is currently residing while receiving home care.
TIME POINTS ITEM(S) COMPLETED
SOC (Patient Tracking Sheet) and updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS
• Enter the two-letter postal service abbreviation of the State in which the patient is CURRENTLY residing, even if this is not the patient's usual (or legal) residence.
DATA SOURCES / RESOURCES
• Clarify the exact (State) location of the residence with municipal, county, or State officials, if necessary.

OASIS ITEM
(M0060) Patient Zip Code: __ __ __ __ __ __ __ __ __ __
ITEM INTENT
Specifies the zip code for the address at which the patient is currently residing while receiving home care.
TIME POINTS ITEM(S) COMPLETED
SOC (Patient Tracking Sheet); updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS
• Enter the zip code for the address of the patient's CURRENT residence, even if this is not the patient's usual (or legal) residence. • Enter at least five digits (nine digits if known). • The patient's zip code is used for *Home Health Compare* to determine places where your agency provided service. Be sure to use the zip code where the service is provided.
DATA SOURCES / RESOURCES
• Verify the zip code with the local post office, if necessary.

OASIS ITEM

(M0063) Medicare Number: __ __ __ __ __ __ __ __ __ __ __ __ __ (including suffix, if any) ☐ **NA – No Medicare**

ITEM INTENT

For Medicare patients only. Specifies the patient's Medicare number, including any prefixes or suffixes.

Use RRB number for railroad retirement program.

TIME POINTS ITEM(S) COMPLETED

SOC (Patient Tracking Sheet); updated if change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS

- Enter the number identified as "Claim No." on the patient's Medicare card. (NOTE: This may or may not be the patient's Social Security number.)
- If the patient does not have Medicare, mark "NA - No Medicare."
- If the patient is a member of a Medicare HMO, another Medicare Advantage plan, or Medicare Part C, enter the Medicare number if available. If not available, mark "NA - No Medicare." Do not enter the HMO identification number.
- Enter Medicare number (if known) whether or not Medicare is the primary payment source for this episode of care.
- If there are fewer digits than spaces provided, leave spaces at the end blank.

DATA SOURCES / RESOURCES

- Patient's Medicare card. Referral information may include the number, but it should be verified with the patient.

OASIS ITEM
(M0064) Social Security Number: __ __ __ -__ __ -__ __ __ __ ☐ **UK - Unknown or Not Available**
ITEM INTENT
Specifies the patient's Social Security number.
TIME POINTS ITEM(S) COMPLETED
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS
• Include all nine numbers. Mark "UK" if unknown or not available (e.g., information cannot be obtained or patient refuses to provide information).
DATA SOURCES / RESOURCES
• Patient's Social Security card, if available. Referral information may include the number, but it should be verified with the patient.

OASIS ITEM
(M0065) Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ☐ **NA – No Medicaid**
ITEM INTENT
Specifies the patient's Medicaid number.
TIME POINTS ITEM(S) COMPLETED
SOC (Patient Tracking Sheet); updated if change occurs during the episode.
RESPONSE—SPECIFIC INSTRUCTIONS
• Include all digits and letters. If patient does not have Medicaid coverage or Medicaid coverage is pending, mark "NA - No Medicaid." • If the patient has Medicaid, answer this item whether or not Medicaid is the payer source for the home care episode. • This number is assigned by an individual state and is found on the patient's Medicaid card.
DATA SOURCES / RESOURCES
• Patient's Medicaid card or other verifying documentation. Make sure that the coverage is still in effect, such as checking the expiration date. Depending on specific State regulations or procedures, you may need to verify coverage and effective dates with the social services agency. • Referral information may include the number, but it should be verified with the patient.

OASIS ITEM
(M0066) Birth Date: __ __ /__ __ /__ __ __ __ month day year
ITEM INTENT
Specifies the birth date of the patient, including month, day, and four digits for the year.
TIME POINTS ITEM(S) COMPLETED
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS
• If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
DATA SOURCES / RESOURCES
• Patient or caregiver report • Other legal documents (e.g., driver's license, state-issued ID card, etc.).

OASIS ITEM
(M0069) Gender: ☐ 1 - Male ☐ 2 - Female
ITEM INTENT
Specifies the gender of the patient.
TIME POINTS ITEM(S) COMPLETED
SOC (Patient Tracking Sheet)
RESPONSE—SPECIFIC INSTRUCTIONS
DATA SOURCES / RESOURCES
• Patient/caregiver interview • Observation • Physical assessment

OASIS ITEM

(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

ITEM INTENT

Specifies the racial/ethnic groups or populations with which the patient is affiliated, as identified by the patient or caregiver. Office of Management and Budget (OMB) regulations state that “unknown” is not a permissible response for this item. The major purpose of this item is to track health disparities.

TIME POINTS ITEM(S) COMPLETED

SOC (Patient Tracking Sheet); updated if change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS

- Response 1 – American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
- Response 2 – Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Response 3 – Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
- Response 4 – Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."
- Response 5 – Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- Response 6 – White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

DATA SOURCES / RESOURCES

- Patient/family interview
- If the patient does not self-identify, referral information (including hospital or physician office clinical record data); observation

OASIS ITEM

(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 (e.g., Title III, V, or XX)
- ☐ 7 - Other government (e.g., TriCare, VA, etc.)
- ☐ 8 - Private insurance
- ☐ 9 - Private HMO/managed care
- ☐ 10 - Self-pay
- ☐ 11 - Other (specify) _____
- ☐ UK Unknown

ITEM INTENT

This item is limited to identifying payers to which any **services** provided during this home care episode and included on the plan of care will be billed by **your home health agency.**

TIME POINTS ITEM(S) COMPLETED

SOC (Patient Tracking Sheet) and updated when change occurs during the episode.

RESPONSE—SPECIFIC INSTRUCTIONS

- Exclude "pending" payment sources.
- Accurate recording of this item is important because assessments for Medicare and Medicaid patients are handled differently than assessments for other payers. If the patient's care is being reimbursed by multiple payers (e.g., Medicare and Medicaid; private insurance and self-pay; etc.), include all sources. If one or more payment sources are known but additional sources are uncertain, mark those that are known.
- Mark all current pay sources, whether considered primary or secondary.
- Do not consider any equipment, medications, or supplies being paid for by the patient, in part or in full.
- Select Response 2 if the payment source is a Medicare HMO, another Medicare Advantage Plan, or Medicare Part C.
- Select Response 3 if the patient is receiving services provided as part of a Medicaid waiver or home and community-based waiver (HCBS) program.
- Select Response 6 if the patient is receiving services through one of the following programs:
  - Title III - State Agency on Aging grants, which encourage State Agencies on Aging to develop and implement comprehensive and coordinated community-based systems of service for older individuals via Statewide planning and area planning. The objective of these services and centers is to maximize the informal support provided to older Americans to enable them to remain in their homes and communities. This program insures that elders receive the services they need to remain independent by providing transportation services, in-home services and caregiver support services,

RESPONSE—SPECIFIC INSTRUCTIONS

- Title V - State programs to maintain and strengthen their leadership in planning, promoting, coordinating and evaluating health care for pregnant women, mothers, infants, and children, and children with special health care needs in providing health services for mothers and children who do not have access to adequate health care;
- Title XX - Social service block grants available to states to provide homemaking, chore service, home management or home health aide services and enable each State to furnish social services best suited to the needs of the individuals residing in the State. Federal block grant funds may be used to provide services directed toward one of the following five goals specified in the law: (1) To prevent, reduce, or eliminate dependency, (2) to achieve or maintain self-sufficiency, (3) to prevent neglect, abuse, or exploitation of children and adults, (4) to prevent or reduce inappropriate institutional care, and (5) to secure admission or referral for institutional care when other forms of care are not appropriate.

- Select Response 7 if the patient is a member of a Tri-Care program, which replaced CHAMPUS.
- Select Response 10 if patient is self pay for all or part of the care (e.g., copayments).

DATA SOURCES / RESOURCES

- Referral information regarding coverage. This can be verified with patient/caregiver.
- Copies of health insurance identification cards. The card(s) will provide the patient ID number as well as current status of coverage.

OASIS ITEM

(M0080) Discipline of Person Completing Assessment:

☐ 1-RN ☐ 2-PT ☐ 3-SLP/ST ☐ 4-OT

ITEM INTENT

Specifies the discipline of the clinician completing the comprehensive assessment during an actual visit to the patient's home at the specified OASIS time points or the clinician reporting the transfer to an inpatient facility or death at home.

TIME POINTS ITEM(S) COMPLETED

All

RESPONSE—SPECIFIC INSTRUCTIONS

- Only one individual completes the comprehensive assessment. Even if two disciplines are seeing the patient at the time a comprehensive assessment is due, while care coordination and consultation are needed, only one individual actually completes and records the assessment.
- According to the comprehensive assessment regulation, when both the RN and PT/SLP are ordered on the initial referral, the RN must perform the SOC comprehensive assessment. An RN, PT, SLP, or OT may perform subsequent assessments.
- LPNs, PTAs, COTAs, MSWs and home health aides do not meet the requirements specified in the comprehensive assessment regulation for disciplines authorized to complete the comprehensive assessment or collect OASIS data.
- When both the RN and qualified therapist are scheduled to conduct discharge visits on the same day, the last qualified clinician to see the patient is responsible for conducting the discharge comprehensive assessment.

DATA SOURCES / RESOURCES

- Agency policy
- Conditions of Participation

OASIS ITEM
(M0090) Date Assessment Completed: __ __ /__ __ /__ __ __ __ month / day / year
ITEM INTENT
Specifies the actual date the assessment is completed.
TIME POINTS ITEM(S) COMPLETED
All
RESPONSE—SPECIFIC INSTRUCTIONS
• If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year. • Date Assessment Completed cannot be before the SOC date. • If agency policy allows assessments to be performed over more than one visit date, the last date (when the final assessment data are collected), is the appropriate date to record. • For the following OASIS time points, Transfer to Inpatient Facility – patient not discharged from agency; Transfer to Inpatient Facility – patient discharged from agency or Death at Home, record the date the agency completes the data collection after learning of the event, as a visit is not necessarily associated with these events. • See information on M0100 Reason for Assessment for additional clarification.
DATA SOURCES / RESOURCES
• Calendar • Patient/caregiver interview for dates of transfer to inpatient facility or death at home

OASIS ITEM

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

Start/Resumption of Care

☐ 1 – Start of care—further visits planned

☐ 3 – Resumption of care (after inpatient stay)

Follow-Up

☐ 4 – Recertification (follow-up) reassessment **[** *Go to M0110* **]**

☐ 5 – Other follow-up **[** *Go to M0110* **]**

Transfer to an Inpatient Facility

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

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

Discharge from Agency — Not to an Inpatient Facility

☐ 8 – Death at home **[** *Go to M0906* **]**

☐ 9 – Discharge from agency **[** *Go to M1032* **]**

ITEM INTENT

Identifies the "time points" - reason why the assessment data are being collected and reported. Accurate recording of this response is important as the logic in the data reporting software will accept or reject certain data according to the specific response that has been selected for this item.

TIME POINTS ITEM(S) COMPLETED

All

RESPONSE—SPECIFIC INSTRUCTIONS

- Mark only one response.
- Response 1: This is the start of care comprehensive assessment. A plan of care is being established, whether or not further visits will be provided after the start of care visit. This is the appropriate response anytime an initial HIPPS code (for a Home Health Resource Group) is required.
- Response 3: This comprehensive assessment is conducted when the patient resumes care following an inpatient stay of 24 hours or longer for reasons other than diagnostic tests. Remember to update the Patient Tracking Sheet ROC date (M0032) when this response is marked. When a patient is discharged from an inpatient facility **and** care is resumed within the last 5 days of the episode (i.e., a recertification assessment is due), a ROC assessment, rather than a recertification assessment, is completed.
- Response 4: This comprehensive follow-up assessment is conducted during the last five days of the 60-day certification period and is completed to continue the patient's services for an additional 60 day episode of care.
- Response 5: This comprehensive assessment is conducted due to a major decline or improvement in patient's health status occurring at a time other than during the last five days of the episode. This assessment is done to reevaluate the patient's condition, allowing revision to the patient's care plan as appropriate.
- Response 6: This "Transfer to an Inpatient Facility" OASIS is completed when the home care patient is admitted to an inpatient facility for 24 hours or longer for reasons other than diagnostic tests with the expectation that home health care will be resumed following inpatient discharge; thus the patient is not discharged from the agency. (When the patient resumes care, a Resumption of Care comprehensive assessment is conducted.) This response does not require a home visit; a telephone call may provide the information necessary to complete the required data items. Short stay observation periods in a hospital, regardless of duration, do not meet the definition for transfer to an inpatient facility.

RESPONSE—SPECIFIC INSTRUCTIONS (Cont'd for OASIS ITEM M0100)

- Response 7: This "Transfer to an Inpatient Facility" OASIS is completed when the home care patient is admitted to an inpatient facility for 24 hours or longer (for reasons other than diagnostic tests) and the patient is discharged from the agency. This response does not require a home visit; a telephone call may provide the information necessary to complete the required data items. No additional OASIS discharge data are required. Short stay observation periods in a hospital, regardless of duration, do not meet the definition for transfer to an inpatient facility.
- Response 8: Data regarding patient death anywhere other than death in an Emergency Department or inpatient facility. A patient who dies **before** being treated in an emergency department or before being admitted to an inpatient facility would have this response marked. Note the "skip pattern" included in the response. A home visit is not required to mark this response; the information necessary to complete the data items may be obtained by telephone.
- Response 9: This comprehensive assessment is conducted when a patient is discharged from the agency for any reason other than transfer to an inpatient facility or death at home. This response includes transfer and **discharge** to another home health agency or an in-home hospice. A patient visit is required to complete this assessment. Note the "skip pattern" present in the response.
- Assessment strategies: Why is the assessment being conducted (or the information being recorded)? What has happened to the patient? Accuracy of this response is critical.

DATA SOURCES / RESOURCES

- Agency case manager or other care team provider
- Clinical record
- Hospital or other health care provider information regarding transfer to inpatient facility or death at home

OASIS ITEM

(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 (or physician designee)

ITEM INTENT

Specifies the date that home care services are ordered to begin, if the date was specified by the physician. The item refers to the order to start home care services (i.e., provide the first covered service), regardless of the type of services ordered (e.g., therapy only).

TIME POINT ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- If the originally ordered start of care is delayed due to the patient's condition or physician request (e.g., extended hospitalization), then the date specified on the updated/revised order to start home care services would be considered the date of physician-ordered start of care (resumption of care). For example, a patient discharged home on May 15 but for whom the physician orders home care to begin May 20 for a specified order (e.g., PT or administration of a subcutaneous drug), would have a physician-ordered start-of-care date of May 20.
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
- Mark "N/A" if the initial orders did not specify a SOC date.

DATA SOURCES / RESOURCES

- Physician orders to initiate home care or resume home care following inpatient facility stay.

OASIS ITEM

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

__ __ /__ __ /__ __ __ __
month / day / year

ITEM INTENT

Specifies the referral date, which is the most recent date that verbal, written, or electronic authorization to begin home care was **received** by the home health agency.

TIME POINT ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- If start of care is delayed due to the patient's condition or physician request (e.g., extended hospitalization), then the date the agency received **updated/revised** referral information for home care services to begin would be considered the date of referral. This does not refer to calls or documentation from others such as assisted living facility staff or family who contact the agency to prepare the agency for possible admission.
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.

DATA SOURCES/ RESOURCES

- Agency referral form
- Agency records specifying the date the referral was received by the agency
- Hospital or nursing home discharge information

OASIS ITEM

(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?

☐ 1 - Early

☐ 2 - Later

☐ UK - Unknown

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

ITEM INTENT

Identifies the placement of the current Medicare PPS payment episode in the patient's current sequence of adjacent Medicare PPS payment episodes.

TIME POINT ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS

- A "sequence of adjacent Medicare home health payment episodes" is a continuous series of Medicare PPS payment episodes, regardless of whether the same home health agency provided care for the entire series.
  - Low utilization payment adjustment (LUPA) episodes (less than 5 total visits) are counted.
  - "Adjacent" means that there was no gap between Medicare-covered episodes of more than 60 days.
  - Periods of time when the patient is "outside" a Medicare payment episode but on service with a different payer - such as HMO, Medicaid, or private pay - are counted as *gap* days when counting the sequence of Medicare payment episodes.
- "Early" includes the only PPS episode in a single episode case OR the first or second PPS episode in a sequence of adjacent PPS episodes. **Select Response 1 – Early – if the episode of care you are assessing the patient for is the patient's first or second episode of care** in a current sequence of adjacent Medicare home health PPS payment episodes.
- "Later" means the third or later PPS episode in a sequence of adjacent episodes. **Select Response 2 – Later – if this episode is the third or later episode of care** in a current sequence of adjacent Medicare home health PPS payment episodes.
- Select the "UK - Unknown" response if the placement of this PPS payment episode in the sequence of adjacent episodes is unknown. For the purposes of assigning a case mix code to the episode, this will have the same effect as selecting the "Early" response.
- Enter "NA" if no Medicare case mix group is to be defined for this episode.
- If the patient needs a case mix code for billing purposes (a HIPPS code), a response other than "NA" is required to generate the code. Some sources that are not Medicare-fee-for-service payers will use this information in setting an episode payment rate.

RESPONSE—SPECIFIC INSTRUCTIONS (continued for M0110 Episode Timing)

- Assessment strategies: Consult all available sources of information to code this item. Medicare systems, such as Health Insurance Query for Home Health (HIQH), can provide this information. If calculating manually, note that the Medicare home health payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date, and that there can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next. Remember that a sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies. Episodes where Medicare fee-for-service is not the payer (such as HMO, Medicaid, or private pay) do NOT count as part of a sequence. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence.

DATA SOURCES / RESOURCE

- Medicare systems, such as Health Insurance Query for Home Health (HIQH).
- Manual calculations. Note that the Medicare home health payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date, and that there can be a gap of up to 60 days between episodes in the same sequence, counting from the last day of one episode until the first day of the next. A sequence of adjacent Medicare payment episodes continues as long as there is no 60-day gap, even if Medicare episodes are provided by different home health agencies. Episodes where Medicare fee-for-service is not the payer (such as HMO, Medicaid, or private pay) do NOT count as part of the sequence. If the period of service with those payers is 60 days or more, the next Medicare home health payment episode would begin a new sequence. Remember that the 60-day gap is counted from the end of the Medicare payment episode, not from the date of the last visit or discharge, which can occur earlier. (If the episode is ended by an intervening event that causes it to be paid as a partial episode payment [PEP] adjustment, then the last visit date is the end of the episode).

OASIS ITEM

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

- ☐ 1 - Long-term nursing facility (NF)
- ☐ 2 - Skilled nursing facility (SNF / TCU)
- ☐ 3 - Short-stay acute hospital
- ☐ 4 - Long-term care hospital (LTCH)
- ☐ 5 - Inpatient rehabilitation hospital or unit (IRF)
- ☐ 6 - Psychiatric hospital or unit
- ☐ 7 - Other (specify) _____
- ☐ NA - Patient was not discharged from an inpatient facility **[*Go to M1016*]**

ITEM INTENT

Identifies whether the patient has been discharged from an inpatient facility within the 14 days (two-week period) immediately preceding the start of care/resumption of care. The purpose of this item is to establish the patient's recent health care history before formulating the plan of care. This determination must be made with sufficient accuracy to allow appropriate care planning. For example, the amount and types of rehabilitation treatment the patient has received and the type of institution that delivered the treatment are important to know when developing the home health plan of care.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Mark all that apply. For example, patient may have been discharged from both a hospital and a rehabilitation facility within the past 14 days.
- An inpatient facility discharge that occurs on the day of the assessment does fall within the 14-day period.
- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any inpatient discharges falling on or after August 6 and prior to the HHA admission would be reported. Discharges on Day 0 should be included.
- Facility type is determined by the facility's state license.
- If the patient was discharged from a Medicare-certified skilled nursing facility, but did not receive care under the Medicare Part A benefit in the 14 days prior to home health care, select Response 1 - Long-term nursing facility.
- Response 2 – Skilled nursing facility means a (a) Medicare certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit or (b) transitional care unit (TCU) within a Medicare-certified nursing facility.

RESPONSE—SPECIFIC INSTRUCTIONS (Cont'd for OASIS ITEM M1000)

Determine responses to the questions below. If all three of the criteria below apply, select Response 2.

1) Was the patient discharged from a Medicare-certified skilled nursing facility? If so, then:

2) While in the skilled nursing facility was the patient receiving skilled care under the Medicare Part A benefit? If so, then:

3) Was the patient receiving skilled care under the Medicare Part A benefit during the 14 days prior to admission to home health care?

- Response 3 – Short-stay acute hospital applies to most hospitalizations.
- Response 4 – Long-term care hospital, applies to a hospital that has an average inpatient length of stay of greater than 25 days.
- Response 5 – Inpatient rehabilitation hospital or unit (IRF) means a freestanding rehab hospital or a rehabilitation bed in a rehabilitation distinct part unit of a general acute care hospital.
- Intermediate care facilities for the mentally retarded (ICF/MR) should be considered Response 7 – Other.
- If patient has been discharged from a swing-bed hospital, it is necessary to determine whether the patient was occupying a designated hospital bed (Response 3), a skilled nursing bed under Medicare Part A (Response 2), or a nursing bed at a lower level of care (Response 1). The referring hospital can answer this question regarding the bed status.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Referral Information
- For Medicare patients, Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare.

OASIS ITEM

(M1005) Inpatient Discharge Date (most recent):

__ __ /__ __ /__ __ __ __
month / day / year

☐ UK - Unknown

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any inpatient discharges falling on or after August 6 and prior to the HHA admission would be reported. Discharges on Day 0 should be included.
- Even though the patient may have been discharged from more than one facility in the past 14 days, use the most recent date of discharge from any inpatient facility.
- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Referral information
- For Medicare patients, data in Medicare's Common Working File (CWF) can be accessed to assist in determining the type of inpatient services received and the date of inpatient facility discharge if the claim for inpatient services has been received by Medicare.

OASIS ITEM

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

	Inpatient Facility Diagnosis	ICD-9-CM Code
a.	_____	__ __ __ . __ __
b.	_____	__ __ __ . __ __
c.	_____	__ __ __ . __ __
d.	_____	__ __ __ . __ __
e.	_____	__ __ __ . __ __
f.	_____	__ __ __ . __ __

ITEM INTENT

Identifies diagnosis(es) for which patient was receiving treatment in an inpatient facility within the past 14 days. This list of diagnoses is intended to include only those diagnoses that required treatment during the inpatient stay and may or may not correspond with the hospital admitting diagnosis. This expanded list allows for a more comprehensive picture of the patient's condition prior to the initiation or resumption of home care.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any diagnoses related to inpatient stays with discharges falling on or after August 6 and prior to the HHA admission would be reported.
- If a diagnosis was not treated during an inpatient admission, it should not be listed. (Example: The patient has a long-standing diagnosis of "osteoarthritis," but was treated during hospitalization only for "peptic ulcer disease." Do not list "osteoarthritis" as an inpatient diagnosis.)
- No surgical codes. List the underlying diagnosis that was surgically treated. If a joint replacement was done for osteoarthritis, list the disease, not the procedure.
- No V-codes or E-codes. List the underlying diagnosis.
- It is not necessary to fill in every line (a-f) if the patient had fewer than six inpatient diagnoses.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Referral information (may include inpatient facility discharge summary, physician history and physical, progress notes, etc.)
- The current ICD-9-CM code book should be the source for coding.

OASIS ITEM

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

	Inpatient Procedure	Procedure Code
a.	_____	__ __ . __ __
b.	_____	__ __ . __ __
c.	_____	__ __ . __ __
d.	_____	__ __ . __ __

☐ NA - Not applicable

☐ UK - Unknown

ITEM INTENT

Identifies medical procedures that the patient received during an inpatient facility stay within the past 14 days that are relevant to the home health plan of care. This item is intended to allow for a more comprehensive picture of the patient's condition prior to the initiation of home care.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Include only those procedures that occurred during the inpatient stay that are relevant to the home health plan of care, based on the information available at start or resumption of care (i.e., a joint replacement surgery that requires home rehabilitation services).
- Do not include inpatient procedures that are not relevant to the home health plan of care. For example, a diagnostic procedure (CT scan) may have been done during the inpatient stay but may have no implications for home health care services. In this case, it is not necessary to list the procedure code for the CT scan.
- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. The 14-day time period applies to the timing of the inpatient discharge, not the date of the procedure. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any procedures related to inpatient stays with discharges falling on or after August 6 and prior to the HHA admission would be reported.

DATA SOURCES / RESOURCES

- Patient/caregiver interviews
- Physician
- Referral information (may include hospital discharge summary, physician history and physical, progress notes, etc.)
- Home health plan of care
- The current ICD-9-CM code book should be the source for coding

Guidance for this item updated 12/18/2009

OASIS ITEM

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

	Changed Medical Regimen Diagnosis	ICD-9-CM Code
a.	_____	__ __ __ . __ __
b.	_____	__ __ __ . __ __
c.	_____	__ __ __ . __ __
d.	_____	__ __ __ . __ __
e.	_____	__ __ __ . __ __
f.	_____	__ __ __ . __ __

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

ITEM INTENT

Identifies if any change has occurred to the patient's treatment regimen, health care services, or medications within the past 14 days. The purpose of this question is to help identify the patient's recent history by identifying new diagnoses or diagnoses that have exacerbated over the past 2 weeks. This information helps the clinician develop an appropriate plan of care, since patients who have recent changes in treatment plans have a higher risk of becoming unstable.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- No surgical codes - list the underlying diagnosis.
- No V-codes or E-codes - list the appropriate diagnosis.
- Response to this item may include the same diagnoses as M1010 if the condition was treated during an inpatient stay AND caused changes in the treatment regimen.
- Mark "NA" if changes in the medical or treatment regimen were made because a diagnosis improved.
- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any diagnoses requiring medical or treatment regimen change on or after August 6 and prior to the HHA admission would be reported.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Physician orders
- Referral information
- The current ICD-9-CM code book should be the source for coding

OASIS ITEM

(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

ITEM INTENT

Identifies existence of condition(s) prior to medical regimen change or inpatient stay within past 14 days. This information is important for care planning and setting goals.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Select Response 7 – None of the above – if the patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, and none of the indicated conditions existed prior to the inpatient stay or change in medical or treatment regimen.
- Select Response "NA" if no inpatient facility discharge and no change in medical or treatment regimen in past 14 days. Note that both situations must be true for this response to be marked "NA."
- Select Response "Unknown" if the patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, and it is unknown whether the indicated conditions existed prior to the inpatient stay or change in medical or treatment regimen.
- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Referral information (e.g., history and physical)

OASIS ITEM

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group. Do not assign symptom control ratings for V- or E-codes.

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

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 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 in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). Refer to Appendix D for additional instruction related to the coding of M1024.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(Continued on next page)

OASIS ITEM (M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses (cont'd)

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		(M1024) Payment Diagnoses (OPTIONAL)	
Column 1	Column 2	Column 3	Column 4
Assigning or Coding Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis**.	Complete **only if** the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. _____	**(V-codes are allowed)** a. (__ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)	**(V- or E-codes NOT allowed)** a._____ (__ __ __ . __ __)
(M1022) Other Diagnoses b. _____	**(V- or E-codes are allowed)** b. (__ __ __ __ . __ __) ☐0 ☐1 ☐2 ☐3 ☐4	**(V- or E-codes NOT allowed)** b._____ (__ __ __ . __ __)	**(V- or E-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._____ (__ __ __ . __ __)

ITEM INTENT

The intent of this item is to accurately code each diagnosis in compliance with Medicare's rules and regulations for coverage and payment. CMS expects HHAs to understand each patient's specific clinical status before selecting and assigning each diagnosis. Each patient's overall medical condition and care needs must be comprehensively assessed **BEFORE** the HHA Identifies and assigns each diagnosis for which the patient is receiving home care. Each diagnosis (other than an E-code) must comply with the "Criteria for OASIS Diagnosis Reporting." (See Appendix D – if a patient has a resolved condition that has no impact on the patient's current plan of care, then the condition does not meet the criteria for a home health diagnosis and should not be coded.) The primary diagnosis (M1020) should be the diagnosis most related to the patient's current plan of care, the most acute diagnosis and, therefore, the chief reason for providing home care.

Secondary diagnoses in M1022 are defined as "all conditions that coexisted at the time the plan of care was established, or which developed subsequently, or affect the treatment or care." In general, M1022 should include not only conditions actively addressed in the patient's plan of care but also any co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. Ensure that the secondary diagnoses assigned to M1022 are listed in the order to best reflect the seriousness of the patient's condition and justify the disciplines and services provided. Agencies should avoid listing diagnoses that are of mere historical interest and without impact on patient progress or outcome. The diagnosis may or may not be related to a patient's recent hospital stay but must relate to the services rendered by the HHA. Skilled services (skilled nursing, physical, occupational, and speech language pathology) are used in judging the relevancy of a diagnosis to the plan of care and to the OASIS.

ITEM INTENT (cont'd for OASIS Items M1020/1022/1024)

The order that secondary diagnoses are entered should be determined by the degree that they impact the patient's health and need for home health care, rather than the degree of symptom control. For example, if a patient is receiving home health care for Type 2 diabetes that is "controlled with difficulty," this diagnosis would be listed above a diagnosis of a fungal infection of a toenail that is receiving treatment, even if the fungal infection is "poorly controlled."

A case-mix diagnosis (Column 3) is a diagnosis that gives a patient a score for Medicare Home Health PPS case-mix group assignment. A case mix diagnosis may be the primary diagnosis, "other" diagnosis, or a manifestation associated with a primary or other diagnosis. Each diagnosis listed in M1020 and M1022 should be supported by the patient's medical record documentation (i.e., the patient's Plan of Care is in compliance with 42 CFR 484.18(a)). The list of case mix diagnosis codes is included in the HH PPS Grouper documentation available on the CMS web site (see Chapter 5 of this manual for a link to this website).

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS

- V-codes may be entered in row "a" of Column 2 (item M1020); V-codes and E-codes may be entered in the other rows in Column 2 (item M1022). CMS expects HHAs to avoid assigning excessive V-codes to the OASIS. V-codes are less specific to the clinical condition of the patient than are numeric diagnosis codes. In the home health setting, V-codes are appropriately assigned to M1020 and M1022 when a patient with a resolving disease or injury requires specific aftercare of that disease or injury (i.e., surgical aftercare or aftercare for rehabilitation).
- V-codes and E-codes <u>may not</u> be entered in optional Columns 3 or 4 as these columns pertain to the Medicare PPS case mix diagnosis only.
- In optional Columns 3 and 4, complete only if a V-code is assigned under certain circumstances to column 2 in place of a case mix diagnosis. (Refer to below and Appendix D, Section D (4)).
- To prevent the loss of case mix points when an underlying case mix diagnosis is associated with the primary V-code diagnosis, HHAs should code the numeric case mix code to the primary diagnosis line (a) of M1024 when the following conditions apply: (1) the primary diagnosis (M1020) is a V-code; (2) the V-code displaces a numeric diagnosis that is a case mix diagnosis, and (3) the numeric case mix diagnosis is contained within one of the following three HH PPS diagnosis groups and to comply with ICD-9-CM coding guidelines, the secondary diagnosis, if needed to support the primary V-code diagnosis, (if appropriate for ICD-9-CM reporting in the home health setting), is reported in M1022 sequenced immediately following the V-code. The three HH PPS diagnosis groups are:
  - Diabetes
  - Skin 1-Traumatic Wounds, burns, and post-operative complications
  - Neuro 1-Brain disorders and paralysis
- ICD-9-CM coding guidelines stipulate that the acute fracture code is only to be used for the initial, acute episode of care, which is why the acute fracture code is no longer appropriate once the patient has been discharged from the hospital to home health care. In this scenario, if a V-code replaces the fracture code in either M1020 or M1022, the HHA can code the acute fracture code in the corresponding occurrence of M1024.
- Complete Columns 1 and 2 from top to bottom, leaving any blank entries at the bottom.
- In Columns 3 and 4 (optional), there may be blank entries in any row. When code(s) are entered in Columns 3 and 4 (optional), ensure that they are placed in the row that shows the corresponding V-code.
- No surgical codes – list the underlying diagnosis.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Items M1020/1022/1024)

Assessment strategies: **M1020/M1022: Primary and Other Diagnoses**

- Interview patient/caregiver to obtain past health history; additional information may be obtained from the physician.
- Review current medications and other treatment approaches. Determine if additional diagnoses are suggested by current treatment regimen, and verify this information with the patient/caregiver and physician.
- The current ICD-9-CM guidelines should be followed in coding these items.
- Assessing degree of symptom control includes review of presenting signs and symptoms, type and number of medications, frequency of treatment readjustments, and frequency of contact with health care provider. Inquire about the degree to which each condition limits daily activities. Assess the patient to determine if symptoms are controlled by current treatments. Clarify which diagnoses/symptoms have been poorly controlled in the recent past.

Assessment strategies: **M1024: Case Mix Diagnoses (OPTIONAL)**

- Select the code(s) that would have been reported as the primary diagnosis under the OASIS-B1 (8/2000) instructions.
- No surgical codes —list the underlying diagnosis.
- V-codes cannot be used in case mix group assignment. If a provider reports a V-code in M1020/1022 in place of a case mix diagnosis, the provider has the option of reporting the case mix diagnosis in M1024.
- If the case mix diagnosis requires multiple diagnoses under ICD-9-CM coding guidelines, enter these codes in Columns 3 and 4 (e.g., if coded as a combination of an etiology and a manifestation code, the etiology code should be entered in Column 3 and the manifestation code should be entered in Column 4).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Physician orders
- Referral information
- Current medication list
- The current ICD-9-CM code book should be the source for coding
- See Appendix D for further guidance on assigning and coding diagnoses in M1020/M1022
- For degree of symptom control, data sources may include patient/caregiver interview, physician, physical assessment, and review of past health history.

OASIS ITEM

(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

ITEM INTENT

Identifies whether the patient is receiving intravenous, parenteral nutrition, or enteral nutrition therapy **at home**, whether or not the home health agency is administering the therapy. This item is not intended to identify therapies administered in outpatient facilities or by any provider outside the home setting.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS

- This item addresses only therapies administered at home, defined as the patient's place of residence. Exclude therapies administered in outpatient facilities or by any provider outside the home setting.
- If the patient will receive such therapy as a result of this SOC/ROC or follow-up assessment (e.g., the IV will be started at this visit or a specified subsequent visit; the physician will be contacted for an enteral nutrition order; etc.), mark the applicable therapy.
- Select Response 1 if a patient receives intermittent medications or fluids via an IV line (including heparin or saline flushes). If IV catheter is present but not active (e.g., site is observed only or dressing changes are provided), do not mark Response 1.
- Select Response 1 if ongoing infusion therapy is being administered at home via central line, subcutaneous infusion, epidural infusion, intrathecal infusion, or insulin pump.
- Select Response 1 if the patient receives hemodialysis or peritoneal dialysis in the home.
- Do not select Response 1 if there are orders for an IV infusion to be given when specific parameters are present (e.g., weight gain), but those parameters are not met on the day of the assessment.
- Select Response 3 if any enteral nutrition is provided. If a feeding tube is in place, but not currently used for nutrition, Response 3 does not apply. A flush of a feeding tube does not provide nutrition.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician orders
- Referral information
- Review of past health history
- Physical assessment

OASIS ITEM

(M1032) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

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

ITEM INTENT

Identifies patient characteristics that may indicate the patient is at risk for hospitalization in the care provider's professional judgment.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Select all responses 1-6 that apply.
- If Response 7 is selected, none of the other responses should be selected.
- Response 3 includes witnessed and reported (unwitnessed) falls.
- In Response 4, medications includes OTC medications.
- Recent decline in mental, emotional, or behavioral status refers to significant changes occurring over the past year that may impact the patient's ability to remain safely in the home and increase the likelihood of hospitalization.
- Frailty includes weight loss in the last year, self-reported exhaustion, and slower movements (sit to stand and while walking).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Review of health history
- Referral information
- Physical assessment

OASIS ITEM

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

☐ 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age).

☐ 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age).

☐ 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.

☐ 3 - The patient has serious progressive conditions that could lead to death within a year.

☐ UK - The patient's situation is unknown or unclear.

ITEM INTENT

Identifies the general potential for health status stabilization, decline, or death in the care provider's professional judgment.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Use information from other providers and clinical judgment to select the response that best identifies the patient's status.
- Consider current health status, medical diagnoses, and information from the physician and patient/family on expectations for recovery or life expectancy.
- A "Do Not Resuscitate" order does not need to be in place for Responses 2 or 3.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Review of health history
- Referral information
- Physical assessment
- Advance Directive

OASIS ITEM

(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

ITEM INTENT

Identifies specific factors that may exert a substantial impact on the patient's health status, response to medical treatment, and ability to recover from current illnesses, in the care provider's professional judgment.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Select all responses, 1-4, that apply.
- If Response 5 is selected, none of the other responses should be selected.
- CMS does not provide a specific definition for each of these factors.
- Amount and length of exposure should be considered when responding (e.g., smoking one cigarette a month may not be considered a risk factor).
- Care providers should use judgment in evaluating risks to current health conditions from behaviors that were stopped in the past.
- For determination of obesity, consider using Body Mass Index guidelines.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Review of past health history
- Physical assessment
- Links to Body Mass Index guidelines for obesity can be found in Chapter 5 of this manual.

OASIS ITEM

(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?

☐ 0 - No

☐ 1 - Yes **[** ***Go to M1050*** **]**

☐ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. **[** ***Go to M1050*** **]**

ITEM INTENT

Identifies whether the patient received an influenza vaccine for the current influenza season from the home health agency during this episode of care This item does not assess flu vaccine given by another care provider or provision of the vaccine by your agency prior to the most recent SOC/ROC, as that information will be reported in M1045. Responses to M1040 and M1045 are combined to report the percentage of eligible patients who received influenza immunization for the current flu season.

TIME POINTS ITEM(S) COMPLETED

Transfer to inpatient facility

Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- The definition of episode of care for this item is the period of time from SOC/ROC to transfer or discharge. For each influenza season, the Centers for Disease Control (CDC) recommends the timeframes for administration of the influenza vaccines. This item meets NQF requirements for harmonization of influenza measures across care settings.
- Only select Responses 0 or 1 if **any** portion of the home health episode (from SOC/ROC to transfer or discharge) occurs between October 1 and March 31. CMS will calculate the measure only for the six month time frame identified.
- Only select Response 1 if the patient received the flu vaccine from your agency during this episode (SOC/ROC to Transfer/Discharge). This item does not assess influenza vaccines given by another health care provider or provision of the flu vaccine by your agency previously (i.e., during a previous episode of care) in the flu season. These situations are reported in the next item, M1045.
- If no part of the home health episode (from most recent SOC/ROC to transfer or discharge) occurs during the time period from October 1 through March 31, mark "NA."

DATA SOURCES / RESOURCES

- Clinical record
- Patient/caregiver interview
- For each influenza season, identify the period of time for which the Centers for Disease Control recommends influenza vaccines be administered. See Chapter 5 of this manual for links to CDC resources.

Guidance for this item updated 12/18/2009

OASIS ITEM

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:

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

ITEM INTENT

Specifies the reason that a patient did not receive an influenza vaccine from your agency during this home health care episode of care (from SOC/ROC to transfer or discharge). For each influenza season, the Centers for Disease Control (CDC) recommend the timeframes for administration of the influenza vaccines. Responses to M1040 and M1045 are combined to report the percentage of eligible patients who received influenza immunization for the current flu season.

TIME POINTS ITEM(S) COMPLETED

Transfer to an inpatient facility
Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Complete if Response 0 for M1040 is selected. Select one response.
- Select Response 1 if there is documentation in the medical record that the patient received the influenza vaccine for the current flu season from another provider. The provider can be the patient's physician, a clinic or health fair providing influenza vaccines, etc.
- Select Response 2 if your agency provided the flu vaccine for this year's flu season prior to this home health episode, (e.g., if the SOC/ROC for this episode was in winter, but your agency provided the vaccine for the current flu season during a previous home health episode in the fall when the vaccine for the current flu season became available).
- Responses 1 and 2 may be selected even if the flu vaccine for this year's influenza season was provided prior to October 1 (i.e., flu vaccine was made available early).
- Select Response 3 if the patient and/or healthcare proxy (e.g., someone with power of attorney) refused the vaccine.
- Select Response 4 if the influenza vaccine is contraindicated for medical reasons. Medical contraindications include anaphylactic hypersensitivity to eggs or other component(s) of the vaccine, history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination, or bone marrow transplant within 6 months.
- Select Response 5 if age/condition guidelines indicate that influenza vaccine is not indicated for this patient. For example, as of 2009, the CDC recommends influenza vaccine for patients age 50 and older or 6 mo. – 18 yrs; OR if the patient resides in a long-term care facility (including nursing homes and skilled nursing facilities); OR is age 19-49 with high-risk conditions of pregnancy, diabetes, end-stage renal disease (ESRD), congestive heart failure (CHF), asthma, chronic obstructive pulmonary disease (COPD), or human immunodeficiency virus (HIV).
- Select Response 6 only in the event that the vaccine is unavailable due to a CDC-declared shortage.
- Select Response 7 only if the home health agency did not provide the vaccine due to a reason other than responses 1-6. If an agency has elected not to administer vaccines to their patients, and the reasons listed in Responses 1-6 (such as vaccine received from another health care provider) do not apply, then Response 7 - None of the above, would be the appropriate response.

Guidance for this item updated 12/18/2009

DATA SOURCES / RESOURCES	
• Clinical record • Patient/caregiver interview • Physician or other health care provider	• For each influenza season, identify the period of time for which the Centers for Disease Control recommends influenza vaccines be administered. A link to CDC Guidelines can be found in Chapter 5 of this manual.

Guidance for this item updated 12/18/2009

OASIS ITEM

(M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?

☐ 0 - No

☐ 1 - Yes ***[Go to M1500 at TRN; Go to M1230 at DC]***

ITEM INTENT

Identifies whether the patient received a PPV from the home health agency during this episode of care (from SOC/ROC to transfer or discharge). This item does not assess PPVs given by another care provider or provision of the PPV by your agency prior to the most recent SOC/ROC, as that information will be reported in M1055. Responses to M1050 and M1055 are combined to report the percentage of eligible patients who ever received PPV.

TIME POINTS ITEM(S) COMPLETED

Transfer to an inpatient facility

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Select Response1 only if the patient received the pneumococcal (PPV) vaccine from your agency during this episode (most recent SOC/ROC to Transfer/Discharge).

DATA SOURCES / RESOURCES

- Clinical record
- Patient/caregiver interview

Guidance for this item updated 12/18/2009

OASIS ITEM

(M1055) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:

- ☐ 1 - Patient has received PPV in the past
- ☐ 2 - Offered and declined
- ☐ 3 - Assessed and determined to have medical contraindication(s)
- ☐ 4 - Not indicated; patient does not meet age/condition guidelines for PPV
- ☐ 5 - None of the above

ITEM INTENT

Explains why the patient did not receive a PPV from the home health agency during this episode of care (from SOC/ROC to transfer or discharge). Responses to M1050 and M1055 are combined to report the percentage of eligible patients who ever received PPV.

TIME POINTS ITEM(S) COMPLETED

Transfer to an inpatient facility

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Response 1 should be selected if the patient received the PPV from your agency or from another provider, (including the patient's physician, a clinic or health fair, etc.) **at any time in the past.** The patient's PPV does not need to be up-to-date to select this response.
- Response 2 should be selected if the patient and/or healthcare proxy (e.g., someone with power of attorney) refused the vaccine.
- Response 3 should be selected if PPV administration is medically contraindicated for this patient. Medical contraindications include anaphylactic hypersensitivity to component(s) of the vaccine, acute febrile illness bone marrow transplant within past 12 months, or receiving course of chemotherapy or radiation therapy within past 2 weeks.
- Select Response 4 if CDC age/condition guidelines indicate that PPV is not indicated for this patient. For example, the 2009 CDC recommendations are that the following patients receive PPV vaccination:
  - all adults 65 years of age or older should get the PPV once in a lifetime, with certain exceptions for medical contraindications as noted above,
  - all patients who reside in a long-term care facility (including nursing homes and skilled nursing facilities),
  - all patients age 5-64 with the high-risk conditions of diabetes, nephrotic syndrome, ESRD, CHF, COPD, HIV, asplenia.
- When responding to this item, the clinician only needs to report whether the patient has ever received PPV. However, when determining whether PPV is appropriate for a patient, the clinician should also consider the following CDC recommendations:
  - Persons 65 years or older should be administered a second dose of vaccine (booster vaccine) if they received the first dose of vaccine more than 5 years earlier and were less than 65 years old at the time of the first dose.
  - Persons less than 65 years of age who smoke or who are living in environments or social settings (e.g., nursing homes, assisted living, or board and care facilities) in which the risk for invasive pneumococcal disease or its complications is increased should receive the PPV if they do not have medical contraindications, as should patients age 5-64 with the high-risk conditions of diabetes, nephrotic syndrome, ESRD, CHF, COPD, HIV, or asplenia.

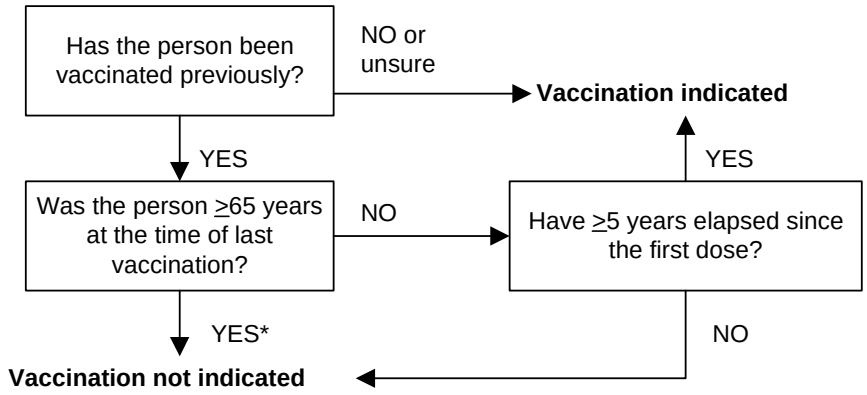
Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1055)

- Also, note that the CDC has evaluated inactivated Influenza vaccine co-administration with the Pneumococcal Polysaccharide Vaccine (PPV) systematically among adults. Simultaneous vaccine administration is safe when administered by a separate injection in the opposite arm. If the patient is an amputee or intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to clinical standards of care.

Note: The following algorithm may be used to assist in determining if PPV should be administered to immunocompetent patients ages 65 and older.

FIGURE 1. Algorithm for vaccinating immunocompetent persons aged 65 years and older.



***For any immunocompetent person who has received a dose of pneumococcal polysaccharide vaccine at age ≥65 years, revaccination is not indicated.**

Figure 1 Adapted from the CDC Recommendations and Reports. Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR April 1997;46(RR-08);1-24.

The CDC also recommends a second (booster) dose for persons who are immunocompromised due to:

- A damaged spleen or no spleen
- Sickle-cell disease
- HIV infections or AIDS
- Cancer, leukemia, lymphoma, multiple myeloma
- Kidney failure
- Nephrotic syndrome
- History of an organ or bone transplant
- Medication regimens that lowers immunity (such as chemotherapy or long-term steroids)

When any of the above conditions are present, persons older than 10 years old (including those 65 years of age and older) should get the second (booster) dose 5 years after the first dose.

- Response 5 should only be selected if the home health agency did not provide the vaccine due to a reason other than Responses 1-4. If an agency has elected not to administer vaccines to their patients, and the reasons listed in Responses 1-4 (such as vaccine received from another health care provider) do not apply, then Response 5 - None of the above, would be the appropriate response.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Resources for CDC Guidelines for PPV administration can be found in Chapter 5 of this manual.

Guidance for this item updated 12/18/2009

OASIS ITEM

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

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 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 (e.g., assisted living)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

ITEM INTENT

This item identifies, using the care provider's professional judgment, a) whether the patient is living alone or with other(s) and b) the availability of caregiver(s) (other than home health agency staff) to provide in-person assistance.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- To answer this question:
  - **First, determine living arrangement** – whether the patient lives alone, in a home with others, or in a congregate setting.
  - **Second, determine availability of assistance** – how frequently caregiver(s) are in the home and available to provide assistance if needed.
  - **Only one response should be marked.** Select the appropriate row (a, b, or c) to reflect the patient's living situation, then select the one response in the column that best describes the availability of in-person assistance at the time of the OASIS assessment.
- **Living Arrangement**
  - Select a response from **Row a** if the patient lives alone in an independent (non-assisted) setting. For example, the patient lives alone in a home, in their own apartment, or in their own room at a boarding house. A patient with only live-in paid help is considered to be living alone. A patient who normally lives alone but temporarily has a caregiver staying in the home to provide assistance is considered to be living alone. A patient who lives alone but can obtain emergency help by phone or life-line, is still living alone.
  - Select a response from **Row b** if the patient lives with others in an independent (non-assisted) setting. For example, the patient lives with a spouse, family member or another significant other in an independent (non-assisted) setting. A patient who normally lives with others but is occasionally alone because caregiver(s) are traveling out of town is still considered to be living with others.

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1100)

- Select a response from **Row c** if the patient lives in an "assisted living" setting (assistance, supervision and/or oversight are provided as part of the living arrangement). For example, the patient lives alone or with a spouse or partner in an apartment or room that is part of an assisted living facility, residential care home, or personal care home.

- If the patient has recently changed their living arrangement due to their condition, report the usual living arrangement prior to the illness, injury or exacerbation for which the patient is receiving care, unless the new living arrangement is expected to be permanent.

- **Availability of Assistance**

  - Identify the frequency with which any in-person assistance is available:

    - **Around the clock** means there is someone available in the home to provide assistance to the patient 24 hours a day.

    - **Regular daytime** means someone is in the home and available to provide assistance during daytime hours every day with infrequent exceptions.

    - **Regular nighttime** means someone is in the home and available to provide assistance during nighttime hours every night with infrequent exceptions.

    - **Occasional/short-term assistance** means someone is available to provide in-person assistance only for a few hours a day or on an irregular basis, or may be only able to help occasionally.

    - **No assistance available** means there is no one available to provide any in-person assistance.

  - Availability of assistance refers to in-person assistance provided in the home of the patient. It includes any type of in-person assistance, including but not limited to ADLs and IADLs. If a person is in a assisted living or congregate setting with a call-bell that summons help, this is considered in-person assistance.

  - The caregiver(s) need not live in the home with the patient, but assistance via telephone is not included in this question.

  - This item documents the time caregiver(s) are in the home and available without regard to the amount or types of assistance the patient requires, or whether the caregiver(s) are able to meet all or only some of the patient's needs. Adequacy of caregiver assistance for different types of needs is captured in M2100.

  - Use your professional judgment to determine if someone will be available to provide any assistance to the patient. If a person is living in the patient's home but is **completely unable to or unwilling to provide any assistance** to the patient, do not count them as a caregiver.

- **Examples:**

  - Patient lives alone in her own apartment. Since her discharge from the hospital, her two daughters alternate staying with her during the day and night so that one of them is always there, except for the times when one goes out to run an errand or pick up a child at day care. Response = 01 *(Patient still considered to be living alone, since daughters are only staying there temporarily. Daughters are providing round-the-clock care, even if one occasionally needs to be out of the house for brief periods.)*

  - Patient lives alone in her home but her son and daughter-in-law live across the street. They bring the patient dinner every night and are available around the clock by telephone. Response = 04 (*Son and daughter-in-law are not there to provide in-person assistance consistently, day or evening, even if they live across the street and are available by phone.)*

  - Patient lives with her daughter who works during the day but is home every evening and sleeps there every night. A paid aide comes in 3 days a week to assist with ADLs. Daughter has back problems that prevent her from lifting patient, but she assists the patient with dressing every morning and takes the patient to doctor's appointments. Response = 08 *(Patient lives in a home with others who are available every night to offer in-person assistance. Even if the daughter can't meet all of patient's needs, she is available all night.)*

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1100)

– Patient lives with her husband who has significant cognitive and functional impairments, is wheel chair bound, and is unable to provide the patient with any assistance. A member of the church comes by one evening a week and brings groceries. Response = 09 *(Patient lives in a home with another person who is there 24 hours but is unavailable to provide assistance. Caregiver from church provides occasional assistance.)*

– Patient lives alone in an apartment that is part of an ALF. The apartment does not have a call-bell but her contract with the ALF includes having a home health aide assist her with ADLs 2 hours every morning. Her son also comes over occasionally to assist with bills, groceries, and errands. Response = 14 *(Patient is living in a congregate setting, One caregiver is available to assist for some part of every day on a regular basis, but not all day, Another caregiver offers occasional assistance.)*

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physical assessment
- Observation
- Referral information
- Assisted Living Facility agreement or contract

Guidance for this item updated 12/18/2009

OASIS ITEM

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

☐ 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.

☐ 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.

☐ 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

ITEM INTENT

Identifies the patient's ability to see and visually manage (function) safely within his/her environment, wearing corrective lenses if these are usually worn.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS

- "Nonresponsive" means that the patient is not able to respond.
- As specified within the OASIS question, only assess functional vision with corrective lenses if the patient usually wears corrective lenses.
- A magnifying glass (as might be used to read newsprint) is not an example of corrective lenses.
- Reading glasses (including "grocery store" reading glasses) are considered to be corrective lenses.
- Assessment strategies: In the health history interview, ask the patient about vision problems (e.g., cataracts) and whether or not the patient uses glasses. Observe ability to locate signature line on consent form, to count fingers at arm's length and ability to differentiate between medications, especially if medications are self-administered. Be sensitive to requests to read, as patient may not be able to read though vision is adequate.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information (e.g., history and physical)

OASIS ITEM

(M1210) Ability to hear (with hearing aid or hearing appliance if normally used):

- ☐ 0 - Adequate: hears normal conversation without difficulty.
- ☐ 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- ☐ 2 - Severely Impaired: absence of useful hearing.
- ☐ UK - Unable to assess hearing.

ITEM INTENT

Identifies the patient's ability to hear spoken language and other sounds (e.g., alarms).

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Hearing is evaluated with the patient wearing hearing aids or devices if he/she usually uses them.
- Select the "UK" response if the patient is not able to respond or if it is otherwise impossible to assess hearing (e.g., severe dementia, schizophrenia, unconscious).
- If evaluating ability to hear with hearing aids, be sure that the devices are in place, turned on, and that the hearing aids are working (i.e., batteries are functional).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information (e.g., history and physical)

OASIS ITEM

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

- ☐ 0 - Understands: clear comprehension without cues or repetitions.
- ☐ 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- ☐ 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- ☐ 3 - Rarely/Never Understands
- ☐ UK - Unable to assess understanding.

ITEM INTENT

Identifies the patient's functional ability to comprehend spoken words and instructions in the patient's primary language. Both hearing and cognitive abilities may impact a patient's ability to understand verbal content.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- The "UK" response should be selected if the patient is not able to respond or if it is otherwise impossible to assess understanding of spoken words and instructions.
- For patients whose primary language differs from the clinician's, an interpreter may be necessary.
- If a patient can comprehend lip reading, they have the ability to understand verbal content, even if they are deaf.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information (e.g., history and physical)
- Interpreter

OASIS ITEM

(M1230) Speech and Oral (Verbal) Expression of Language (in patient's own language):

☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.

☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).

☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.

☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.

☐ 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).

☐ 5 - Patient nonresponsive or unable to speak.

ITEM INTENT

Identifies the patient's physical and cognitive ability to communicate with words in the patient's primary language. The item does not address communicating in sign language, in writing, or by any nonverbal means.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Augmented speech (e.g., a trained esophageal speaker, use of an electrolarynx) **is** considered verbal expression of language.
- Presence of a tracheostomy requires further evaluation of the patient's ability to speak. Can the trach be covered to allow speech? If so, to what extent can the patient express him/herself?
- Select Response 5 for a patient who communicates entirely nonverbally (e.g., by sign language or writing) or is unable to speak.
- "Nonresponsive" means that the patient is not able to respond.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information (e.g., history and physical)
- Interpreter

OASIS ITEM

(M1240) Has this patient had a formal **Pain Assessment** using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)?

- ☐ 0 - No standardized assessment conducted
- ☐ 1 - Yes, and it does not indicate severe pain
- ☐ 2 - Yes, and it indicates severe pain

ITEM INTENT

Identifies if a standardized pain assessment is conducted and whether a clinically significant level of pain is present, as determined by the assessment tool used. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

RESPONSE—SPECIFIC INSTRUCTIONS

- A standardized tool is one that 1) has been scientifically tested on a population with characteristics similar to that of the patient being assessed and shown to be effective in identifying level of pain; and 2) includes a standard response scale (e.g., a scale where patients rate pain from 0-10). The standardized tool must be appropriately administered as indicated in the instructions and must be relevant for the patient's ability to respond. Severe pain is defined according to the scoring system for the standardized tool being used. CMS does not endorse a specific tool.
- If the standardized tool does not define levels of "severe" pain, then the agency or care provider should use the level(s) of pain identified in the standardized tool that best reflect the concept of "severe."
- Select Response 0 if such a tool was not used to assess pain.
- In order to select Response 1 or 2, the pain assessment must be conducted by agency staff during the time frame specified by CMS for completion of the assessment (SOC within 5 days; ROC within 48 hours following inpatient discharge).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physical assessment
- Clinical record
- A variety of standardized pain assessment approaches have been tested and are available for provider use in patient assessment. These approaches include visual analog scales, the Wong-Baker FACES Pain Rating Scale, numerical scales, and the Memorial Pain Assessment Card. Links to these and other assessment tools can be found in Chapter 5 of this manual.

Guidance for this item updated 12/18/2009

OASIS ITEM

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

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

ITEM INTENT

Identifies frequency with which pain interferes with patient's activities, with treatments if prescribed.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Responses are arranged in order of least to most interference with activity or movement.
- Pain interferes with activity when the pain results in the activity being performed less often than otherwise desired, requires the patient to have additional assistance in performing the activity, or causes the activity to take longer to complete.
- When reviewing patient's medications, the presence of medication for pain or joint disease provides an opportunity to explore the presence of pain, when the pain is the most severe, activities with which the pain interferes, and the frequency of this interference with activity or movement. Be careful not to overlook seemingly unimportant activities (for example, the patient says she/he sits in the chair all day and puts off going to the bathroom, because it hurts so much to get up from the chair or to walk). Evaluating the patient's ability to perform ADLs and IADLs can provide additional information about such pain. Assessing pain in a nonverbal patient involves observation of facial expression (e.g., frowning, gritting teeth), monitoring heart rate, respiratory rate, perspiration, pallor, pupil size, irritability, or use of visual pain scales (e.g., FACES). The patient's treatment for pain (whether pharmacologic or nonpharmacologic) must be considered when evaluating whether pain interferes with activity or movement. Pain that is well controlled with treatment may not interfere with activity or movement at all.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation of nonverbal indications of pain
- Physical assessment
- Referral information (e.g., history and physical)
- Standardized pain assessment tools. Links to these tools can be found in Chapter 5 of this manual.

OASIS ITEM

(M1300) Pressure Ulcer Assessment: Was this patient assessed for **Risk of Developing Pressure Ulcers**?

- ☐ 0 - No assessment conducted **[** *Go to M1306* **]**
- ☐ 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
- ☐ 2 - Yes, using a standardized tool, e.g., Braden, Norton, other

ITEM INTENT

Identifies whether the home health agency care providers assessed the patient's risk of developing pressure ulcers. CMS does not require the use of standardized tools, nor does it endorse one particular tool.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

RESPONSE—SPECIFIC INSTRUCTIONS

- Select Response 0 if the patient was not assessed for pressure ulcer risk.
- Select Response 1 if the patient's risk for pressure ulcer development was clinically assessed, but no formal pressure ulcer screening tool was used.
- Select Response 2 only if the patient was screened using a validated standardized screening tool. This is defined as a tool that 1) has been scientifically tested and evaluated with a population with characteristics similar to the patient who is being evaluated and shown to be effective in identifying people at risk for developing pressure ulcers; and 2) includes a standard response scale. The standardized tool must be appropriately administered as indicated in the instructions.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Physician
- See link in Chapter 5 of this manual to the Braden Scale for Predicting Pressure Sore Risk and the Norton Scale

Guidance for this item updated 12/18/2009

OASIS ITEM

(M1302) Does this patient have a **Risk of Developing Pressure Ulcers**?

☐ 0 - No
☐ 1 - Yes

ITEM INTENT

Identifies if the patient is at risk for developing pressure ulcers. This item should be skipped if response 0 was selected for M1300 (no pressure ulcer risk assessment).

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

RESPONSE—SPECIFIC INSTRUCTIONS

- If pressure ulcer risk was assessed using a validated standardized screening tool, use the scoring parameters specified for the tool to identify if a patient is at risk for developing pressure ulcers. If the tool does not define levels of risk or if the evaluation was based on clinical factors (without a validated standardized screening tool), then the agency or care provider may define what constitutes risk.
- A validated standardized screening tool is a tool that 1) has been scientifically tested and evaluated with a population with characteristics similar to the patient who is being evaluated and shown to be effective in identifying people at risk for developing pressure ulcers; and 2) includes a standard response scale. The standardized tool must be appropriately administered as indicated in the instructions.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Physician
- Established, validated pressure ulcer risk tools include the Braden Scale for Predicting Pressure Sore Risk and the Norton Scale. Links can be found in Chapter 5 of this manual.

This page was revised 12/18/2009

OASIS ITEM

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer at Stage II or Higher** or designated as "unstageable"?

☐ 0 - No **[** *Go to M1322* **]**
☐ 1 - Yes

ITEM INTENT

Identifies the presence or absence of unstageable or unhealed **Stage II or higher** pressure ulcers only.

TIME POINTS ITEM(S) COMPLETED

Start of care
Resumption of care
Follow-up
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- The NPUAP definition of pressure ulcer is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
- Select Response 0 – No, if the only pressure ulcer(s) is Stage 1 OR if a former Stage 2 pressure ulcer has healed AND the patient has no other pressure ulcers.
- Select Response 1 – Yes, if the patient has an unhealed Stage II, OR a Stage III, or Stage IV pressure ulcer at any healing status level OR if the patient has an unstageable ulcer(s), defined as:
  - Pressure ulcers that are known to be present or that the care provider suspects may be present based on clinical assessment findings (e.g., patient report of discomfort, past history of skin breakdown in the same area, etc.), but that are unobservable due to dressings or devices (e.g., casts) that cannot be removed to assess the skin underneath.
  - Pressure ulcers that the care provider suspects may be present based on clinical assessment findings (e.g., patient report of discomfort, past history of skin breakdown in the same area), but that cannot be staged due to full thickness tissue loss in which the true wound depth is obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.
  - Suspected deep tissue injury in evolution, which is defined by the NPUAP as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.
- In 2004, based on advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), it was determined that Stage I and Stage II (partial thickness) pressure ulcers can heal through the process of regeneration of the epidermis across a wound surface, known as “epithelialization.”
- Stage III and IV (full thickness) pressure ulcers heal through a process of contraction, granulation, and epithelialization. They can never be considered "fully healed" but they can be considered closed when they are fully granulated and the wound surface is covered with new epithelial tissue.

DATA SOURCES / RESOURCES (cont'd for OASIS Item M1306)

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Physician
- Consult published guidelines of NPUAP for additional clarification and/or resources for training. Other resources can be found in Chapter 5 of this manual.

OASIS ITEM

(M1307) The Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge

☐ 1 - Was present at the most recent SOC/ROC assessment

☐ 2 - Developed since the most recent SOC/ROC assessment:

record date pressure ulcer first identified: __ __ /__ __ /__ __ __ __
month / day / year

☐NA - No non-epithelialized Stage II pressure ulcers are present at discharge

ITEM INTENT

The intent of this item is to a) identify the oldest Stage II pressure ulcer that is present at the time of discharge and is not fully epithelialized, and b) assess the length of time this ulcer remained unhealed while the patient received care from the home health agency and c) identify patients who develop Stage II pressure ulcers while under the care of the agency.

TIME POINTS ITEM(S) COMPLETED

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- THIS ITEM REFERS **ONLY** TO NONEPITHELIALIZED STAGE II PRESSURE ULCERS. DO NOT CONSIDER STAGE III OR IV ULCERS WHEN ANSWERING THIS ITEM.
- Do not reverse stage pressure ulcers.
- Based on advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), it has been determined that Stage II (partial thickness) pressure ulcers can heal through epithelialization (the process of regeneration of the epidermis across a wound surface).
- Select Response 1 if the oldest Stage II pressure ulcer that is not fully epithelialized was already present when the SOC/ROC assessment was completed.
- Select Response 2 if the oldest Stage II pressure ulcer that is not fully epithelialized was first identified since the most recent SOC/ROC visit (i.e., since the last time the patient was admitted to home care or had a resumption of care after an inpatient stay).
- If Response 2 is selected, specify the date of onset. Use two digits to indicate the month (e.g., September is 09), single-digit dates should begin with 0, and use four digits to indicate the year (e.g., September 2, 2009 be 09/02/2009).
- Select Response "NA" if the patient has no Stage II pressure ulcers at the time of discharge, or all Stage II pressure ulcers have been fully epithelialized.
- An ulcer that is suspected of being a Stage II, but is unstageable, should not be identified as the "oldest Stage II pressure ulcer." For this item, "unstageable" refers to pressure ulcers that are known to be present or that the care provider suspects may be present based on clinical assessment findings (e.g., patient report of discomfort, past history of skin breakdown in the same area), but that are unobservable due to dressings or devices (e.g., casts) that cannot be removed to assess the skin underneath.

DATA SOURCES / RESOURCES

• Patient/caregiver interview • Observation • Physical assessment	• Clinical Record • Consult published guidelines of NPUAP for additional clarification and/or resources for training. Other resources can be found in Chapter 5 of this manual.

Guidance for this item updated 12/18/2009

OASIS ITEM

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

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

ITEM INTENT

Identifies the number of Stage II or higher pressure ulcers at each stage present at the time of assessment. Stage I pressure ulcers are not reported in this item.

TIME POINTS ITEM(S) COMPLETED

Start of care – Column 1

Resumption of care – Column 1

Follow-up – Columns 1 and 2

Discharge from agency – not to inpatient facility – Columns 1 and 2

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1308)

- For Column 1, report the number of Stage II or higher pressure ulcers on the current day of assessment. This column must be completed at Start of Care, Resumption of Care, Follow-up, and Discharge.
- For Column 2, report the number of Stage II or higher pressure ulcers that were identified in column 1 and were present on the most recent SOC/ROC. Column 2 is completed only at Follow-up and Discharge.
  - Example 1: Patient has no Stage II pressure ulcers on admission, but develops one during the first episode that is present at the time of follow-up. In this case, row a, column 1 would be "0" at SOC. At follow-up, row a, column 1 would be "1" and row a column 2 would be "0," indicating the pressure ulcer was not present on admission.
  - Example 2: Patient has a Stage III pressure ulcer on admission that is assessed to be a Stage IV at follow-up. In this case, row b, column 1 would be "1" at SOC. At follow-up, row b, columns 1 and 2 would both be "0," as the patient no longer has a Stage III ulcer. Row c, column 1 would be "1" and column 2 would be "1" indicating the ulcer was present on admission, **even though it was at a different stage**.
  - Example 3: Patient has a Stage II pressure ulcer on admission that heals within the first 2 weeks, but then develops another Stage II pressure ulcer prior to discharge at week 4. In this case, row a, column 1 would be "1" at SOC. At Follow-up, row a, column 1 would be "1" and row a, column 2 would be "0", indicating the pressure ulcer that is present at follow up or discharge was not present on admission.

For both Columns 1 and 2:

- Mark a response for each row of this item: a, b, c, d1, d2, and d3. If there are NO ulcers at a given stage, enter "0" for that stage.
- **Stage I and II ulcers**
  - Stage I and II pressure ulcers are described as "partial thickness" ulcers. Based on advances in wound care research and the opinion of the National Pressure Ulcer Advisory Panel (NPUAP), it has been determined that Stage I and Stage II (partial thickness) pressure ulcers can heal through the process of regeneration of the epidermis across a wound surface known as "epithelialization."
  - Stage I ulcers are not reported in this item.
  - Stage II ulcers that have healed are not reported in this item.
- **Stage III and IV ulcers**
  - Stage III and IV ulcers are described as "full thickness" ulcers. Stage IV ulcers involve full thickness skin loss with extensive destruction accompanied by tissue necrosis with damage to muscle, bone, tendon, or joint capsule. Stage III and IV (full thickness) pressure ulcers close through a process of granulation, contraction, and epithelialization. They can never be considered "fully healed" but they can be considered closed when they are fully granulated and the wound surface is covered with new epithelial tissue.
  - Reverse staging of granulating Stage III and Stage IV pressure ulcers is NOT an appropriate clinical practice according to the NPUAP. If a pressure ulcer is Stage III at SOC and is granulating at the follow-up visit, the ulcer remains a Stage III ulcer.
  - Although the wording in M1308 includes the term "non epithelialized," for this item, a closed Stage III or Stage IV pressure ulcer should be reported as a pressure ulcer at its worst stage, even if it has re-epithelialized.
  - A previously closed Stage III or Stage IV pressure ulcer **that is currently open again** should also be reported at its worst stage.
  - If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it challenging to know the stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient's physician) to determine the stage of the wound at its worst. An ulcer's stage can worsen, and this item should be answered appropriately if this occurs.

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1308)

- A muscle flap, skin advancement flap, or rotational flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer. A pressure ulcer that has been surgically debrided remains a pressure ulcer. It does not become a surgical wound. Response d.1 refers to pressure ulcers that are known to be present or that the care provider suspects may be present based on clinical assessment findings (e.g., patient report of discomfort, past history of skin breakdown in the same area), but that are unstageable due to dressings or devices (e.g., casts) that cannot be removed to assess the skin underneath. The number of pressure ulcers meeting this definition should be counted to determine the response to d.1.
- Response d.2 refers to pressure ulcers that the care provider suspects may be present based on clinical assessment findings (e.g., patient report of discomfort, past history of skin breakdown in the same area), but cannot be staged due to full thickness tissue loss in which the true wound depth is obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. The number of pressure ulcers meeting this definition should be counted to determine the response to d.2.
- Response d.3 refers to a suspected deep tissue injury in evolution, which is defined by the NPUAP as a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue. The number of pressure ulcers meeting this definition should be counted to determine the response to d.3. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Clinical record
- Referral documentation
- Physician
- Consult published guidelines of NPUAP for additional clarification and/or resources for training. Resources and links can be found in Chapter 5 of this manual.
- See Chapter 5 of this manual for NPUAP staging illustrations.

Guidance for this item updated 12/18/2009

OASIS ITEM

Directions for M1310, M1312, and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the **Stage III or IV pressure ulcer with the largest surface dimension (length x width)** and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320.

(M1310) Pressure Ulcer Length: Longest length "head-to-toe" | ___ | ___ | . | ___ | (cm)

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

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

(M1314) Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area

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

ITEM INTENT

Identifies the length, width, and depth of the pressure ulcer with the largest surface area (length x width) that is also an unhealed Stage III or IV pressure ulcer or pressure ulcer unstageable due to the presence of slough or eschar (as reported in M1308 d.2).

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

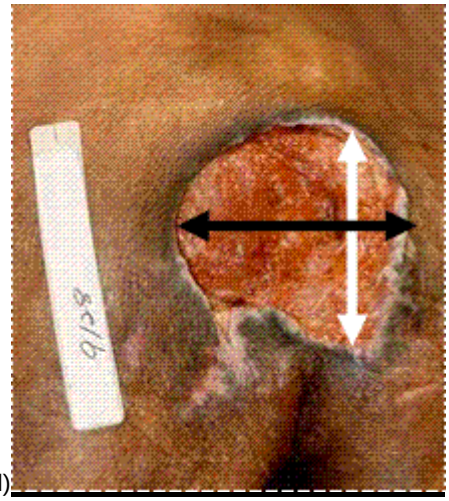
- Complete these items only if M1308 Column 1, rows b, c, or d.2 is greater than 0. Otherwise, leave these items blank.
- Identify the pressure ulcer reported in M1308, Column 1, rows b, c, or d.2, with the largest surface dimension (length x width) and record in centimeters.
- If all existing Stage III or IV pressure ulcers are closed (completely re-epithelialized) and the patient has no pressure ulcers that are unstageable due to coverage of the wound bed by slough and/or eschar, enter 00.0 for M1310, M1312, and M1314.
- Measure every existing non-epithelialized stage III or IV pressure ulcer or pressure ulcer that is unstageable due to the presence of slough or eschar (as reported in M1308 d.2) to determine which has the largest surface dimension (length x width). Depth should not be considered in determining which pressure ulcer is largest.
- Once the largest pressure ulcer has been determined, report length (M1310), width (M1312), and depth (M1314) dimensions for that pressure ulcer. Depth for a wound covered/filled with eschar can be entered as 00.0.
- Measurement should be based on observation of the pressure ulcer after the dressing and any exudate are removed.
- To measure pressure ulcers, use a disposable measuring device, a cotton-tipped applicator, a camera, or other wound technology that calculates measurements. If using a cotton-tipped applicator, mark on the applicator the distance between healthy skin tissue at each margin and lay the applicator next to a centimeter ruler to determine length, width, and depth. Round the measurement to the nearest tenth of a centimeter.

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Items M1310, M1312, and M1314)

- Any wound or pressure ulcer that you are able to visualize even if all you see is a wound bed that is 100% covered with slough/eschar needs to be measured.
- Determine longest length head to toe (white line) and longest width (black line) of each pressure ulcer (see picture below). Width is measured at the widest width perpendicular (i.e., at a 90 degree angle) to the length forming a cross, side to side).

(picture attached)



DATA SOURCES / RESOURCES

- Observation
- Physical assessment

Guidance for this item updated 12/18/2009

OASIS ITEM

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

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

ITEM INTENT

Identifies the degree of closure visible in the most problematic observable pressure ulcer, stage II or higher. Please note, Stage I pressure ulcers are not considered for this item.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Determine the most problematic pressure ulcer. Visualization of the wound is necessary to identify the degree of healing evident in the ulcer identified in M1320.
- "Most problematic" may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.
- If the patient has only one observable pressure ulcer, then that ulcer is the most problematic.
- Mark the response that most accurately describes the healing process you see occurring in the most problematic pressure ulcer.
- Stage III and IV pressure ulcers close by contraction, granulation, and epithelialization. Epithelialization is regeneration of the epidermis across a wound surface.
- Mark response 0 – Newly epithelialized – when epithelial tissue has completely covered the wound surface of the pressure ulcer, regardless of how long the pressure ulcer has been re-epithelialized. This is an appropriate response for Stage III and IV pressure ulcers, but not for Stage II ulcers as fully epithelialized Stage II ulcers should not be reported.
- Response 1 – Fully Granulating – is the appropriate response for a Stage III or IV pressure ulcer that is fully granulated, but epithelial tissue has not completely covered the wound surface.
- Because Stage II ulcers do not granulate and newly epithelialized Stage II ulcers are not counted, the only appropriate response for Stage II ulcers is 3 – Not healing.
- The healing status of deep tissue injury in evolution should always be considered not healing.
- "No observable" pressure ulcer includes only those that cannot be observed due to the presence of a dressing or device that cannot be removed (including casts). (When determining the healing status of a pressure ulcer for answering M1320, the presence of necrotic tissue does NOT make the pressure ulcer NA – No observable pressure ulcer.)
- A pressure ulcer with necrotic tissue (eschar/slough) obscuring the wound base cannot be staged, but its healing status is either Response 2 – Early/partial granulation if necrotic or avascular tissue covers <25% of the wound bed, or Response 3 - Not healing, if the wound has ≥25% necrotic or avascular tissue.

Guidance for this item updated 12/18/2009

DATA SOURCES / RESOURCES (cont'd for OASIS Item M1320)

- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- Additional resources for the WOCN, the NPUAP, and the NQF can be found in Chapter 5 of this manual.

Guidance for this item updated 12/18/2009

OASIS ITEM

(M1322) Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

ITEM INTENT

Identifies the presence of Stage I pressure ulcers.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- NPUAP defines a stage I ulcer as follows: “Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.”
- **Further description: “**The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).”

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- See Chapter 5 of this manual for more information regarding NPUAP staging illustrations.

OASIS ITEM

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

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

ITEM INTENT

Identifies the stage of the most problematic observable Stage 1 or higher pressure ulcer. Definitions of pressure ulcer stages derived from the National Pressure Ulcer Advisory Panel.

TIME POINTS ITEM(S) COMPLETED

Start of Care
Resumption of Care
Follow-up
Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Determine the most problematic pressure ulcer. Visualization of the wound base is necessary to identify the degree of healing evident in the ulcer.
- "Most problematic" may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.
- Mark the response that most accurately describes the stage of the most problematic pressure ulcer.
- If the patient has only one observable pressure ulcer, then that ulcer is the most problematic.
- Use the NPUAP definitions to determine the stage of the most problematic pressure ulcer.
- Select "NA" if the patient has NO pressure ulcers or has pressure ulcers that cannot be observed due to the presence of necrotic tissue (including eschar or slough) that obscures visualization of the wound base, or a dressing or device that cannot be removed (e.g., a cast).
- Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel (NPUAP). If a pressure ulcer is Stage III at SOC and is granulating at the follow-up visit, the ulcer remains a Stage III ulcer. A healed Stage III or Stage IV pressure ulcer continues to be regarded as a pressure ulcer at its worst stage. However, an unhealed active ulcer at a lower stage may be the most problematic ulcer. A previously healed Stage III or Stage IV pressure ulcer that breaks down again should be staged at its worst stage.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral documentation
- Review of health history
- Physician
- See Chapter 5 of this manual for links to published guidelines of NPUAP, NPUAP staging illustrations, and WOCN guidelines.

OASIS ITEM

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

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

ITEM INTENT

Identifies patients with ulcers caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis.

Stasis ulcers DO NOT include arterial lesions or arterial ulcers. If the home health clinician conducting the assessment is not sure the wound fits the definition of a stasis ulcer, the clinician should contact the physician for clarification.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- A response of "Yes" identifies the presence of an ulcer caused by inadequate venous circulation in the area affected (usually lower legs).
- It is important to differentiate stasis ulcers from other types of skin lesions, and only report stasis ulcers in this item.
- Select Response 1 if the patient has both an observable stasis ulcer AND a reported stasis ulcer that cannot be observed because of a cast or dressing (e.g., Unna boot) that cannot be removed. Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.
- Select Response 3 ONLY if the patient has a reported stasis ulcer that cannot be observed because of a cast or dressing (e.g., Unna boot) that cannot be removed, and has no observable stasis ulcers. Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician
- Physician's orders
- Referral information
- Review of health history
- Observation
- Physical assessment
- A link to the Clinical Fact Sheet – Quick Assessment of Leg Ulcers can be found in Chapter 5 of this manual.

OASIS ITEM

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

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

ITEM INTENT

Identifies the number of visible (observable) stasis ulcers.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- All stasis ulcers except those that are covered by a nonremovable dressing or cast are considered observable.

DATA SOURCES / RESOURCES

- Observation
- Physical Assessment
- Review of health history
- Physician
- Referral information

OASIS ITEM

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

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

ITEM INTENT

Identifies the degree of healing present in the most problematic, observable stasis ulcer. The "most problematic" ulcer may be the largest, the most resistant to treatment, an ulcer that is infected, etc., depending on the specific situation.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- If the patient has only one stasis ulcer, that ulcer is the most problematic.
- Newly epithelialized refers to stasis ulcers that have been covered with epithelial tissue.

DATA SOURCES / RESOURCES

- Observation
- Physical Assessment
- Review of health history
- To determine healing status of the stasis ulcer, further resource links can be found in Chapter 5 of this manual.

OASIS ITEM

(M1340) Does this patient have a **Surgical Wound?**

☐ 0 - No **[** *Go to M1350* **]**
☐ 1 - Yes, patient has at least one (observable) surgical wound
☐ 2 - Surgical wound known but not observable due to non-removable dressing **[** *Go to M1350* **]**

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Old surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds and should not be included in this item.
- If the patient has both an observable and an unobservable wound, the best response is 1 – Yes, patient has at least one (observable) surgical wound).
- Select Response 2 if a wound is not observable. A wound is considered not observable if it is covered by a dressing (or cast) which is not to be removed **per physician order**.
- For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection. After 30 days, it is generally described as a scar and should not be included in this item. If the home health clinician conducting the assessment is not sure the wound fits the definition of a surgical incision, the clinician should contact the physician for clarification.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer. It <u>does not</u> become a surgical wound.
- A muscle flap, skin advancement flap, or rotational flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer.
- Debridement or the placement of a skin graft does not create a surgical wound, as these are treatments performed to an existing wound. The wound would continue to be defined as the type of wound previously identified.
- A bowel ostomy is excluded as a surgical wound, unless a "take-down" procedure of a previous bowel ostomy is performed, in which case the surgical take-down produces a surgical wound. A bowel ostomy being allowed to close on its own is excluded as a surgical wound.
- All other ostomies are excluded from consideration under this item and should not be counted as surgical wounds. There are many types of "ostomies," all of which involve a surgically formed opening from outside the body to an internal organ or cavity. A suprapubic tube site is a cystostomy; an ileal conduit opens to the skin as a urostomy; etc. These may be reported in M1350 if they are receiving intervention from the home health agency.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1340)

- Orthopedic pin sites, central line sites, stapled or sutured incisions, and wounds with drains are all considered surgical wounds. Medi-port sites and other implanted infusion devices or venous access devices are considered surgical wounds.
- A PICC line is NOT a surgical wound, as it is peripherally inserted.
- Cataract surgery of the eye, surgery to the mucosal membranes, or a gynecological surgical procedure via a vaginal approach does not create a surgical wound for the purpose of this item.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- See Chapter 5 of this manual for resource links.

OASIS ITEM

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

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

ITEM INTENT

Identifies the degree of healing present in the most problematic, observable surgical wound.

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

Follow-up

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- If the patient has only one observable surgical wound, that wound is the most problematic. The "most problematic" surgical wound may be the largest, the most resistant to treatment, an infected surgical wound, etc., depending on the specific situation.
- For the purpose of this OASIS item, a surgical site closed primarily (with sutures, staples, or a chemical bonding agent) is generally described in documentation as a surgical wound until re-epithelialization has been present for approximately 30 days, unless it dehisces or presents signs of infection. After 30 days, it is generally described as a scar.
- Select Response 0 for implanted venous access devices and infusion devices when the insertion site is healed. Epithelialization is regeneration of the epidermis across a wound surface.
- At follow-up, skip this item if the patient no longer has surgical wounds(s).

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician
- Links to the Wound, Ostomy, and Continence Nurses' guidelines are provided in Chapter 5 of this manual.

OASIS ITEM

(M1350) Does this patient have a **Skin Lesion** or **Open Wound,** excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency?

☐ 0 - No

☐ 1 - Yes

ITEM INTENT

Identifies the presence or absence of a skin lesion or open wound NOT ALREADY ADDRESSED IN PREVIOUS ITEMS **that is receiving clinical assessment or intervention from the home health agency**.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- A lesion is a broad term used to describe an area of pathologically altered tissue. Sores, skin tears, burns, ulcers, rashes, etc., are all considered lesions. All alterations in skin integrity are considered to be lesions, except for bowel ostomies (which are reported in OASIS item M1630). Persistent redness without a break in the skin is also considered a lesion.
- Skin lesions or open wounds that are not receiving clinical intervention from the home health agency should not be considered when responding to this question.
- If the patient has any skin condition that is being clinically assessed on an ongoing basis as indicated on the home health agency's plan of care (e.g., wound measurements), then the lesion or wound is receiving clinical intervention and this item should be answered "Yes."
- Response 1 – Yes refers to those types of other wounds NOT described in detail by other specific OASIS items (burns, diabetic ulcers, cellulitis, abscesses, wounds caused by trauma of various kinds, etc.).
- PICC line and peripheral IV sites are considered skin lesions / open wounds.
- Ostomies, other than bowel ostomies, (e.g., tracheostomy, thoracostomy, urostomy) ARE considered to be skin lesions or open wounds if clinical interventions (e.g., cleansing, dressing changes) are being provided by the home health agency during the home health care episode.
- This item does not address cataract surgery of the eye, surgery to mucosal membranes, or gynecological surgical procedures by a vaginal approach.
- This item does not include tattoos, piercings, and other skin alterations unless ongoing assessment and/or clinical intervention by the home health agency is a part of the planned/provided care.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical Assessment
- Referral documentation
- Review of health history
- Physician

OASIS ITEM

(M1400) When is the patient dyspneic or noticeably **Short of Breath**?

- ☐ 0 - Patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

ITEM INTENT

Identifies the level of exertion/activity that results in a patient's dyspnea or shortness of breath.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- If the patient uses oxygen continuously, select the response based on assessment of the patient's shortness of breath while using oxygen. If the patient uses oxygen intermittently, mark the response based on the patient's shortness of breath WITHOUT the use of oxygen.
- The responses represent increasing severity of shortness of breath.
- For a chairfast or bedbound patient, evaluate the level of exertion required to produce shortness of breath. The chairfast patient can be assessed for level of dyspnea while performing ADLs or at rest. Response 0 would apply if the patient has not been short of breath during the day of assessment. Response 1 would be appropriate if demanding bed-mobility activities produce dyspnea in the bedbound patient (or physically demanding transfer activities produce dyspnea in the chairfast patient). See Responses 2, 3, and 4 for assessment examples for these patients as well as ambulatory patients.

DATA SOURCES / RESOURCES

- Observation
- Physical assessment
- Patient/caregiver interview
- Review of health history

OASIS ITEM

(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

ITEM INTENT

Identifies any of the listed respiratory treatments being used by this patient in the home.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Excludes any respiratory treatments that are not listed in the item (e.g., does not include nebulizers, inhalers).
- Option 3 reflects both CPAP and BiPAP.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physician's orders
- Referral information
- Review of health history

OASIS ITEM

(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (such as dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment?

☐ 0 - No **[** ***Go to M2004 at TRN; Go to M1600 at DC*** **]**

☐ 1 - Yes

☐ 2 - Not assessed **[*Go to M2004 at TRN; Go to M1600 at DC*]**

☐ NA - Patient does not have diagnosis of heart failure **[*Go to M2004 at TRN; Go to M1600 at DC*]**

ITEM INTENT

Identifies whether a patient with a diagnosis of heart failure experienced one or more symptoms of heart failure at the time of the most recent OASIS assessment or since that time.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices/assessments stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Transfer to inpatient facility

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Select only response options 0, 1, or 2 if the patient has a diagnosis of heart failure in any one or all of:
  - M1010: Inpatient Diagnoses,
  - M1016: Diagnoses Causing Change in Treatment, or
  - M1020/1022/1024: Primary/Secondary diagnoses for home care.
- Select "NA" if the patient does not have a diagnosis of heart failure.
- Consider any new or ongoing heart failure symptoms that occurred at the time of the previous OASIS assessment or since that time.

DATA SOURCES / RESOURCES

- Review of clinical record including physical assessment data, weight trends, clinical notes using HHA systems put into place to accomplish such a review (e.g., flow sheets, reports from electronic health record data).
- A complete list of symptoms of heart failure can be found in clinical heart failure guidelines in Chapter 5 of this manual.

Guidance for this item updated 12/18/2009

OASIS ITEM

(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? **(Mark all that apply.)**

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

ITEM INTENT

Identifies actions the home health care providers took in response to symptoms of heart failure that occurred at the time of the most recent OASIS assessment or since that time. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Transfer to an inpatient facility

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Include any actions that were taken at least one time at the time of the last OASIS assessment or since that time.
- If the interventions are not completed as outlined in this item, select Response 0 – No action taken. However, in this case, the care provider should document rationale in the clinical record.
- If Response 0 is selected, none of the other responses should be selected.
- Response 1 includes communication to the physician or primary care practitioner made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status. Response 1 is an appropriate response only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions. In many situations, other responses also will be marked that indicate the action taken as a result of the contact (i.e., any of responses 2-5).
- Response 3 would be the best response for a situation in which either the home care clinician reminds the patient to implement or is aware that the patient is following physician-established parameters for treatment

DATA SOURCES / RESOURCES

- Review of clinical record including physical assessment data, weight trends, clinical notes, etc., at the time of the previous OASIS assessment or since that time.
- Physician-ordered home health plan of care
- Examples of standard clinical guidelines can be found in Chapter 5 of this manual.

OASIS ITEM

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

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

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care or discharge. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any treatment for a UTI occurring on or after August 6 would be considered.
- Unknown is not an option at discharge from agency.
- Select Response 0 – No, if patient has not been treated for a UTI within the past two weeks, including if the patient had symptoms of a UTI or a positive culture for which the physician did not prescribe treatment, or the treatment ended more than 14 days ago.
- Select Response 1 – Yes, when the patient has been prescribed an antibiotic within the past 14 days specifically for a confirmed or suspected UTI.
- Select Response 1 – Yes, if the patient is on prophylactic treatment and develops a UTI.
- Select Response NA – if the patient is on prophylactic treatment to prevent UTIs.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician orders
- Review of health history
- Referral information
- Physician
- Medication list

OASIS ITEM

(M1610) Urinary Incontinence or Urinary Catheter Presence:

☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[** *Go to M1620* **]**

☐ 1 - Patient is incontinent

☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[** *Go to M1620* **]**

ITEM INTENT

Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling. The etiology (cause) of incontinence is not addressed in this item.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Select Response 0 if the patient has anuria or an ostomy for urinary drainage (e.g., an ileal conduit), or if the patient has a urinary diversion that is pouched (ileal conduit, urostomy, ureterostomy, nephrostomy), with or without a stoma.
- Select Response 1 if the patient is incontinent AT ALL (i.e., “occasionally,” “only when I sneeze,” “sometimes I leak a little bit,” etc.).
- Select Response 1 if the patient is incontinent or is dependent on a timed-voiding program. Timed voiding is defined as scheduled toileting assistance or prompted voiding to manage incontinence based on identified patterns. Time voiding is a compensatory strategy; it does not cure incontinence.
- Select Response 2 if a catheter or tube is utilized for drainage (even if catheterizations are intermittent).
- Select Response 2 if the patient requires the use of a urinary catheter for any reason (e.g., retention, post-surgery, incontinence). Select Response 2 and follow the skip pattern if the patient is <u>both</u> incontinent and requires a urinary catheter.
- A leaking urinary drainage appliance is not incontinence.
- Assessment strategies: Review the urinary elimination pattern as you take the health history. Does the patient admit having difficulty controlling the urine, or is he/she embarrassed about needing to wear a pad so as not to wet on clothing? Do you have orders to change a catheter? Is your stroke patient using an external catheter? Be alert for an odor of urine, which might indicate there is a problem with bladder sphincter control. If the patient receives aide services for bathing and/or dressing, ask for input from the aide (at follow-up assessment). This information can then be discussed with the patient. Urinary incontinence may result from multiple causes, including physiologic reasons, cognitive impairments, or mobility problems.

DATA SOURCES / RESOURCES (cont'd for OASIS Item M1610)

- Patient/caregiver interview
- Observation
- Physical assessment
- Physician orders
- Review of health history
- Referral information

OASIS ITEM

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

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - Occasional stress incontinence
- ☐ 2 - During the night only
- ☐ 3 - During the day only
- ☐ 4 - During the day and night

ITEM INTENT

Identifies when the urinary incontinence occurs.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Select Response 0 if timed-voiding defers incontinence. Timed voiding determines the patient's pattern for voiding and schedules toileting to prevent episodes of leaking. The patient can self-schedule toileting or the caregiver can prompt or bring the patient to the toilet. Time voiding is a compensatory strategy; it does not cure incontinence. If timed voiding does not defer incontinence, do not select Response 0.
- Select Response 1 – Occasional stress incontinence - when the patient is unable to prevent escape of relatively small amounts of urine when coughing, sneezing, laughing, lifting, moving from sitting to standing position, or other activities (stress), which increase abdominal pressure.
- If urinary incontinence happens with regularity or in other circumstances than those described in the definition of stress incontinence, determine when the incontinence usually occurs and select Response 2, 3, or 4 as appropriate.
- Select Response 2 – During the night only – when the patient's incontinence occurs while the patient is sleeping at night.
- Select Response 3 – During the day only – when the patient's incontinence occurs while the patient is up/awake during the day. Includes incontinence during daytime naps.
- Select Response 4 – During the day and night – when the patient is incontinent when sleeping at night and up/awake during the day.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Review of health history
- Referral information

OASIS ITEM

(M1620) Bowel Incontinence Frequency:

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

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Responses are arranged in order of least to most frequency of bowel incontinence.
- Response 4 – On a daily basis – indicates that the patient experiences bowel incontinence once per day.
- Response NA is used if patient has an ostomy for bowel elimination.
- Unknown is not an option at follow-up or discharge.
- Assessment strategies: Review the bowel elimination pattern as you take the health history. Observe the cleanliness around the toilet when you are in the bathroom. Note any visible evidence of soiled clothing. Ask the patient if she/he has difficulty controlling stools, has problems with soiling clothing, uncontrollable diarrhea, etc. The patient's responses to these items may make you aware of an as yet unidentified problem that needs further investigation. If the patient is receiving aide services, question the aide about evidence of bowel incontinence at follow-up time points. This information can then be discussed with the patient. Incontinence may result from multiple causes, including physiologic reasons, mobility problems, or cognitive impairments.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Review of health history
- Referral information

OASIS ITEM

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

☐ 0 - Patient does not have an ostomy for bowel elimination.

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

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

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS

- Applies to any type of ostomy for bowel elimination (e.g., colostomy, ileostomy). This item only addresses bowel ostomies, not other types of ostomies (e.g., urinary ostomies, tracheostomies).
- If an ostomy has been reversed, then the patient does not have an ostomy at the time of assessment.
- If patient does not have an ostomy for bowel elimination, select Response 0 – Patient does not have an ostomy for bowel elimination.
- If the patient does have an ostomy for bowel elimination, determine whether the ostomy was related to an inpatient stay or necessitated a change in the medical or treatment regimen within the last 14 days.
- The term “past fourteen days” is the two-week period immediately preceding the start/resumption of care or follow-up assessment. This means that for purposes of counting the 14-day period, the date of admission/assessment is day 0 and the day immediately prior to the date of admission/assessment is day 1. For example, if the patient’s SOC date is August 20, any ostomy related to an inpatient stay or requiring medical or treatment regimen change that occurred on or after August 6 would be considered.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Physician orders
- Review of health history
- Referral information
- Physician
- Supplies list

OASIS ITEM

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

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

ITEM INTENT

Identifies the patient's current (at the time of the assessment and in the preceding 24 hours) level of cognitive functioning, including alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Responses progress from no impairment to severely impaired.
- Consider the patient's signs/symptoms of cognitive dysfunction that have occurred over the past 24 hours.
- Consider the amount of supervision and care the patient has required due to cognitive deficits.
- Patients with diagnoses such as dementia, delirium, development delay disorders, mental retardation, etc., will have various degrees of cognitive dysfunction. Consider the degree of impairment.
- Patients with neurological deficits related to stroke, mood/anxiety disorders, or who receive opioid therapy may have cognitive deficits.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Links to cognitive assessment tools can be found in Chapter 5 of this manual.
- Review of past health history
- Physician

OASIS ITEM

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

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

ITEM INTENT

Identifies the time of day or situations when the patient experienced confusion, if at all.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- This item may not relate directly to Item M1700. Assess specifically for confusion in the past 14 days.
- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care or discharge. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any confusion occurring on or after August 6 would be considered.
- If it is reported that the patient is "occasionally" confused, identify the situation(s) in which confusion has occurred within the last 14 days, if at all.
- "Nonresponsive" means that the patient is unable to respond or the patient responds in a way that you can't make a clinical judgment about the patient's level of orientation.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Review of past health history
- Physician
- Links to a resource for patients with Alzheimer's disease or dementia can be found in Chapter 5 of this manual.

OASIS ITEM

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

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

ITEM INTENT

Identifies the frequency with which the patient has felt anxious within the past 14 days.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Anxiety includes:
  - Worry that interferes with learning and normal activities,
  - Feelings of being overwhelmed and having difficulty coping, or
  - Symptoms of anxiety disorders.
- Responses appear in order of increasing frequency of anxiety.
- "Nonresponsive" means that the patient is unable to respond.
- The term "past fourteen days" is the two-week period immediately preceding the start/resumption of care. This means that for purposes of counting the 14-day period, the date of admission is day 0 and the day immediately prior to the date of admission is day 1. For example, if the patient's SOC date is August 20, any anxiety occurring on or after August 6 would be considered.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Review of recent (past 14 days) health history
- Physician
- Links to standardized anxiety screening tools can be found in Chapter 5 of this manual.

OASIS ITEM

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

☐ 0 - No

☐ 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

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

☐ 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.

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

ITEM INTENT

Identifies if the home health agency screened the patient for depression using a standardized depression screening tool. CMS does not mandate that clinicians conduct depression screening for all patients, nor is there a mandate for the use of the PHQ-2© or any other particular standardized tool. This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Depressive feelings, symptoms, and/or behaviors may be observed by the clinician or reported by the patient, family, or others.
- To meet the definition of "standardized," the depression screening tool must 1) be scientifically tested on a population with characteristics similar to that of the patient being assessed and shown to be effective in identifying people with depression; and 2) include a standard response scale. The standardized tool must be appropriately administered as indicated in the instructions.
- If a standardized depression screening tool is used, use the scoring parameters specified for the tool to identify if a patient meets criteria for further evaluation of depression.
- Select Response 0 if a standardized depression screening was not conducted.
- Select Response 1 if the PHQ-2© is completed when responding to the question. (The results for rows a & b are for agency use only and will not be encoded and transmitted with OASIS data.) If the patient/caregiver scores three points or more on the PHQ-2©, then further depression screening is indicated.

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1730)

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

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Physician
- A link with more information on the PHQ–2© can be found in Chapter 5 of this manual.
- There are many depression screening tools available. Links to several tools can be found in Chapter 5 of this manual.

Guidance for this item updated 12/18/2009

OASIS ITEM

(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 (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

ITEM INTENT

Identifies specific behaviors associated with significant neurological, developmental, behavioral or psychiatric disorders.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Behaviors may be observed by the clinician or reported by the patient, family, or others.
- Include behaviors which are severe enough to
  - make the patient unsafe to self or others,
  - cause considerable stress to the caregivers, or
  - require supervision or intervention.
- If Response 7 is selected, none of the other responses should be selected.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Physician
- Links to standardized cognitive screening tools can be found in Chapter 5 of this manual.

OASIS ITEM

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

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

ITEM INTENT

Identifies frequency of any behaviors that are disruptive or dangerous to the patient or the caregivers.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Consider if the patient has any problematic behaviors – not just the behaviors listed in M1740 – which jeopardize or could jeopardize the safety and well-being of the patient or caregiver. Then consider how frequently these behaviors occur.
- Include behaviors considered symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders. Use clinical judgment to determine if the degree of the behavior is disruptive or dangerous to the patient or caregiver.
- Behaviors can be observed by the clinician or reported by the patient, family, or others.
- Examples of disruptive/dangerous behaviors include sleeplessness, “sun-downing,” agitation, wandering, aggression, combativeness, getting lost in familiar places, etc.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Physical assessment
- Referral information
- Review of past health history
- Physician
- Links to additional information sources can be found in Chapter 5 of this manual.

OASIS ITEM

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

☐ 0 - No

☐ 1 - Yes

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Observation
- Referral information
- Physician orders/plan of care
- Clinical record
- HHAs may elect to reference Section 40.1.2.15 of Chapter 7 in the Medicare Benefit Policy Manual for additional information

OASIS ITEM

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

- ☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- ☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- ☐ 2 - Someone must assist the patient to groom self.
- ☐ 3 - Patient depends entirely upon someone else for grooming needs.

ITEM INTENT

Identifies the patient's ability to tend to personal hygiene needs, excluding bathing, shampooing hair, and toileting hygiene.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely perform grooming, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., accessing grooming aids, mirror and sink)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.
- The grooming scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is currently able to do.
- Grooming includes several activities. The frequency with which selected activities are necessary (i.e., washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more frequently performed activities (e.g. washing hands and face) but unable to do less frequently performed activities (trimming fingernails) should be considered to have more ability in grooming.
- In cases where a patient's ability is different for various grooming tasks, select the response that best describes the patient's level of ability to perform the majority of grooming tasks.
- Response 2 includes standby assistance or verbal cueing.

DATA SOURCES / RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1810) Current **Ability to Dress <u>Upper</u> Body** safely (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
☐ 2 - Someone must help the patient put on upper body clothing.
☐ 3 - Patient depends entirely upon another person to dress the upper body.

ITEM INTENT

Identifies the patient's ability to dress upper body, including the ability to obtain, put on and remove upper body clothing. Assess ability to put on whatever clothing is routinely worn. This specifically includes the ability to manage zippers, buttons, and snaps if these are routinely worn.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely dress the upper body, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Prosthetic, orthotic, or other support devices applied to the upper body (e.g., upper extremity prosthesis, cervical collar, or arm sling) should be considered as upper body dressing items.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.
- The ability to dress upper body scale presents the most independent level first then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.
- In cases where a patient's ability is different for various dressing upper body tasks, pick the response that best describes the patient's level of ability to perform the majority of dressing upper body tasks.
- If the patient requires standby assistance (a "spotter") to dress <u>safely</u> or requires verbal cueing/reminders, select Response 2.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1810)

- Assessment strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has difficulty dressing upper body. Observe the patient's general appearance and clothing to determine if the patient has been able to dress appropriately. Opening and removing upper body garments during the physical assessment of the heart and lung provides an excellent opportunity to evaluate the upper extremity range of motion, coordination, and manual dexterity needed for dressing. The patient can also be asked to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

DATA SOURCES / RESOURCES

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

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

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

ITEM INTENT

Identifies the patient's ability to dress lower body, including the ability to obtain, put on and remove lower body clothing. Assess ability to put on whatever clothing is routinely worn.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely dress the lower body, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Prosthetic, orthotic, or other support devices applied to the lower body (e.g., lower extremity prosthesis, ankle-foot orthosis [AFO], or TED hose) should be considered as lower body dressing items.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.
- The ability to dress lower body scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.
- In cases where a patient's ability is different for various dressing lower body tasks, pick the response that best describes the patient's level of ability to perform the majority of dressing lower body tasks.
- If the patient requires standby assistance (a "spotter") to dress safely or verbal cueing/reminders, select Response 2.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. The patient can report the lower body dressing procedure. Observe spinal flexion, joint range of motion, shoulder and upper arm strength, and manual dexterity during the assessment. Ask the patient to demonstrate the body motions involved in dressing. Assess ability to put on whatever clothing is routinely worn.

DATA SOURCES / RESOURCES (cont'd for OASIS Item M1820)

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

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

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

ITEM INTENT

Identifies the patient's ability to bathe entire body and the assistance that may be required to safely bathe, including transferring in/out of the tub/shower. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely bathe, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Specifically excludes washing face and hands, and shampooing hair.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.
- The bathing scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.
- If the patient requires standby assistance to bathe safely in the tub or shower or requires verbal cueing/reminders, then select Response 2 or Response 3, depending on whether the assistance needed is intermittent ("2") or continuous ("3").

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1830)

- If the patient's ability to transfer into/out of the tub or shower is the only bathing task requiring human assistance, select Response 2. If a patient requires one, two, or all three of the types of assistance listed in Response 2 of M1830 but not the continuous presence of another person as noted in Response 3, then Response 2 is the best response.
- If a patient is medically restricted from stair climbing, and the only tub/shower requires climbing stairs, the patient is temporarily unable to bathe in the tub or shower due to combined medical restrictions and environmental barriers. Responses 4, 5, or 6 would apply, depending on the patient's ability to participate in bathing activities. For Response 4, the patient must be able to safely and independently bathe outside the tub/shower, including independently accessing water at the sink, or setting up basin at the bedside, etc. For Response 5, the patient must be unable to bathe in the tub/shower, can participate in bathing self but needs assistance.
- If the patient does not have a tub or shower in the home, or if the tub/shower is nonfunctioning or not safe for patient use, the patient should be considered unable to bathe in the tub or shower, select Response 4 or 5, based on the patient's ability to bathe outside the tub/shower. The patient's status should not be based on an assumption of a patient's ability to perform a task with equipment they do not currently have.
- If the patient is totally unable to participate in bathing and is totally bathed by another person, select Response 6 regardless of where bathing occurs or if patient has a functioning tub or shower.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient what type of assistance is needed to wash entire body in tub or shower. Observe the patient's general appearance to determine if the patient has been able to bathe self as needed. Observe patient actually stepping into shower or tub to determine how much assistance the patient needs to perform the activity safely. The patient who only performs a sponge bath may be able to bathe in the tub or shower if person or device is available to assist. Evaluate the amount of assistance needed for the patient to be able to safely bathe in tub or shower.

DATA SOURCES / RESOURCES

- Observation/demonstration is the preferred method.
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

Guidance for this item updated 12/18/2009

OASIS ITEM

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

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

ITEM INTENT

Identifies the patient's ability to safely get to and from and transfer on and off the toilet or bedside commode.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely perform toilet transferring, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Excludes personal hygiene and management of clothing when toileting.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.
- The toilet transferring scale presents the most optimal level first, then proceeds to less optimal toileting methods. Read each response carefully to determine which one best describes what the patient is able to do.
- If the patient can get to and from the toilet during the day independently, but uses the commode at night for convenience, select Response 0.
- If the patient requires standby assistance to get to and from the toilet safely or requires verbal cueing/reminders, select Response 1.
- If the patient needs assistance getting to/from the toilet or with toileting transfer or both, then Response 1 is the best option.
- A patient who can independently get to the toilet, but who requires assistance to get on and off the toilet would be scored as a "1."

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1840)

- A patient who is unable to get to/from the toilet or bedside commode, but is able to place and remove a bedpan/urinal independently, should be marked Response 3. This is the best response whether or not a patient requires assistance to empty the bedpan/urinal.
- Assessment Strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient if he/she has any difficulty getting to and from the toilet or bedside commode. Observe the patient during transfer and ambulation to determine if the patient has difficulty with balance, strength, dexterity, pain, etc. Determine the level of assistance needed by the patient to safely use the toilet or commode. Tasks related to personal hygiene and management of clothing are not considered when responding to this item.

DATA SOURCES / RESOURCES

- Observation/demonstration is the preferred method.
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

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

- ☐ 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.

ITEM INTENT

Identifies the patient's ability to manage personal hygiene and clothing when toileting.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely perform toileting hygiene, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Toileting hygiene includes several activities, including pulling clothes up or down and adequately cleaning (wiping) the perineal area.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.
- The toileting hygiene scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.
- This item refers the patient's ability to manage personal hygiene and clothing with or without assistive devices. The word "assistance" in this question refers to assistance from another person by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- Select Response 0 if the patient is independent in managing toileting hygiene and managing clothing.
- Select Response 1 if the patient is able to manage toileting hygiene and manage clothing IF supplies are laid out for the patient.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1845)

- If the patient can participate in hygiene and/or clothing management but needs some assistance with either or both activities, select Response 2.
- Response 2 includes standby assistance or verbal cueing.

DATA SOURCES / RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

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

- ☐ 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.

ITEM INTENT

Identifies the patient's ability to safely transfer from bed to chair (and chair to bed), or position self in bed if bedfast.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely transfer, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- For most patients, the transfer between bed and chair will include transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.
- The transferring scale presents the most optimal level first, then proceeds to less optimal levels of transferring. Read each response carefully to determine which one best describes what the patient is able to do.
- Able to bear weight refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (e.g., a patient with a weight-bearing restriction of one lower extremity may be able to support his/her entire weight through the other lower extremity and upper extremities).
- If the patient is able to transfer self from bed to chair, but requires standby assistance to transfer safely, or requires verbal cueing/reminders, select Response 1.
- For response 1, "minimal human assistance" could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance.

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1850)

- If the patient transfers either with minimal human assistance (but not device), or with the use of a device (but no human assistance), select Response 1. If the patient requires both minimal human assistance and an assistive device to transfer safely, select Response 2.
- If the patient can bear weight and pivot, but requires more than minimal human assist, Response 2 should be marked.
- The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, select Response 3.
- If the patient is bedfast, select Response 4 or 5, depending on the patient's ability to turn and position self in bed. Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about transferring ability. Taking extra time or pushing up with both arms can help ensure the patient's stability and safety during the transfer process, but they do not mean that the patient is not independent. Observe the patient during transfers and determine the amount of assistance required for safe transfer from bed to chair.

DATA SOURCES / RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

Guidance for this item updated 12/18/2009

OASIS ITEM

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- ☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- ☐ 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- ☐ 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- ☐ 3 - Able to walk only with the supervision or assistance of another person at all times.
- ☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- ☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.
- ☐ 6 - Bedfast, unable to ambulate or be up in a chair.

ITEM INTENT

Identifies the patient's ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely ambulate/locomote, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Variety of surfaces refers to typical surfaces that the patient would routinely encounter in his/her environment, and may vary based on the individual residence.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.
- The ambulation/locomotion scale presents the most optimal level first, then proceeds to less optimal mobility abilities. Read each response carefully to determine which one best describes what the patient is able to do.
- Regardless of the need for an assistive device, if the patient requires human assistance (hands on, supervision and/or verbal cueing) to safely ambulate, select Response 2 or Response 3, depending on whether the assistance required is intermittent ("2") or continuous ("3").
- If the patient is safely able to ambulate without a device on a level surface, but requires minimal assistance on stairs, steps and uneven surfaces, then Response 2 is the best response (requires human supervision or assistance to negotiate stairs or steps or uneven surfaces).

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1860)

- If a patient does not require human assistance, but safely ambulates with a walker in some areas of the home, and a cane in other areas (due to space limitations, distances, etc.), select the response that reflects the device that best supports safe ambulation on all surfaces the patient routinely encounters (e.g., Response 2 is appropriate if a walker is required for safe ambulation in the hallway and living room, even if there are some situations in the home where a cane provides adequate support.)
- If a patient does not have a walking device but is clearly not safe walking alone, select Response 3, able to walk only with the supervision or assistance should be reported, unless the patient is chairfast.
- Responses 4 and 5 refer to a patient who is unable to ambulate, even with the use of assistive devices and/or continuous assistance. A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate should be considered chairfast, and would be scored 4 or 5, based on ability to wheel self.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Ask the patient about ambulation ability. Observe the patient ambulating across the room or to the bathroom and the type of assistance required. Note if the patient uses furniture or walls for support, and assess if patient should use a walker or cane for safe ambulation. Observe patient's ability and safety on stairs. If chairfast, assess ability to safely propel wheelchair independently, whether the wheelchair is a powered or manual version.

DATA SOURCES / RESOURCES

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

(M1870) Feeding or Eating: Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- ☐ 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.

ITEM INTENT

Identifies the patient's ability to feed him/herself, including the process of eating, chewing, and swallowing food.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely self-feed, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform ADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or hearing, pain)
- environmental barriers (e.g., stairs, narrow doorways, location of bathroom or laundry)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- This item excludes evaluation of the preparation of food items, and transport to the table. Respond to this item based on the assistance needed by the patient to feed himself once the food is placed in front of him. Assistance means human assistance by verbal cueing/reminders, supervision, and/or stand-by or hands-on assistance.
- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.
- The feeding/eating scale presents the most optimal level first, then proceeds to less optimal feeding/eating abilities. Read each response carefully to determine which one best describes what the patient is able to do.
- Meal "set-up" (Response 1) includes activities such as mashing a potato, cutting up meat/vegetables when served, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, arranging the food on the plate for ease of access, etc. -- all of which are special adaptations of the meal for the patient.
- Responses 4 and 5 include non-oral intake.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M1870)

- If a tube is being used to provide all or some nutrition, select Responses 3 or 4, depending on the patient's ability to take in nutrients orally. If a patient is being weaned from tube feeding, Responses 3 or 4 will continue to apply until the patient no longer uses the tube for nutrition, at which time, select Responses 0, 1, or 2. This is true, even if the tube remains in place, unused for a period of time.
- Response 5 is the best response for patients who are not able to take in nutrients orally or by tube feeding. This may the case for patients who receive all nutrition intravenously (e.g. TPN) or for patients who are only receiving intravenous hydration.

DATA SOURCES / RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Nutritional assessment
- Physician orders
- Plan of care
- Referral information
- Review of past health history
- Environmental assessment

OASIS ITEM

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

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

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

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

ITEM INTENT

Identifies the patient's physical, cognitive, and mental ability to plan and prepare meals, even if the patient does not routinely perform this task.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely perform light meal planning and preparation, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform IADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision, pain)
- environmental barriers (e.g., stairs, narrow doorways)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment.
- In cases where a patient's ability is different for various light meal preparati**o**n tasks, pick the response that best describes the patient's level of ability to perform the majority of light meal preparation tasks
- Response 0 indicates that during the day of assessment, the patient has the consistent physical and cognitive ability to plan and prepare meals.
- Response 1 indicates that during the day of assessment, the patient has inconsistent ability to prepare light meals (e.g., can't prepare breakfast due to morning arthritic stiffness, but can prepare other meals throughout day).
- Response 2 indicates patient does not have the ability to prepare light meals at any point during the day of assessment.
- While nutritional appropriateness of the patient's food selections is not the focus of this item, any prescribed diet requirements (and related planning/preparation) should be considered when selecting a response.
- When a patient's prescribed diet consists either partially or completely of enteral nutrition, the clinician must assess the patient's ability to plan and prepare their prescribed diet, including their knowledge of the feeding amount and ability to prepare the enteral feeding, based on product used. Note that the ability to set up, monitor and change the feeding equipment is excluded from M1880, as it is addressed on row "e" of M2100.

DATA SOURCES / RESOURCES (cont'd for OASIS Item M1880)

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Nutritional assessment
- Environmental assessment

OASIS ITEM

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

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

ITEM INTENT

Identifies the ability of the patient to answer the phone, dial number, and effectively use the telephone to communicate.

The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely use the telephone, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a holistic perspective in assessing ability to perform IADLs. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited range of motion, impaired balance)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision or hearing, pain)
- environmental barriers (e.g., stairs, narrow doorways)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- The patient's ability may change as the patient's condition improves or declines, as medical restrictions are imposed or lifted, or as the environment is modified. The clinician must consider what the patient is *able to do* on the day of the assessment. If ability varies over time, choose the response describing the patient's ability more than 50% of the time period under consideration.
- The telephone use scale presents the most independent level first, then proceeds to the most dependent. Read each response carefully to determine which one best describes what the patient is able to do.
- Ability to use telephone identifies the patient's ability to safely answer the phone, dial a number and effectively use the telephone to communicate. If a speech impaired patient can only communicate using a phone equipped with texting functionality, Response "1" able to use a specially adapted telephone would be selected.

DATA SOURCES / RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Environmental assessment

OASIS ITEM

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

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

ITEM INTENT

Identifies changes that have occurred in the patient's ability to perform ADL and IADL activities since the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. The intent of the item is to identify the patient's prior ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. This item is used for risk adjustment and can be helpful for setting realistic goals for the patient.

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

RESPONSE—SPECIFIC INSTRUCTIONS

- For each functional area, select a response.
- "Independent" means that the patient had the ability to complete the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper.
- "Needed some help" means that the patient contributed effort but required help from another person to accomplish the task/activity safely.
- "Dependent" means that the patient was physically and/or cognitively unable to contribute effort toward completion of the task, and the helper must contribute all the effort.
- "Self-care" refers specifically grooming, dressing, bathing, and toileting hygiene. Medication management is not included in the definition of self-care for M1900 as it is addressed in a separate question (M2040).
- "Ambulation" refers to walking (with or without assistive device). Wheelchair mobility is not directly addressed in this item. A patient who is unable to ambulate safely (even with devices and/or assistance), but is able to use a wheelchair (with or without assistance) would be reported as "Dependent" in Ambulation for M1900.
- "Transfer" refers specifically to tub, shower, commode, and bed to chair transfers.
- "Household tasks" refers specifically to light meal preparation, laundry, shopping, and phone use.
- If the patient was previously independent in some self-care tasks (or some transfers, or some household tasks), but needed help or was completely dependent in others, pick the response that best describes the patient's level of ability to perform the majority of included tasks.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Referral information
- Review of past health history
- Physician

Guidance for this item updated 12/18/2009

OASIS ITEM

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

- ☐ 0 - No multi-factor falls risk assessment conducted.
- ☐ 1 - Yes, and it does not indicate a risk for falls.
- ☐ 2 - Yes, and it indicates a risk for falls.

ITEM INTENT

Identifies whether the home health agency has assessed the patient and home environment for characteristics that place the patient at risk for falls. Patients under the age of 65 will be excluded from the denominator of the publicly reported measure. The multi-factor falls risk assessment must include at least one standardized tool that 1) has been scientifically tested on a population of community dwelling elders and shown to be effective in identifying people at risk for falls; and 2) includes a standard response scale. The standardized tool must be appropriately administered as indicated in the instructions.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

RESPONSE—SPECIFIC INSTRUCTIONS

- CMS does not mandate that clinicians conduct falls risk screening for all patients, nor is there a mandate for the use of a specific tool.
- For Responses 1 and 2, an agency may use a single comprehensive multi-factor falls risk assessment tool that meets the criteria as described in the item intent. Alternatively, an agency may incorporate several tools as long as one of them meets the criteria as described in the item intent. For example, a physical performance component (e.g., Timed Up and Go), a medication review, review of patient history of falls, assessment of lower limb function and selected OASIS items (e.g., OASIS items for cognitive status, vision, incontinence, ambulation, transferring).
- Use the scoring parameters specified in the tool to identify if a patient is at risk for falls. Select response 1 if the standardized response scale rates the patient as no-risk, low-risk, or minimal risk. Select response 2 if the standardized response scale rates the patient as anything above low/minimal-risk.
- For Responses 1 and 2, the assessment must have been completed by the home health agency during the CMS-specified time frames for completion of the comprehensive assessment (5 days for SOC; 48 hours following inpatient facility discharge, or knowledge of patient's return home for ROC).
- For Responses 1 and 2, the fall risk assessment must have been completed by the clinician completing the SOC or ROC Comprehensive Assessment.
- Select Response 0 if:
  - a standardized validated multi-factor falls risk screening was NOT conducted by the home health agency,
  - a standardized validated multi-factor falls risk screening was conducted by the home health agency but NOT during the required assessment time frame,
  - a standardized validated multi-factor falls risk screening was conducted during the assessment time frame, but NOT by the assessing clinician.

Guidance for this item updated 12/18/2009

DATA SOURCES / RESOURCES (cont'd for OASIS Item M1910)

- Observation
- Patient/caregiver interview
- Physical assessment
- Environmental assessment
- Referral information
- Review of past health history
- Several links to guidelines listing fall risk assessment factors can be found in Chapter 5 of this manual.

Guidance for this item updated 12/18/2009

OASIS ITEM

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

- ☐ 0 - Not assessed/reviewed **[** ***Go to M2010*** **]**
- ☐ 1 - No problems found during review **[** ***Go to M2010*** **]**
- ☐ 2 - Problems found during review
- ☐ NA - Patient is not taking any medications **[** ***Go to M2040*** **]**

ITEM INTENT

Identifies if a review of the patient's medications indicated the presence of potential clinically significant problems. This item captures information for calculation of a process measure to identify best practices related to medications.

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

RESPONSE—SPECIFIC INSTRUCTIONS

- Includes all medications, prescribed and over the counter, administered by any route (e.g. oral, topical, inhalant, pump, injection).
- If portions of the drug regimen review (e.g., identification of potential drug-drug interactions or potential dosage errors) are completed by agency staff other than the clinician responsible for completing the SOC/ROC OASIS, information on drug regimen review findings must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2000 may be selected. Collaboration in which the assessing clinician evaluates patient status (e.g., presence of potential ineffective drug therapy or patient noncompliance), and another clinician (in the office) assists with review of the medication list (e.g. for possible duplicate drug therapy or omissions) does not violate the requirement that the comprehensive patient assessment is the responsibility of and must be ultimately completed by one clinician. Agency policy and practice will determine this process and how it is documented. The M0090 date – the date the assessment is completed – would be the date the two clinicians collaborated and the assessment was completed.
- The definition of a problem for responses 1 and 2 includes the following:

  Potential clinically significant medication issues which include adverse reactions to medications (e.g., rash), ineffective drug therapy (e.g., analgesic that does not reduce pain), side effects (e.g. potential bleeding from an anticoagulant), drug interactions (e.g., serious drug-drug, drug-food and drug-disease interactions), duplicate therapy (e.g. generic name and brand name drugs that are equivalent both prescribed), omissions (missing drugs from an ordered regimen), dosage errors (e.g., either too high or too low), noncompliance (e.g., regardless of whether the noncompliance is purposeful or accidental) or impairment or decline in an individual's mental or physical condition or functional or psychosocial status.

  Note: Medication interaction is the impact of another substance (such as another medication, nutritional supplement including herbal products, food, or substances used in diagnostic studies) upon a medication. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2000)

Note: Adverse drug reaction (ADR) is a form of adverse consequences. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term "side effect" is often used interchangeable with ADR, however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

In addition to the guidance provided above:

- Select Response 1 – no problems found – when (as applicable) :
  - Patient's list of medications from the inpatient facility discharge instructions matches the medications the patient shows the clinician at the SOC/ROC assessment visit.
  - Assessment shows that diagnoses/symptoms for which patient is taking medications are adequately controlled (as able to be assessed within the clinician's scope of practice).
  - Patient possesses all medications prescribed.
  - Patient has a plan for taking meds safely at the right time.
  - Patient is not showing signs/symptoms that could be adverse reactions caused by medications.
- Select Response 2 – problems found – when (as applicable):
  - Patient's list of medications from the inpatient facility discharge instructions DO NOT match the medications the patient shows the clinician at the SOC/ROC assessment visit.
  - Assessment shows that diagnoses/symptoms for which patient is taking medications are NOT adequately controlled (as able to be assessed within the clinician's scope of practice).
  - Patient seems confused about when/how to take medications indicating a high risk for medication errors.
  - Patient has not obtained medications or indicates that he/she will probably not take prescribed medications because of financial, access, cultural, or other issues with medications.
  - Patient has signs/symptoms that could be adverse reactions from medications.
  - Patient takes multiple non-prescribed medications (OTCs, herbals) that could interact with prescribed meds.
  - Patient has a complex medication plan with meds prescribed by multiple physicians and/or obtained from multiple pharmacies so that the risk of med interactions is high.

DATA SOURCES / RESOURCES

- Patient assessment, specifically the drug regimen review as required by Conditions of Participation (i.e., §484.55)
- Clinical record
- Communication notes
- Medication list
- Discussions with other agency staff responsible for completing drug regimen review
- Since medication issues continue to evolve and new medications are being approved regularly, it is important to refer to a current authoritative source for detailed medication information such as indications and precautions, dosage, monitoring or adverse consequences.
- Physician's Drug Reference (PDR) or other clinical medication handbook or software intended to provide warning of severity levels of risk for medication review.
- Several online resources for evaluating drug reactions, side effects, interactions, etc., can be found in Chapter 5 of this manual.

OASIS ITEM

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

☐ 0 - No
☐ 1 - Yes

ITEM INTENT

Identifies if potential clinically significant problems identified through a medication review were addressed with the physician within one calendar day following identification of medication issue(s).

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

RESPONSE—SPECIFIC INSTRUCTIONS

- Complete if Response 2 for M2000 is selected**.**
- Clinically significant medication issues are those that, in the care provider's clinical judgment, pose an actual or potential threat to patient health and safety, such as drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, medication omissions, dosage errors, or nonadherence to prescribed medication regimen.
- Contact with physician is defined as communication to the physician made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status.
- Select Response 1 – Yes, only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions.
- If the interventions are not completed as outlined in this item, select Response 0 – No. However, in this case, the care provider should document rationale in the clinical record.
- If agency staff other than the clinician responsible for completing the SOC/ROC OASIS contacted the physician to follow up on clinically significant medication issues, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2002 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and must ultimately be completed by one clinician.

DATA SOURCES / RESOURCES

- Clinical record
- Communication notes
- Plan of care
- Medication list
- Discussions with other agency staff responsible for completing drug regimen review

OASIS ITEM

(M2004) Medication Intervention: If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?

☐ 0 - No
☐ 1 - Yes
☐ NA - No clinically significant medication issues identified since the previous OASIS assessment

ITEM INTENT

Identifies if potential clinically significant problems such as adverse effects or drug reactions identified at the time of the most recent OASIS assessment or after that time were addressed with the physician.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Transfer to inpatient facility

Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Clinically significant medication issues are those that, in the care provider's clinical judgment, pose an actual or potential threat to patient health and safety, such as drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, medication omissions, dosage errors, or nonadherence to prescribed medication regimen.
- Contact with physician is defined as communication to the physician made by telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the message of patient status.
- Select Response 1 – Yes, only if a physician responds to the agency communication with acknowledgment of receipt of information and/or further advice or instructions.
- If the interventions are not completed as outlined in this item, select Response 0 – No. However, in this case, the care provider should document rationale in the clinical record.
- If agency staff other than the clinician responsible for completing the transfer or discharge OASIS contacted the physician to follow up on clinically significant medication issues, this information must be communicated to the clinician responsible for the transfer or discharge OASIS assessment so that the appropriate response for M2004 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and ultimately must be completed by one clinician.

DATA SOURCES / RESOURCES

- Clinical record
- Communication notes
- Medication list
- Plan of care
- Discussions with other agency staff responsible for completing drug regimen review

OASIS ITEM

(M2010) Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

☐ 0 - No

☐ 1 - Yes

☐ NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

ITEM INTENT

Identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes. High-risk medications are those identified by quality organizations (Institute for Safe Medication Practices, JCAHO, etc.) as having considerable potential for causing significant patient harm when they are used erroneously.

This item is targeted to high-risk medications as it may be unrealistic to expect that patient education on all medications occur on admission and failure to provide patient education on high-risk medications such as hypoglycemics and anticoagulants (and others) at SOC/ROC could have severe negative impacts on patient safety and health.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

RESPONSE—SPECIFIC INSTRUCTIONS

- Select Response 0 – No, if the interventions are not completed as outlined in this item. However, in this case, the care provider should document rationale in the clinical record unless the patient is not taking any drugs.
- Select Response 1 – Yes, if high-risk medications are prescribed and education was provided.
- High-risk medications should be identified based on one or more authoritative sources.
- If patient/caregiver is fully knowledgeable about special precautions associated with high-risk medications, select "NA."
- If agency staff other than the clinician responsible for completing the SOC/ROC OASIS provided education to the patient/caregiver on high-risk medications, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2010 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of, and ultimately must be completed by one clinician.

DATA SOURCES / RESOURCES (cont'd for OASIS Item M2010)

- Clinical record
- Communication notes
- Medication list
- Plan of care
- Discussions with other agency staff responsible for educating patient/caregivers on medications.
- Sources to identify high-risk medications for the purposes of responding to this item can include the ISMP High Alert Medication List, Beer's Criteria, Joint Commission's High Alert Medication lists, or other authoritative resources. Links to resources for identifying high-risk medications can be found in Chapter 5 of this manual.

OASIS ITEM

(M2015) Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?

☐ 0 - No
☐ 1 - Yes
☐ NA - Patient not taking any drugs

ITEM INTENT

Identifies if clinicians instructed the patient/caregiver about how to manage medications effectively and safely.

Drug education interventions for M2015 should address all medications the patient is taking – prescribed and over-the-counter – by any route.

Effective, safe management of medications includes knowledge of effectiveness, potential side effects and drug reactions, and when to contact the appropriate care provider.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Transfer to an inpatient facility

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- If the interventions are not completed as outlined in this item, select Response 0 – No. However, in this case, the care provider should document rationale in the clinical record.

DATA SOURCES / RESOURCES

- Review of clinical record including teaching guidelines, flow sheets, clinical notes, etc.
- Medication list
- Plan of care
- Discussions with other agency staff responsible for educating patient/caregivers on medications.
- Links to a resource for drug information can be found in Chapter 5 of this manual.

OASIS ITEM

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

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

ITEM INTENT

This item is intended to identify the patient's ability to take **all** oral (p.o.) medications reliably and safely at **all** times. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely take oral medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a wholistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited manual dexterity)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision, pain)
- environmental barriers (e.g., access to kitchen or medication storage area, stairs, narrow doorways)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Includes all prescribed and OTC (over-the-counter) medications that the patient is currently taking and are included on the plan of care.
- Exclude topical, injectable, and IV medications.
- Only medications whose route of administration is p.o. should be considered for this item. Medications given per gastrostomy (or other) tube are not administered p.o., but are administered "per tube."
- If the patient sets up her/his own "planner device" and is able to take the correct medication in the correct dosage at the correct time as a result of this, select Response 0.
- Select Response 1 if the patient is independent in oral medication administration if another person must prepare individual doses (e.g., set up a "planner device") **and/or** if another person must develop a drug diary or chart which the patient relies on to take medications appropriately.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2020)

- Select Response 2 if daily reminders to take medications are necessary, regardless of whether the patient is independent or needs assistance in preparing individual doses (e.g., set up a "planner device") and/or developing a drug diary or chart. (Reminders provided by a device that the patient can independently manage are not considered "assistance" or "reminders.")
- If the patient's ability to manage oral medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.

DATA SOURCES / RESOURCES

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Cognitive assessment
- Environmental assessment

OASIS ITEM

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

☐ 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.

☐ 1 - Able to take injectable medication(s) at the correct times if:
(a) individual syringes are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.

☐ 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection

☐ 3 - Unable to take injectable medication unless administered by another person.

☐ NA - No injectable medications prescribed.

ITEM INTENT

This item is intended to assess the patient's ability to take **all** injectable medications reliably and safely at **all** times. The intent of the item is to identify the patient's ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. These items address the patient's ability to safely manage injectable medications, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. The patient must be viewed from a wholistic perspective in assessing ability to perform medication management. Ability can be temporarily or permanently limited by:

- physical impairments (e.g., limited manual dexterity)
- emotional/cognitive/behavioral impairments (e.g., memory deficits, impaired judgment, fear)
- sensory impairments, (e.g., impaired vision, pain)
- environmental barriers (e.g., access to kitchen or medication storage area, stairs, narrow doorways)

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Excludes IV medications, infusions (i.e., medications given via a pump), and medications given in the physician's office or other settings outside the home.
- If the patient sets up her/his own individual doses and is able to take the correct medication in the correct dosage at the correct time as a result of this, select Response 0.
- Select Response 1 for a patient independent in injectable medication administration if another person must prepare individual doses **and/or** if another person must develop a drug diary or chart.
- If reminders to take medications are necessary, then select Response 2, regardless of the whether the patient is independent or needs assistance in preparing individual doses and/or developing a drug diary or chart. (Reminders provided by a device that the patient can independently manage are not considered "assistance" or "reminders.")
- If the patient's ability to manage injectable medications varies from medication to medication, consider the medication for which the most assistance is needed when selecting a response.
- Assessment strategies: A combined observation/interview approach with the patient or caregiver is required to determine the most accurate response for this item. Observe patient preparing the injectable medications. If it is not time for the medication, ask the patient to describe and demonstrate the steps for administration. The cognitive/mental status and functional assessments contribute to determining the appropriate response for this item.

DATA SOURCES / RESOURCES (cont'd for OASIS Item M2030)

- Observation/demonstration is the preferred method
- Patient/caregiver interview
- Physical assessment
- Cognitive assessment
- Environmental assessment

OASIS ITEM

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

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral medications	☐0	☐1	☐2	☐na
b. Injectable medications	☐0	☐1	☐2	☐na

ITEM INTENT

Identifies changes that have occurred in the patient's ability to manage all prescribed oral and injectable medications since the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is most recent) that initiated this episode of care. The intent of the item is to identify the patient's prior ABILITY, not necessarily actual performance. "Willingness" and "compliance" are not the focus of these items. This item is used for risk adjustment and can be helpful for setting realistic goals for the patient.

TIME POINTS ITEM(S) COMPLETED

Start of Care

Resumption of Care

RESPONSE—SPECIFIC INSTRUCTIONS

- For each functional area (oral medications and injectable medications), select a response.
- If the patient's prior ability to manage oral or injectable medications varied from medication to medication, consider the medication for which the most assistance was needed when selecting a response.
- "Independent" means that the patient completed the activity by him/herself (with or without assistive devices) without physical or verbal assistance from a helper or reminders from another person. (Reminders provided by a device that the patient can independently manage are not considered "assistance" or "reminders.")
- "Needed some help" means that the patient required some help from another person to accomplish the task/activity.
- "Dependent" means that the patient was incapable of performing any of the task/activity. For oral medications, this means that the patient was capable only of swallowing medications that were given to her/him. For injectable medications, this means that someone else must have prepared and administered the medication.
- Select Response "NA" if there were no oral medications (row a) or no injectable medications (row b) used.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Referral information
- Review of past health history
- Physician

Guidance for this item updated 12/18/2009

OASIS ITEM

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

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

ITEM INTENT

Identifies availability and ability of the caregiver(s) (other than home health agency staff) to provide categories of assistance needed by the patient.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency – not to an inpatient facility

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (Cont'd for OASIS Item M2100)

- For each row a-g, select one description of caregiver assistance.
- If patient needs assistance with any aspect of a category of assistance (e.g., needs assistance with some IADLs but not others), consider the aspect that represents the most need and the availability and ability of the caregiver(s) to meet that need.
- If more than one response in a row applies, (e.g., the caregiver(s) provides the assistance but also needs training or assistance), select the response that represents the greatest need ("caregiver(s)needs training/supporting services to provide assistance").
- "Caregiver(s) not likely to provide" indicates that the caregiver(s) has indicated an unwillingness to provide assistance, or that the caregiver(s) is/are physically and/or cognitively unable to provide needed care.
- "Unclear if caregiver(s) will provide" indicates that the caregiver(s) may express willingness to provide care, but their ability to do so is in question or there is reluctance on the part of the caregiver(s) that raises questions as to whether the caregiver will provide the needed assistance.
- Row a – ADLs include basic self-care activities such as the examples listed.
- Row b – IADLs include activities associated with independent living necessary to support the ADLs such as the examples listed.
- Row c – Medication administration refers to any type of medication (prescribed or OTC) and any route of administration including oral, inhalant, injectable, topical, or administration via g-tube/j-tube, etc.
- Row d – Medical procedures/treatments include procedures/treatments that the physician or physician-designee has ordered for the purpose of improving health status. Some examples of these procedures/treatments include wound care and dressing changes, range of motion exercises, intermittent urinary catheterization, postural drainage, electromodalities, etc.
- Row e – Management of equipment refers to the ability to safely use medical equipment as ordered. Examples of medical equipment include oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies, continuous passive motion machine, wheelchair, hoyer lift, etc.
- Row f – Supervision and safety includes needs related to the ability of the patient to safely remain in the home. This category of assistance needs includes a wide range of activities that may be necessary due to cognitive, functional, or other health deficits. Such assistance may range from calls to remind the patient to take medications, to in-person visits to ensure that the home environment is safely maintained, to the need for the physical presence of another person in the home to ensure that the patient doesn't wander, fall, or for other safety reasons (i.e., leaving the stove burner on).
- Row g – Advocacy or facilitation of patient's participation in appropriate medical care includes taking patient to medical appointments, following up with filling prescriptions, or making subsequent appointments, etc.

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Review of previous health history

Guidance for this item updated 12/18/2009

OASIS ITEM

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

- ☐ 1 - At least daily
- ☐ 2 - Three or more times per week
- ☐ 3 - One to two times per week
- ☐ 4 - Received, but less often than weekly
- ☐ 5 - No assistance received
- ☐ UK - Unknown*

*at discharge, omit Unknown response.

ITEM INTENT

Identifies the frequency of the assistance with ADLs (e.g., bathing, dressing, toileting, transferring, ambulating, feeding, etc.) or IADLs (e.g., medication management, meal preparation, housekeeping, laundry, shopping, financial management) provided by any non-agency caregivers.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Responses are arranged in order of most to least assistance received from caregivers.
- Note that this question is concerned broadly with ADLs and IADLs, not just the ones specified in other OASIS items. ADLs are defined as the tasks of everyday life. Basic ADLs include eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet. Instrumental activities of daily living (IADL) are activities related to independent living and include preparing meals, managing money, shopping, doing housework, and using a telephone.
- Select the response that reports how often the patient receives assistance with any ADL or IADL.

DATA SOURCES / RESOURCES

- Patient/caregiver interview

OASIS ITEM

(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.

ITEM INTENT

Identifies the total number of therapy visits (physical, occupational, or speech therapy combined) planned for the Medicare payment episode for which this assessment will determine the case mix group, and only applies to payers utilizing a payment model based on case mix group assignment.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

Follow-up

RESPONSE—SPECIFIC INSTRUCTIONS

- Therapy visits must (a) relate directly and specifically to a treatment regimen established by the physician through consultation with the therapist(s), and (b) be reasonable and necessary to the treatment of the patient's illness or injury. The Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.
- Report a number that is "zero filled and right justified." For example, 11 visits should be reported as "011."
- Answer "000" if no therapy services are needed.
- Once patient eligibility has been confirmed and the plan of care contains physician orders for the qualifying service as well as other Medicare covered home health services, the qualifying service does not have to be rendered prior to the other Medicare covered home health services ordered in the plan of care. The sequence of visits performed by the disciplines must be dictated by the individual patient's plan of care. For example, for an eligible patient in an initial 60-day episode that has both physical therapy and occupational therapy orders in the plan of care, the sequence of the delivery of the type of therapy is irrelevant as long as the need for the qualifying service is established prior to the delivery of other Medicare covered services and the qualifying discipline provides a billable visit prior to transfer or discharge in accordance with 42 CFR 409.43 (f).
- For multidisciplinary cases - Nursing and Therapy may collaborate to answer this item correctly. The PT, OT, and/or SLP are responsible to communicate the number of visits ordered by the physician to the RN completing this item. Coordination of patient care is specified in the Conditions of Participation (42 CFR 484.14).
- When a patient is discharged home from an inpatient facility admission in the last five days of a certification period (i.e., the requirement to complete a Resumption of Care assessment overlaps with the requirement to complete a Recert assessment), CMS allows the agency to complete a single ROC assessment to meet the requirements of both timepoints. In such cases, the total number of therapy visits planned for the upcoming 60-day episode should be reported in M2200.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2200)

- Answer "Not Applicable" when this assessment will not be used to determine a case mix group for Medicare, or other payers using a Medicare PPS-like model. Usually, the "Not Applicable" response will be checked for patients whose payment source is not Medicare fee-for-service (i.e., M0150, Response 1 is not checked), or for an assessment that will not be used to determine a Medicare case mix group. However, payers other than the Medicare program may use this information in setting an episode payment rate. If the HHA needs a case mix code (HIPPS code) for billing purposes, a response other than "Not Applicable" is required to generate the case mix code.
- Assessment strategies: When the assessment and care plan are complete, review the plan of care to determine whether therapy services are ordered by the physician. If not, answer "000." If therapy services are ordered, how many total visits are indicated over the 60-day payment episode? If the number of visits that will be needed is uncertain, provide your best estimate. As noted in item intent above, the Medicare payment episode ordinarily comprises 60 days beginning with the start of care date, or 60 days beginning with the recertification date.

DATA SOURCES / RESOURCES

- Physician's orders
- Referral information
- Plan of care
- Clinical record

OASIS ITEM

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

Plan / Intervention	No	Yes	Not Applicable	
a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings	☐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 bilateral amputee
c. Falls prevention interventions	☐0	☐1	☐na	Patient is not assessed to be at risk for falls
d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment	☐0	☐1	☐na	Patient has no diagnosis or symptoms of depression
e. Intervention(s) to monitor and mitigate pain	☐0	☐1	☐na	No pain identified
f. Intervention(s) to prevent pressure ulcers	☐0	☐1	☐na	Patient is not assessed to be at risk for pressure ulcers
g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician	☐0	☐1	☐na	Patient has no pressure ulcers with need for moist wound healing

ITEM INTENT

Identifies if the physician-ordered home health plan of care incorporates specific best practices. The "physician ordered plan of care" means that the patient condition has been discussed and there is agreement as to the plan of care between the home health agency staff and the physician.

This item is used to calculate process measures to capture the agency's use of best practices following the completion of the comprehensive assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

TIME POINTS ITEM(S) COMPLETED

Start of care

Resumption of care

RESPONSE—SPECIFIC INSTRUCTIONS

- Select "Yes" if the POC contains orders for best practice interventions as specified in each row, based on the patients needs.
- This question can be answered "Yes" prior to the receipt of signed orders if the clinical record reflects evidence of communication with the physician to include specified best practice interventions in the plan of care. Assuming all other OASIS information is completed, the Date Assessment Completed (M0090) then becomes the date of the communication with the physician to establish the Plan of Care that includes interventions listed in M2250.

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item 2250)

- Select "No" if the best practice interventions specified in this item are not included in the plan of care that was developed as a result of the comprehensive assessment, unless the plans/interventions specified in that row are not appropriate for this patient - see guidance on selecting NA for each row below.
- Select "No" when orders for interventions have been requested but not authorized by the end of the comprehensive assessment time period, unless otherwise indicated in row g. In this case, the care provider should document rationale in the clinical record. Reminder: These Plan of Care orders must be in place within the 5-day SOC window and the 2-day ROC window in order to meet the measure definition. See 42 CFR 409.43 (d).
- After reviewing physician orders for home health care and conducting a comprehensive assessment of the patient, the plan of care should be developed as required by Conditions of Participation: 484.14 Standard: Plan of Care. If the physician refers the patient under a plan of care that cannot be completed until after an initial visit and eligibility has been determined, the physician is consulted to approve additions or modification to the original plan.
- If the assessing clinician chooses to wait to complete M2250 until after discussion with another discipline that has completed their assessment and care plan development, this does not violate the requirement that the comprehensive assessment be completed by one clinician within the required time frame (five days for SOC, two days for ROC). For example, if the RN identifies fall risk during the SOC comprehensive assessment, the RN can wait until the PT conducts his/her evaluation and develops the PT care plan to determine if the patient's Plan of Care includes interventions to prevent fall risk. The M0090 date should reflect the last date that information was gathered that was necessary for completion of the assessment.
- For each row a-g, select one response.
- Row a: If the physician-ordered plan of care contains specific clinical parameters relevant to the patient's condition that, when exceeded, would indicate that the physician should be contacted, select "Yes." The parameters may be ranges and may include temperature, pulse, respirations, blood pressure, weight, wound measurements, pain intensity ratings, intake and output measurements, blood sugar levels, or other relevant clinical assessment findings. Select "NA" if the physician chooses not to identify patient-specific parameters and the agency will use standardized guidelines that are made accessible to all care team members.
- Row b: If the physician-ordered plan of care contains both orders for a) monitoring the skin of the patient's lower extremities for evidence of skin lesions AND b) patient education on proper foot care, select "Yes." If the physician-ordered plan of care contains orders for only one (or none) of the interventions, select "No." Select "NA" if the patient does not have a diagnosis of diabetes or is a bilateral amputee.
- Row c: If the physician-ordered plan of care contains specific interventions to reduce the risk of falls, select "Yes." Environmental changes and strengthening exercises are examples of possible fall prevention interventions. If the plan of care does not include interventions for fall prevention, mark "No" for the applicable line, whether or not an assessment for falls risk was conducted. Select "NA" if the clinician completed an assessment that indicated the patient was at low, minimal, or no risk for falls.
- Row d: If the physician-ordered plan of care contains orders for further evaluation or treatment of depression, select "Yes." Interventions for depression may include new medications, adjustments to already-prescribed medications, or referrals to agency resources (e.g., social worker). If the patient is already under physician care for a diagnosis of depression, interventions may include monitoring medication effectiveness, teaching regarding the need to take prescribed medications, etc. Select "NA" if the patient has no diagnosis of depression or the clinician completed an assessment that indicated the patient has no symptoms of depression (or does not meet criteria for further evaluation or treatment if a standardized depression screening tool is used).
- Row e: If the physician-ordered plan of care contains interventions to monitor AND mitigate pain, select "Yes." Medication, massage, visualization, biofeedback, and other intervention approaches have successfully been used to monitor or mitigate pain severity. If the physician-ordered plan of care contains orders for only one (or none) of the interventions (e.g., pain medications but no monitoring plan), select "No." Select "NA" only if the clinician completed an assessment that indicated the patient has no pain.

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item 2250)

- Row f: If the physician-ordered plan of care includes planned clinical interventions to reduce pressure on bony prominences or other areas of skin at risk for breakdown, select "Yes." Planned interventions can include teaching on frequent position changes, proper positioning to relieve pressure, careful skin assessment and hygiene, use of pressure-relieving devices such as enhanced mattresses, etc. Select "NA"only if the clinician completed an assessment that indicated the patient is not at risk for pressure ulcers.
- Row g: If the physician-ordered plan of care contains orders for pressure ulcer treatments based on principles of moist wound healing (e.g., moisture retentive dressings) OR if such orders have been requested from the physician, select "Yes." Select "NA" if the patient has no pressure ulcers needing moist wound healing treatments.

DATA SOURCES / RESOURCES

- Plan of care
- Physician's orders
- Clinical record
- Communication notes
- See Chapter 5 of this manual for links to additional resources.

Guidance for this item updated 12/18/2009

OASIS ITEM

(M2300) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?

☐ 0 - No **[** *Go to M2400* **]**
☐ 1 - Yes, used hospital emergency department WITHOUT hospital admission
☐ 2 - Yes, used hospital emergency department WITH hospital admission
☐ UK - Unknown **[** *Go to M2400* **]**

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Transfer to an inpatient facility - with or without agency discharge

Discharge from agency

RESPONSE—SPECIFIC INSTRUCTIONS

- This item **excludes** urgent care services not provided in a hospital emergency department, including doctor's office visits scheduled less than 24 hours in advance, care provided by an ambulance crew without transport, or care received in urgent care facilities. This item only includes holding and observation in the emergency department setting.
- An urgent care facility is defined as a freestanding walk-in clinic (not a department of a hospital) for patients in need of immediate medical care. Urgent care centers treat many problems that can be seen in a primary care physician's office, but urgent care centers offer some services that are generally not available in primary care physician offices. For example, X-ray facilities allow for treatment of minor fractures and foreign bodies, such as nail gun injuries. Most urgent care centers offer extended hours in evenings and on weekends for patients to receive treatment when their personal physician is not available.
- If a patient went to a hospital emergency department, regardless of whether the patient/caregiver independently made the decision to seek emergency department services or was advised to go the emergency department by the physician, home health agency, or other health care provider, then Response 1 or 2 should be selected depending on whether or not a hospital admission occurred.
- If a patient went to a hospital emergency department, was “held” at the hospital for observation, then released, the patient did receive emergent care. The time period that a patient can be "held" without admission can vary. "Holds" can be longer than 23 hours but emergent care should be reported regardless of the length of the observation "hold." An OASIS transfer assessment is not required if the patient was never actually admitted to an inpatient facility.
- If a patient went to a hospital emergency department and was subsequently admitted to the hospital, select Response 2. An OASIS transfer assessment is required (assuming the patient stay was for 24 hours or more for reasons other than diagnostic testing).
- If a patient is admitted to the hospital for a stay requiring an OASIS Transfer, Response 0 – No – should only be marked if the patient was directly admitted to the hospital (was not treated or evaluated in the emergency room), and had no other emergency department visits since the last OASIS assessment.

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2300)

- Select Response 1 for a patient who, since the last time OASIS was collected, has experienced both a direct admission to the hospital without treatment or evaluation AND accessed a hospital emergency department that did not result in an inpatient admission.
- If a patient utilized a hospital emergency department more than once since the last OASIS assessment, select Response 2 if any emergency department visit since the last OASIS assessment resulted in hospital admission, otherwise select Response 1.
- In Responses 1 and 2, "hospital admission" is defined as admission to a hospital where the stay is for 24 hours or longer, for reasons other than diagnostic testing.
- A patient who dies in a hospital emergency department is considered to have been under the care of the emergency department, not the home health agency. In this situation, a transfer assessment, not an assessment for "Death at Home," should be completed. For M2300, the best response would be " 1 - Yes, used hospital emergency department WITHOUT hospital admission."

DATA SOURCES / RESOURCES

- Patient/caregiver interview
- Clinical record
- Hospital emergency department discharge information
- Referral information for the ROC, if the patient had a hospital admission and home health care ROC since the previous OASIS assessment
- Physician
- Hospital emergency department staff

OASIS ITEM

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

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

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Transfer to an inpatient facility - with or without agency discharge

Discharge from agency

RESPONSE—SPECIFIC INSTRUCTIONS

- This item does not address urgent care services not provided in a hospital emergency department, including doctor's office visits scheduled less than 24 hours in advance, care provided by an ambulance crew without transport, or care received in urgent care facilities.
- If more than one reason contributed to the hospital emergency department visit, mark all appropriate responses. For example, if a patient received care for a fall at home and was found to have medication side effects, mark both responses.
- If the reason is not included in the choices, mark Response 19 - Other than above reasons.
- If the patient has received emergent care in a hospital emergency department multiple times since the last time OASIS data were collected, include the reasons for all visits.

DATA SOURCES / RESOURCES (cont'd for OASIS Item M2310)

- Patient/caregiver interview
- Clinical record
- Hospital emergency department discharge information
- Referral information for the ROC, if the patient had a hospital admission and home health care ROC since the previous OASIS assessment
- Physician
- Hospital emergency department

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

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

Identifies if specific interventions focused on specific problems were both included on the physician-ordered home health plan of care AND implemented as part of care provided during the home health care episode (at the time of the previous OASIS assessment or since that time). The physician-ordered plan of care means that the patient condition was discussed and there was agreement as to the plan of care between the home health agency staff and the patient's physician.

This item is used to calculate process measures to capture the use of best practices. The problem-specific interventions referenced in the item may or may not directly correlate to stated requirements in the Conditions of Participation.

The formal assessment that is referred to in the last column for rows b – e refers to the assessment defined in OASIS items for M1240, M1300, M1730, and M1910.

Transfer to inpatient facility - with or without agency discharge

Discharge from agency - not to an inpatient facility

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2400)

- For response "Yes" to be selected, the clinical intervention must have been included in the plan of care AND implemented at the time of the previous OASIS assessment or since that time. If the intervention was on the plan of care but not implemented, or if the intervention was implemented but not on the plan of care, select "No."
- Select "No" if the interventions are not on the plan of care OR if the interventions are on the plan of care but the interventions were not implemented by the time the discharge or transfer assessment was completed. For "No" responses, the care provider should document rationale in the clinical record. If the plans/interventions specified in the row are not appropriate for this patient, NA is the correct response - see guidance on selecting NA for each row below.
- Interventions provided by home health agency staff, including the assessing clinician, may be reported by the assessing clinician in M2400. For example, if the RN finds a patient to be at risk for falls, and the physical therapist implements fall prevention interventions included on the plan of care prior to the end of the allowed assessment time frame, the RN may select "Yes" for row b of M2400. The M0090 Date Assessment Completed should report the date the last information was gathered to complete the Comprehensive Assessment.
- For each row a-f, select one response.
- For rows b, c, e, and f, the intervention specified in the first column must be both on the physician-ordered plan of care AND implemented for "Yes" to be selected.
- For rows a and d, both of the interventions specified in the first column must be both on the physician-ordered plan of care AND implemented for "Yes" to be selected.
- For rows b-e, a formal assessment (as defined in the relevant OASIS item M1240, M1300, M1730, and M1910) must have been performed to select "Not Applicable."
- Row a: If the physician-ordered plan of care contains both orders for a) monitoring the skin of the patient's lower extremities for evidence of skin lesions AND b) patient education on proper foot care and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select "Yes." If the physician-ordered plan of care contains orders for only one of the interventions and/or only one type of intervention (monitoring or education) or no intervention is documented in the clinical record, select "No." Select "NA" if the patient does not have a diagnosis of diabetes or is a bilateral amputee.
- Row b: If the physician-ordered plan of care contains specific interventions to reduce the risk of falls and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select "Yes." Environmental changes, strengthening exercises, and consultation with the physician regarding medication concerns are examples of possible falls prevention interventions. If the plan of care does not include interventions for fall prevention, and/or there is no documentation in the clinical record that these interventions were performed at the time of the previous OASIS assessment or since that time, mark "No." Select "NA" if a formal multi-factor Fall Risk Assessment indicates the patient was at low, minimal, or no risk for falls since the last OASIS assessment.
- Row c: If the physician-ordered plan of care contains interventions for evaluation or treatment of depression and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select "Yes." Interventions for depression may include new medications, adjustments to already-prescribed medications, or referrals to agency resources (e.g., social worker). If the patient is already under physician care for a diagnosis of depression, interventions may include monitoring medication effectiveness, teaching regarding the need to take prescribed medications, etc. If the plan of care does not include interventions for treating depression and/or if no interventions related to depression are documented in the clinical record at the time of the previous OASIS assessment or since that time, select "No." Select "NA" if formal assessment indicates patient did not meet criteria for further evaluation or treatment of depression AND patient did not have diagnosis of depression.

Guidance for this item updated 12/18/2009

RESPONSE—SPECIFIC INSTRUCTIONS (cont'd for OASIS Item M2400)

- Row d: If the physician-ordered plan of care contains interventions to monitor AND mitigate pain and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select "Yes." Medication, massage, visualization, biofeedback, and other intervention approaches have successfully been used to mitigate pain severity. If the physician-ordered plan of care contains orders for only one of the interventions (e.g., pain medications but no monitoring plan) and/or only one type of intervention (i.e., administering pain medications but no pain monitoring) or no interventions were documented at the time of the previous OASIS assessment or since that time, select "No." Select "NA" if formal assessment did not indicate pain.
- Row e: If the physician-ordered plan of care includes planned clinical interventions to reduce pressure on bony prominences or other areas of skin at risk for breakdown and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select "Yes." Planned interventions can include teaching on frequent position changes, proper positioning to relieve pressure, careful skin assessment and hygiene, use of pressure-relieving devices such as enhanced mattresses, etc. If the plan of care does not include interventions to prevent pressure ulcers and/or no interventions were documented in the clinical record at the time of the previous OASIS assessment or since that time, select "No." Select "NA" if formal assessment indicates the patient was not at risk for pressure ulcers.
- Row f: If the physician-ordered plan of care contains orders for pressure ulcer treatments based on principles of moist wound healing (e.g., moisture retentive dressings) and the clinical record contains documentation that these interventions were performed at the time of the previous OASIS assessment or since that time, select "Yes." If the plan of care does not contain orders for pressure ulcer treatments based on principles of moist wound healing and/or no pressure ulcer treatments based on principles of moist wound healing were documented at the time of the previous OASIS assessment or since that time, select "No." Select "NA" if dressings that support the principles of moist wound healing were not indicated for this patient's pressure ulcers OR patient has no pressure ulcers with need for moist wound healing.

DATA SOURCES / RESOURCES

- Plan of care
- Physician's orders
- Clinical record
- Clinical assessment
- Communication notes
- Home Health Conditions of Participation
- Guidance on each particular item for the plan of care and intervention can be found in other item-by-item tips within this document.

Guidance for this item updated 12/18/2009

OASIS ITEM

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

☐ 1 - Hospital **[** ***Go to M2430*** **]**
☐ 2 - Rehabilitation facility **[** ***Go to M0903*** **]**
☐ 3 - Nursing home **[** ***Go to M2440*** **]**
☐ 4 - Hospice **[** ***Go to M0903*** **]**
☐ NA - No inpatient facility admission

ITEM INTENT

Identifies the type of inpatient facility to which the patient was admitted.

TIME POINTS ITEM(S) COMPLETED

Transfer to inpatient facility - with or without agency discharge

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- If the patient was admitted to more than one facility, indicate the facility to which the patient was admitted first (e.g. the facility type that they were transferred to from their home).
- When a patient dies in a hospital emergency department, the Transfer to an Inpatient Facility OASIS is completed. In this unique situation, clinicians are directed to select Response 1 – Hospital for M2410, even though the patient was not admitted to the inpatient facility.
- Admission to a freestanding rehabilitation hospital, a certified distinct rehabilitation unit of a nursing home, or a distinct rehabilitation unit that is part of a short-stay acute hospital is considered a rehabilitation facility admission.
- Admission to a skilled nursing facility (SNF), an intermediate care facility for the mentally retarded (ICF/MR), or a nursing facility (NF) is a nursing home admission
- When completing a Transfer, select Response 1, 2, 3, or 4. NA should be omitted from this item for transfer.
- When completing a Discharge from agency – not to an inpatient facility, select Response "NA."

DATA SOURCES / RESOURCES

- Patient family interview (for agency discharge)
- Telephone contact with caregiver or family if patient was transferred
- Facility

OASIS ITEM

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

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

[*Go to M0903* **]**

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Discharge from agency - not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS

- Patients who are in assisted living or board and care housing are considered to be living in the community with formal assistive services.
- Formal assistive services include community-based services like homemaking services under Medicaid waiver programs, home-delivered meals, home care or private duty care from another agency, and other types of community-based services
- Noninstitutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not in an inpatient hospice facility.

DATA SOURCES / RESOURCES

- Patient/caregiver/family interview
- Physician
- Community resources

OASIS ITEM

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

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

[*Go to M0903* **]**

ITEM INTENT

Identifies the specific condition(s) necessitating hospitalization.

TIME POINTS ITEM(S) COMPLETED

Transfer to inpatient facility - with or without agency discharge

RESPONSE—SPECIFIC INSTRUCTIONS

- Mark all that apply. For example, if a psychotic episode results from an untoward medication side effect, both Response 1 and Response 17 would be marked. As another example, if a patient requires hospitalization for both heart failure and pneumonia, both Response 3 and Response 5 would be marked.

DATA SOURCES / RESOURCES

- Telephone contact with patient/caregiver/family
- Facility discharge planner or case manager
- Physician
- Insurance case manager

OASIS ITEM

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

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

[*Go to M0903* **]**

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Transfer to inpatient facility - with or without agency discharge

RESPONSE—SPECIFIC INSTRUCTIONS

- This item excludes acute care facility and rehabilitation facility admissions, which are defined as admissions to a freestanding rehabilitation hospital, a certified distinct rehabilitation unit of a nursing home, or part of a general acute care hospital.
- Mark all that apply. For example, if a patient has dementia and is unsafe for care at home and there is no plan for the patient to leave the facility, both Response 4 and Response 5 would be marked.

DATA SOURCES / RESOURCES

- Telephone contact with caregiver or family
- Insurance case manager
- Physician
- Nursing home facility

OASIS ITEM

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

__ __ /__ __ / __ __ __ __
month / day / year

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Transfer to an inpatient facility - with or without agency discharge

Death at home

Discharge from agency

RESPONSE—SPECIFIC INSTRUCTIONS

- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits of the year.
- If the agency policy is to have an RN complete the comprehensive assessment in a therapy-only case, the RN can perform the discharge assessment after the last visit by the therapist.

DATA SOURCES / RESOURCES

- Clinical record

OASIS ITEM

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

__ __ /__ __ / __ __ __ __
month / day / year

ITEM INTENT

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

TIME POINTS ITEM(S) COMPLETED

Transfer to an inpatient facility - with or without agency discharge

Death at home

Discharge from agency

RESPONSE—SPECIFIC INSTRUCTIONS

- If the date or month is only one digit, that digit is preceded by a "0" (e.g., May 4, 1998 = 05/04/1998). Enter all four digits for the year.
- The date of discharge is determined by agency policy or physician order.
- The transfer date is the actual date the patient was admitted to an inpatient facility.
- The death date is the actual date of the patient's death at home. Exclude death occurring in an inpatient facility or in an emergency department, as both situations would result in Transfer OASIS collection and would report the date of transfer. Include death that occurs while a patient is being transported to an emergency department or inpatient facility (before being seen in the emergency department or admitted to the inpatient facility).

DATA SOURCES / RESOURCES

- Agency policy or physician order
- Telephone contact with the family or medical service provider may be required to verify the date of transfer to an inpatient facility or death at home.

CHAPTER 4 — ILLUSTRATIVE CLINICAL RECORD FORM PAGES WITH OASIS-C ITEMS INTEGRATED

Chapter 4 of this manual contains sample illustrative clinical record forms showing the integration of OASIS-C items. These one-page illustrative forms are included for the following timepoints:

Illustration 1 -- Start of Care Assessment

Illustration 2 – Start of Care Assessment

Illustration 3 – Discharge Assessment

Illustration 4 – Transfer to Inpatient Facility

ILLUSTRATION 1
Sample Page from Clinical Record Form with Integrated OASIS Items.

START OF CARE ASSESSMENT
(Also used for Resumption of Care Following Inpatient Stay)

(Page 1 of __)

Client's Name: _____

Client Record No. _____

A. DEMOGRAPHIC INFORMATION - Update Patient Tracking Sheet at ROC

1. **(M0080) Discipline of Person Completing Assessment:**

☐ 1 - RN ☐ 3 - SLP/ST

☐ 2 - PT ☐ 4 - OT

2. **(M0090) Date Assessment Completed:**

__ __ /__ __ /__ __ __ __
month / day / year

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

Start/Resumption of Care

☐ **1 - Start of care—further visits planned**

☐ **3 - Resumption of care (after inpatient stay)**

Follow-Up

4 - Recertification (follow-up) reassessment

5 - Other follow-up

Transfer to an Inpatient Facility

6 - Transferred to an inpatient facility—patient not discharged from agency

7 - Transferred to an inpatient facility—patient discharged from agency

Discharge from Agency — Not to an Inpatient Facility

8 - Death at home

9 - Discharge from agency

4. **(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

5. **(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

6. **(M0110) Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes?

☐ 1 - Early

☐ 2 - Later

☐ UK - Unknown

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

7. **Economic/Financial Problems or Needs** (describe):

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

☐ 1 - Long-term nursing facility (NF)

☐ 2 - Skilled nursing facility (SNF / TCU)

☐ 3 - Short-stay acute hospital (IPP S)

☐ 4 - Long-term care hospital (LTCH)

☐ 5 - Inpatient rehabilitation hospital or unit (IRF)

☐ 6 - Psychiatric hospital or unit

☐ 7 - Other (specify) _____

☐ NA - Patient was not discharged from an inpatient facility **[*Go to M1016*]**

9. **(M1005) Inpatient Discharge Date** (most recent):

__ __ /__ __ /__ __ __ __
month / day / year

☐ UK - Unknown

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

	Inpatient Facility Diagnosis	ICD-9-C M Code
a.	_____	__ __ __ . __ __
b.	_____	__ __ __ . __ __
c.	_____	__ __ __ . __ __
d.	_____	__ __ __ . __ __
e.	_____	__ __ __ . __ __
f.	_____	__ __ __ . __ __

ILLUSTRATION 2
Sample Page from Clinical Record Form with Integrated OASIS Items.

START OF CARE ASSESSMENT
(Also used for Resumption of Care Following Inpatient Stay)
(Page __ of __)

Client's Name: _____
Client Record No._____

L. REVIEW OF SYSTEMS/PHYSICAL ASSESSMENT (cont'd)

14. NEURO / EMOTIONAL / BEHAVIORAL STATUS

____ Hx of previous psych. illness ____ Other (specify) _____

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

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

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

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

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

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

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

- ☐ 0 - No
- ☐ 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

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

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

(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 (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

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

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

- ☐ 0 - No
- ☐ 1 - Yes

ILLUSTRATION 3
Sample Page from Clinical Record Form with Integrated OASIS Items.

DISCHARGE ASSESSMENT

(Page __ of __)

Client's Name: _____

Client Record No._____

C. IMMUNIZATION/SCREENING TESTS

1. **Immunizations:** Flu Yes ___ No ___ Date _____ Pneumonia Yes ___ No ___ Date _____
   Tetanus Yes ___ No ___ Date _____ Other:_____ Date _____

2. **Screening:** Cholesterol level Yes ___ No ___ Date _____ Colon cancer screen Yes ___ No ___ Date _____
   Mammogram Yes ___ No ___ Date _____ Prostate cancer screen Yes ___ No ___ Date _____

3. **Self-Exam Frequency:** Breast self-exam frequency _____ Testicular self-exam frequency _____

4. **(M1040) Influenza Vaccine:** Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care?

   ☐ 0 - No
   ☐ 1 - Yes **[** *Go to M1050* **]**
   ☐ NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. **[** *Go to M1050* **]**

5. **(M1045) Reason Influenza Vaccine not received:** If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:

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

6. **(M1050) Pneumococcal Vaccine:** Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?

   ☐ 0 - No
   ☐ 1 - Yes **[** *Go to M1230* **]**

7. **(M1055) Reason PPV not received:** If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:

   ☐ 1 - Patient has received PPV in the past
   ☐ 2 - Offered and declined
   ☐ 3 - Assessed and determined to have medical contraindication(s)
   ☐ 4 - Not indicated; patient does not meet age/condition guidelines for PPV
   ☐ 5 - None of the above

D. RISK FACTORS

1. **(M1032) Risk for Rehospitalization:** Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

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

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

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

3. **(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

ILLUSTRATION 4
Sample Page from Clinical Record Form with Integrated OASIS Items.

TRANSFER TO INPATIENT FACILITY

(Page 1 of __)

Client's Name: _____

Client Record No._____

A. DEMOGRAPHIC/GENERAL INFORMATION - Update Patient Tracking Sheet as needed.

1. **(M0080) Discipline of Person Completing Assessment:**
   - ☐ 1 - RN
   - ☐ 2 - PT
   - ☐ 3 - SLP/ST
   - ☐ 4 - OT

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

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

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

Follow-Up
- 4 - Recertification (follow-up) reassessment
- 5 - Other follow-up

Transfer to an Inpatient Facility
- ☐ **6 - Transferred to an inpatient facility—patient not discharged from agency**
- ☐ **7 - Transferred to an inpatient facility—patient discharged from agency**

Discharge from Agency — Not to an Inpatient Facility
- 8 - Death at home
- 9 - Discharge from agency

B. EMERGENT CARE

(M2300) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?

- ☐ 0 - No **[** ***Go to M2400*** **]**
- ☐ 1 - Yes, used hospital emergency department WITHOUT hospital admission
- ☐ 2 - Yes, used hospital emergency department WITH hospital admission
- ☐ UK - Unknown **[** ***Go to M2400*** **]**

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

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

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

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

CHAPTER 5 – RESOURCES / LINKS

This chapter provides information on print and electronic resources available to support you in OASIS accuracy, quality, safety and best practice.

Disclaimer

CMS does not control the content of the websites that are not listed as CMS. The links are valid at the time this document is being prepared but we cannot determine whether they will remain valid indefinitely. The opinions expressed may or may not match those of CMS policy. Users are urged to work with their OASIS Education Coordinators for questions regarding official CMS policy.

General Sources, Publications, and Web Sites

CMS websites

CMS Internet-Only Manuals (IOMs) http://www.cms.hhs.gov/Manuals/iom/list.asp

Conditions of Participation http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html

HAVEN https://www.qtso.com/havendownload.html and
http://www.cms.hhs.gov/OASIS/045_HAVEN.asp#TopOfPage

HHA Center http://www.cms.hhs.gov/center/hha.asp

Home Health Compare http://www.medicare.gov/HHCompare/Home.asp

Med Learn Network http://www.cms.hhs.gov/MLNGenInfo/

NPI Registry https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

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

OASIS-C http://www.cms.hhs.gov/HomeHealthQualityInits/06_OASISC.asp#TopOfPage

OASIS Data Specifications https://www.qtso.com/hhadownload.html
http://www.cms.hhs.gov/OASIS/04_DataSpecifications.asp#TopOfPage

OBQI http://www.cms.hhs.gov/HomeHealthQualityInits/16_HHQIOASISOBQI.asp#TopOfPage

OBQM http://www.cms.hhs.gov/HomeHealthQualityInits/18_HHQIOASISOBQM.asp#TopOfPage

Open Door Forum http://www.cms.hhs.gov/OpenDoorForums/17_ODF_HHHDME.asp#TopOfPage

Paperwork Reduction Act
http://www.cms.hhs.gov/PaperworkReductionActof1995/PRAL/list.asp?filtertype=dual&datefiltertype=&datefilterinterval=&filtertype=keyword&keyword=OASIS&intNumPerPage=10&cmdFilterList=Show+Items

Home Health PPS Payment http://www.cms.hhs.gov/HomeHealthPPS/01_overview.asp#TopOfPage

General Sources, Publications, and Web Sites (continued)

CMS websites

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

OASIS Privacy Rights Notice http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage

Home Health Quality http://www.cms.hhs.gov/HomeHealthQualityInits/

Quality Measures Management Information System (QMIS) Frequently Asked Questions
https://www.cms.hhs.gov/apps/QMIS/

OASIS Regulations http://www.cms.hhs.gov/OASIS/03_Regulations.asp#TopOfPage

Rulemaking http://www.cms.hhs.gov/eRulemaking/

State OAC/OEC information http://www.cms.hhs.gov/OASIS/06_EducationCoord.asp#TopOfPage

http://www.cms.hhs.gov/OASIS/07_AutomationCoord.asp#TopOfPage

State by State Comparison of Measures

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

CMS Survey and Certification

http://www.cms.hhs.gov/SurveyCertificationGenInfo/01_Overview.asp#TopOfPage

OASIS Q&A's Submit and Review questions

Q&A Tracking Table https://www.qtso.com/hhadownload.html

Mailbox http://www.cms.hhs.gov/OASIS/09_HHAQA.asp#TopOfPage
(to be updated in association with OASIS C)

Guidelines and Best Practices

Home Health Best Practice Intervention Packages (QIO)

http://www.homehealthquality.org/hh/hha/interventionpackages/default.aspx

Falls Prevention Best Practice Intervention Package (A comprehensive Best Practice Implementation Package from the Home Health Quality Improvement Campaign that helps home health agencies to design and implement a fall prevention program for their patients.)

http://www.qualitynet.org/dcs/ContentServer?cid=1200602385264&pagename=Medqic%2FMQTools%2FToolTemplate&c=MQTools

Evidence-Based Practice Guidelines, University of Iowa, College of Nursing

http://www.ahrq.gov/clinic/cpgonline.htm

National Guideline Clearinghouse™ (NGC): http://www.guideline.gov/browse/guideline_index.aspx

VNSNY Geriatric Home Care Excellence http://www.champ-program.org/

General Sources, Publications, and Web Sites (continued)

Healthcare Technology

NQF and HIT http://www.qualityforum.org/Topics/Health_Information_Technology_(HIT).aspx

Office of the National Coordinator for Health Information Technology (ONC) http://healthit.hhs.gov

http://www.hhs.gov/healthit/onc/mission/

http://www.himss.org/ASP/index.asp

http://www.hhs.gov/healthit/initiatives/

http://www.hitsp.org/news.aspx

http://www.nationalehealth.org/

http://nhinwatch.com/

Infection Control and Immunizations

CDC http://www.cdc.gov/vaccines/default.htm

http://www.cdc.gov/flu/

http://www.cdc.gov/az/

Medical Resources

Activities of Daily Living Definitions http://www.cancer.gov/Templates/db_alpha.aspx?CdrID=430402

Congestive Heart Failure

http://www.nlm.nih.gov/medlineplus/ency/article/000158.htm

http://www.emedicinehealth.com/congestive_heart_failure/article_em.htm

Diabetes

http://www.diabetes.org/

http://diabetes.niddk.nih.gov/

Diabetic Foot Care

http://diabetes.niddk.nih.gov/dm/pubs/complications_feet/index.htm

http://www.ndep.nih.gov/media/Feet_HCGuide.pdf

MEDLINE Medications http://www.nlm.nih.gov/medlineplus/druginformation.html

General Sources, Publications, and Web Sites (continued)

Mental Health Resources

Alzheimer's http://www.alz.org/living_with_alzheimers_caring_for_alzheimers.asp

BIMS' performance in national testing in community setting is included in a final report to CMS. Saliba D, Buchanan J. 2008. "Cognitive Patterns" Chapter 5 in Development & Validation of a Revised Nursing Home Assessment Tool: MDS 3.0.

Depression Recognition & Assessment in Older Home Care Patients e-learning module, Weill Medical College of Cornell University:

http://www.geriu.org/uploads/applications/DepressionInHomecare/DinHomecare.html

Brown EL, Raue PJ, Roos BA, Sheeran T, Bruce ML. 2009. "Training Nursing Staff to Recognize Depression in Home Healthcare." Journal of the American Geriatrics Society. Retrieved from http://dx.doi.org/10.1111/j.1532-5415.2009.02626.x

CMS website. Available: http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS30FinalReport.pdf

Chodosh J, Edelen MO, Buchanan JL Yosef JA, Ouslander JG, Berlowitz DR, Streim JE, Saliba D. "Nursing Home Assessment of Cognitive Impairment: 2008. Development and Testing of a **Brief Instrument of Mental Status**." Journal of the American Geriatrics Society 56(11): 2069-2075.

Caregivers http://www.nextstepincare.org/

Cognitive assessment tools http://alzheimers.about.com/od/diagnosisissues/a/clock_test.htm (clock test)

Mini-Mental Status exam http://www.minimental.com/

Risk Assessment Tools and Condition-Specific Resources

American Heart Association Statements and Practice Guidelines http://www.americanheart.org

Depression

PHQ-2 resources http://www.innovations.ahrq.gov/content.aspx?id=2280

PHQ-2 resources (University of Washington Impact Program)

http://impact-uw.org/tools/phq9.html

Falls Risk

Home Care Fall Reduction Initiative risk Assessment Screening Tool (A multi-factor falls risk screening tool from the Missouri Alliance for Home Care, specifically designed for home care patients at Start of Care and Re-certification)

http://www.homehealthquality.org/shared/content/hhqi_campaign/bpip_falls_prevention/Fall_Risk_Assessment_Screening_Tool__final.doc

Risk Assessment Tools and Condition-Specific Resources

Timed Up and Go (TUG) Test Demonstration video (Demonstration of how to administer the Timed Up and Go (TUG) test -- can be used as one component of a multi-factor risk assessment used to identify persons that are at risk of falling due to balance or gait problems)

http://www.qualitynet.org/dcs/ContentServer?cid=1216667046043&pagename=Medqic%2FMQPresentations%2FPresentationTemplate&c=MQPresentations

Get-up and Go Test (A brief assesment of gait and balance – University of Iowa, Iowa Geriatric Education Center)

http://www.healthcare.uiowa.edu/igec/tools/categoryMenu.asp?categoryID=3

National Heart Lung and Blood Institute

Body Mass Index guidelines http://www.nhlbisupport.com/bmi/

Pain

Non-verbal patient pain assessment: http://prc.coh.org/PAIN-NOA.htm

Geriatric Pain: http://www.champ-program.org/

Pressure Ulcers

Established, validated pressure ulcer risk tools include the Braden Scale for Predicting Pressure Sore Risk and the Norton Scale (both of which are available at http://providers.ipro.org/index/nhqi-tools

Braden http://www.bradenscale.com/

Norton scale http://www.woundcarehelpline.com/NortonScale.pdf

NQF Framework http://www.qualityforum.org/Projects/n-r/Pressure_Ulcer/Pressure_Ulcers.aspx

National Pressure Ulcer Advisory Panel (NPUAP) (www.npuap.org)

Pressure ulcer definitions: http://www.npuap.org/pr2.htm

Pressure ulcer pictures: http://www.npuap.org/resources.htm

NPUAP 's Pressure Ulcer Scale for Healing (PUSH) http://npuap.org/tools.htm

Wound Ostomy and Continence Nurses Society (WOCN) http://www.wocn.org/

Leg ulcers: http://www.wocn.org/pdfs/WOCN_Library/Fact_Sheets/C_QUICK1.pdf

OASIS guidance http://www.wocn.org/WOCN_Library
(Look for the upcoming *OASIS-C Guidance Document)*

General Sources, Publications, and Web Sites (continued)

Professional Organizations

ANA http://www.nursingworld.org/

ANA Releases Revised Scope and Standards of Practice for Home Health Nurses (11/21/07)

http://www.nursingworld.org/FunctionalMenuCategories/MediaResources/PressReleases/2007/RevisedScopeandStandardsforHomeHealthNurses.aspx

AOTA http://www.aota.org/

APTA http://www.apta.org/AM/Template.cfm?Section=Home_Health1&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=55148

ASHA http://www.asha.org/default.htm

Quality Resources

Agency for Healthcare Research and Quality http://www.ahrq.gov/

AHRQ's Health Care Innovations Exchange Web site http://www.innovations.ahrq.gov/
(Innovations and QualityTools classified by disease or clinical category, patient population, stage of care, setting of care, and more.)

AHRQ's Quality Measures Database - National Quality Measures Clearinghouse (NQMC).
http://www.qualitymeasures.ahrq.gov/

Commonwealth Fund Commission on a High Performance Health System: http://www.commonwealthfund.org/

Diversity:The Provider's Guide to Quality and Culture
http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English

Institute for Clinical Systems Improvement

http://www.icsi.org/

http://www.icsi.org/guidelines_and_more/patient_education_resources/

Institute for Healthcare Improvement

http://www.ihi.org/

http://www.ihi.org/ihi/workspace/

Institute of Medicine

http://www.iom.edu/CMS/28312/RT-EBM.aspx

http://www.iom.edu/CMS/3718.aspx

http://books.nap.edu/openbook.php?isbn=0309072808&page=1

General Sources, Publications, and Web Sites (continued)

Quality Resources

MedQIC http://www.qualitynet.org/dcs/ContentServer?pagename=Medqic/MQPage/Homepage

National Transitions of Care Coalition (NTOCC) http://www.ntocc.org/

Safety Resources

AHRQ Patient Safety http://www.psnet.ahrq.gov/

Joint Commission http://www.jointcommission.org/AccreditationPrograms/HomeCare/

Joint Commission National Patient Safety Goal

http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/09_ome_npsgs.htm

Fall Risk/Safety http://www.nice.org.uk/nicemedia/pdf/CG021quickrefguide.pdf

Geriatric http://www.champ-program.org/page/51/tools

Medication Safety Institute for Safe Medication Practices (ISMP)

http://www.ismp.org/Tools/anticoagulantTherapy.asp

http://www.ismp.org/Tools/highalertmedications.pdf

QualityNet -- Tools for evaluating potential inappropriate medications http://www.qualitynet.org

TJC - Medication Management:

http://www.jointcommission.org/NR/rdonlyres/A4E32C3D-FFDA-4B3A-9754-DBAA8054145A/0/OME_MM.pdf

Teamwork/TeamSTEPPS Training Curriculum Materials http://teamstepps.ahrq.gov/index.htm

VA National Center for Patient Safety http://www.va.gov/NCPS/TIPS/tips.html

APPENDIX A – OASIS AND THE COMPREHENSIVE ASSESSMENT

1. WHAT IS A COMPREHENSIVE ASSESSMENT?

Patient assessment is an essential component of health care delivery. Assessment requires the collection of pertinent data regarding the patient, supportive assistance, and the patient's environment. Clinicians of all types systematically collect and categorize such data, analyze and evaluate these data, and draw conclusions from the data that guide their subsequent interventions. It is the interventions that then are directed toward improving or maintaining health status (or supporting the patient in a dignified dying process). Assessment involves the active gathering of accurate and well-defined patient status information.

A comprehensive assessment involves collecting data on multiple aspects of the patient and the environment. The patient receiving home care particularly benefits from a comprehensive assessment because the interrelated aspects of patient and environment all influence current and future health status. An assessment with too narrow a focus omits many components relevant to care delivery. Consider the example of a patient with an open surgical wound requiring dressing changes. A narrowly focused assessment would evaluate only the wound status. Such an assessment fails to take into account other factors relevant for wound healing, such as nutrition. The comprehensive assessment will consider the patient's nutritional status, which must address the actual food intake, the ability to prepare food, the ability to shop for food, and the presence of financial factors that may limit the ability to purchase food. The presence (or absence) of sanitation hazards, also important for wound healing, can be identified by the comprehensive assessment. In addition, the patient's ability to perform his/her own dressing change or the availability, willingness, and ability of a family member (or other caregiver) to change the dressing will also be evaluated in the comprehensive assessment. By collecting data on the variety of interrelated aspects of patient and environment that affect health status, such an assessment clearly provides a better base for care planning and delivery.

It should be noted that the data items in OASIS are not, in and of themselves, a complete or comprehensive assessment. Home health agencies will need to supplement the OASIS data items with others necessary for a full assessment. For example, the OASIS items do not include vital signs, assessment of breath sounds, or collection of data on fluid intake, which are part of a more complete assessment. Each agency will be expected to incorporate the OASIS items into its own comprehensive assessment documentation and related policies and procedures.

2. HOW ARE THE COMPREHENSIVE ASSESSMENT DATA COLLECTED AND DOCUMENTED?

Patient assessment data are collected through a combination of methods -- including interaction with patient/family, observation, and measurement. When used in combination, these methods provide a full picture of the patient's health status. Interaction and interview (i.e., report) data can be verified through observation and measurement; observation data can identify factors that require additional interview questions.

Interaction and interview involve purposeful communication with the patient or family. Some interview questions are short and direct (e.g., what is your birth date?, are you taking/receiving any injectable medications?), while others begin with an open-ended question that leads to further inquiries with a more specific focus (e.g., "what kind of assistance do you receive from

family or friends?," can be followed by more specific questions about types and frequency of assistance if an affirmative response is obtained). In all cases, the patient is the preferred source for interview/interaction data, though the family/caregiver (or other health care provider) can provide information if the patient is unable to do so. Information such as biographical data, pertinent health and social history, and the review of body systems can only be obtained through interview/interaction. Observation often supplements and enriches the interview data. For example, the clinician observing a healed surgical wound scar may supplement the health history when additional questions identify disease conditions not previously mentioned.

Observation techniques obtain data through the senses. Using sight, sound, smell, and touch, the clinician collects and records patient status information. Measurement is a form of observation that uses a calibrated "instrument" to obtain data. For example, blood pressure, joint range of motion, height, and weight are all obtained by measurement. In all observational approaches, consistency and objectivity are particularly important. Standards for clinical observation are important to apply in conducting patient assessment.

All these methods and techniques should be used in conducting the comprehensive assessment and collecting OASIS data. Using only one approach limits both the amount and quality of the information obtained. Direct observation is the preferred method for data collection, but some historical data may only be obtained by interview. This interaction should supplement, not replace, observational techniques.

The patient receiving care at home presents both unique opportunities and challenges for clinicians in assessing patients. One opportunity is that the clinician is able to collect data on environmental characteristics (such as safety features) through first-hand observation rather than needing to rely exclusively on report. Thus, the accuracy of the patient status information is increased, which also increases the likelihood of appropriate pertinent interventions. Within this setting, however, the patient and family exercise control, in contrast to other health care delivery settings where the provider controls the environment. The clinician does not have the immediate and constant support of rules, policies, and colleagues to aid in data verification or compliance. The home care clinician often is required to exercise creativity and flexibility in collecting patient assessment data for care planning. For example, assessment of the home care patient begins even before the clinician enters the home. The initial referral provides an introduction to the client situation. A telephone contact with the patient/family to arrange the visit furnishes additional data. Environmental characteristics of the neighborhood and the patient residence are apparent as the clinician approaches the home. When the comprehensive assessment is documented, the clinician's actual observations that describe the patient's current status should be recorded. The conclusions derived from these assessment data will direct the subsequent care planning activities.

3. COMPREHENSIVE ASSESSMENT AND OASIS REGULATION

In 1999, the Centers for Medicare & Medicaid Services (CMS) revised the Conditions of Participation (CoP) that home health agencies (HHAs) must meet to participate in the Medicare program. Specifically, this added rule states that each patient receive from the HHA a patient-specific, comprehensive assessment that identifies the patient's need for home care and that meets the patient's medical, nursing, rehabilitative, social, and discharge planning needs. The rule requires that as part of the comprehensive assessment, HHAs use OASIS when evaluating adult, nonmaternity patients. Additionally, the OASIS meets the condition specified in §1891(d) of the Social Security Act, which requires the Secretary of the Department of Health and Human Services to designate an assessment instrument for use by an agency in order to evaluate the

extent to which the quality and scope of services furnished by the HHA attain and maintain the highest practicable functional capacity of the patient as reflected in the plan of care. These components were identified as an integral part of CMS' efforts to achieve broad-based improvements in the quality of care furnished through Federal programs and in the measurement of that care. The following briefly describes the CoP relevant to OASIS data collection. Specific regulatory language can be found within the CoP at http://cms.hhs.gov/manuals/Downloads/som107ap_b_hha.pdf

Condition of Participation: Comprehensive Assessment of Patients

42 CFR 484.55 requires that a patient receive from the HHA a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must (1) identify the patient's continuing need for home care; (2) meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs; and (3) for Medicare patients, identify eligibility for the home health benefit, including the patient's homebound status. The comprehensive assessment must also incorporate the exact use of the current version of the OASIS data set, which is found on the CMS OASIS web site at http://www.cms.hhs.gov/oasis; click on "Data Set." A comprehensive assessment identifies patient progress toward desired outcomes or goals of the care plan.

CMS expects that HHAs will collect OASIS data in the context of a comprehensive assessment on adult Medicare or Medicaid patients (age 18 or over) receiving skilled health services from the HHA, except for patients receiving care for pre- and post-partum conditions. Patients receiving skilled health services, whose care is reimbursed by other than Medicare or Medicaid, must receive comprehensive assessments, but the collection of OASIS data is not required. For patients receiving only personal care services, regardless of payer source, a comprehensive assessment is also required, but not the collection of OASIS data. Patients who receive only services such as homemaker, chore, or companion services do not require the comprehensive assessment.

Five standards are contained in the Comprehensive Assessment CoP. Following are the requirements for each standard.

a. §484.55 Standard: Initial Assessment Visit

The initial visit is performed to determine the immediate care and support needs of the patient. This visit is conducted within 48 hours of referral or within 48 hours of a patient's return home from an inpatient stay, or on the physician-ordered start of care date. The initial assessment visit is intended to ensure that the patient's most critical needs for home care services are identified and met in a timely fashion. For Medicare patients, this initial assessment determines eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be conducted by a registered nurse unless rehabilitation therapy services are the only services ordered by the physician. Under the Medicare home health benefit, any one of three services (skilled nursing, physical therapy, or speech-language pathology) can establish program eligibility. If rehabilitation therapy services are the only services ordered by the physician, the initial assessment may be made by the appropriate rehabilitation skilled professional if the need for that service establishes eligibility for the home health benefit. The law governing home health eligibility prevents occupational therapy from

establishing eligibility for the Medicare home health benefit at the initial assessment, though once eligibility is established, then continuing occupational therapy could establish eligibility for a subsequent episode (meaning that the occupational therapist could complete the Recertification assessment). If no skilled service is delivered at this initial assessment, this visit will not be considered the SOC nor is it considered a reimbursable visit for the Medicare home health benefit.

Note that for payers other than Medicare, the occupational therapist may complete the initial assessment if the need for occupational therapy establishes program eligibility.

The comprehensive assessment is not required to be completed at the initial assessment visit, although the HHA may choose to do so. If a skilled service is delivered at the initial assessment visit, thus establishing the SOC, the comprehensive assessment may be initiated at this visit and completed within the time frames discussed below, depending on agency policy.

b. §484.55(b) Standard: Completion of the Comprehensive Assessment

The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than five calendar days after the start of care.

This requirement does not preclude an HHA from completing the comprehensive assessment during the SOC visit, and many HHAs currently operate in such a manner. This time frame provides operational flexibility to the HHA while maintaining patient safety in ensuring that all patient needs will be identified within a standard time period. Some HHAs have policies requiring that a nurse conduct the comprehensive assessment. Home care staff should follow agency policies governing which disciplines can complete the comprehensive assessment.

c. §484.55(c) Standard: Drug Regimen Review

Under this requirement, the comprehensive assessment must include a review of all medications the patient is currently using to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects and drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

While patients receive their drug regimen from the physician, review of this regimen is an integral part of the comprehensive assessment. In addition, this review is an important safeguard for patients who may receive medications from a variety of physicians and pharmacies. Some agencies have policies requiring nurses to do the drug regimen review. In addition, some state practice acts may preclude therapists from completing the drug regimen review. Home care staff should follow state regulations and agency polices governing which disciplines can complete the drug regimen review.

d. §484.55(d) Standard: Update of the Comprehensive Assessment

The comprehensive assessment, which includes OASIS items for Medicare and Medicaid patients, must be updated and revised as frequently as the patient's condition requires, but not less frequently than every 60 days beginning with the start of care date; within 48 hours of the patient's return home from an inpatient facility stay of 24 hours or more for any reason except diagnostic testing; and at discharge. The update of the

comprehensive assessment must include completion of all required OASIS items for that time point, plus any others determined necessary by the HHA for a comprehensive assessment. This assessment provides information for determination of changes in treatment or plan of care. Therefore, a comprehensive assessment also is required when there is a major decline or improvement in a patient's health status as defined by the HHA.

An inpatient facility admission as an event is generally a predictor of a change in the patient's health status and therefore should be captured in the OASIS data. In addition, because patients frequently improve rapidly upon returning home from an inpatient facility, it is important for the HHA to assess the patient's true needs as quickly as possible after discharge from the inpatient facility. Therefore, the comprehensive assessment is required within 48 hours of the patient's return to the home from an in-patient facility admission of 24 hours or more for any reason other than diagnostic tests.

Follow-up assessments must be completed every 60 days that a patient is under care. For Medicare and Medicaid patients, when a follow-up assessment is due, it must be completed no earlier than four calendar days before, and no later than the day marking the end of the 60-day period (i.e., day 56 through day 60 of the period).

e. §484.55(e) Standard: Incorporation of the OASIS Data Set

OASIS must be incorporated into the HHA's own assessment, exactly as written. Both the language and the groupings of the OASIS items must be maintained. Integrating the OASIS items into the agency's own assessment system in the sequence presented in the OASIS form would facilitate data entry of the items into data collection and reporting software. However, HHAs may integrate the items in such a way that best suits the agency's own assessment.

The OASIS data set is not intended to constitute a complete comprehensive assessment instrument. Rather, the data set comprises items that are a necessary part of a complete comprehensive assessment and that are essential to uniformly and consistently measure patient outcomes. An HHA can use the data set as the foundation for valid and reliable information for patient assessment, care planning, service delivery, and improvement efforts.

The OASIS items are already used in one form or another by virtually all HHAs that conduct thorough assessments, and simply adding the OASIS data set to the rest of the HHA's paperwork would be burdensome and duplicative. Therefore, we expect HHAs to replace similar assessment items with OASIS items in their assessment forms to avoid lengthening the assessment unnecessarily. This may be accomplished by modification of existing forms or using commercially available comprehensive assessment forms that include OASIS items. The Mxxxx numbers for each OASIS data item should be retained to allow for easy recognition of the required OASIS item in the HHA comprehensive assessments.

APPENDIX B – OASIS DATA ACCURACY

1. DATA ACCURACY

Medicare Home Health Care Conditions of Participation §484.20(b) Standard: Accuracy of Encoded OASIS Data stipulates that the encoded OASIS data must accurately reflect the patient's status at the time the information is collected. Before transmission, the HHA must ensure that data items on its own clinical record match the encoded data that are sent to the State. Once the qualified skilled professional completes the assessment, the HHA should develop means to ensure that the OASIS data input into the computer and transmitted to the State agency (or CMS contractor) exactly reflect the data collected by the skilled professional. Chapter 12 of the original *OASIS Implementation Manual* contains recommendations for conducting data quality audits on a routine basis. This information is summarized below. In addition, the State survey process for HHAs may include review of OASIS data collected versus data encoded and transmitted to the State.

2. DATA QUALITY AUDITS

Data-driven systems, such as OASIS data collection and outcome measurement, depend on the accuracy of source data describing patient health status. It follows that minimizing data errors that could affect accuracy of clinical data or outcome analyses is a necessary condition. This function is the responsibility of the agency since, ultimately, agency-level outcome reports reflect the data agencies input into the system. Internal staff development and training must focus on data accuracy not only at the start-up of OASIS data collection, but on a continuing basis. We recommend that data quality audits be conducted in agencies on a routine basis. Some data audit activities should be conducted monthly, while others can be conducted at less frequent intervals, such as quarterly.

The following guidelines provide a method for monitoring the quality of data in an agency. Types of audits, their recommended frequency, and categories of staff members (to conduct data audit activities and summarize findings) are suggested. If problems are identified, it is also recommended that the agency develop and implement a plan to correct data quality problems. Table B.1 displays the data quality audit approaches discussed and summarizes the purpose, frequency, and procedures for each. .

Table B.1: Data Quality Audits.

Audit Type	Purpose	Frequency	Overview of Procedure	Performed By
Clinical Record Audit	To verify accuracy of OASIS patient status items compared to other related patient documentation	Monthly	Review at least five SOC records and five discharge records. Compare OASIS items to other documentation from the SOC or discharge visits and from other visits surrounding SOC or discharge.	QI coordinator or clerical staff

Table B.1: Data Quality Audits. (cont'd)

Audit Type	Purpose	Frequency	Overview of Procedure	Performed By
Data Entry Audit	To verify accuracy of OASIS data entry and the data in the clinical record (or using double data entry)	Monthly	Either: (1) Obtain a hardcopy of OASIS data that were entered for five patients. Compare to OASIS items in clinical record; or (2) Data enter OASIS information for five patients twice. Compare data entered the first time to data entered the second time for each patient.	QI coordinator, IS/IT coordinator, or data entry staff
Clinical Audit Visits	To verify accuracy of OASIS assessment data, i.e., evaluate assessment methodology and assessment skills of clinical staff	Quarterly	For at least three or four patients, a supervisor or peer auditor attends the SOC visit. The auditor completes OASIS items while the care provider conducts the assessment and completes SOC paperwork. OASIS items are compared for consistency between auditor and care provider.	QI coordinator, clinical supervisor, or clinical staff

a. Monthly Audit Activities

Clinical Record Audits: Clinical record audits allow an agency to monitor the validity of OASIS data. The quality check assesses the congruence of OASIS data with other patient status information found in the clinical record. This audit allows an agency to check for systematic bias in describing patient status. Most often, this will take the form of exaggerating illness or disability at start of care to enhance the justification for providing services and, under prospective payment, to maximize payment. There may also be a concomitant bias in the opposite direction for a discharge assessment, driven by a desire to make patient outcomes appear in a more favorable light or simply as a justification for discharge (e.g., the goal of reaching a certain level of functioning has been met).

To conduct a clinical record audit, an abbreviated record review can be conducted for at least five new admissions and five patients discharged from the agency (but not due to an inpatient facility admission). Records should be randomly selected, in order to evaluate data quality for a cross-section of patients and care providers. The selection process might be as follows:

- Choose a standing date for record selection (for example, the first Tuesday of every month). On that day each month, alphabetically compile a list of all skilled care patients admitted to the agency for the previous month. For example, if the record selection date for February falls on February 3rd, compile a list of all patients admitted to the agency from January 3rd to February 2nd.

- Count the number of patients on the list. Divide that number by five, rounding down to the nearest whole number. For example, if there are 42 patients on the list, 42 ÷ 5 = 8.4, which would be rounded to 8. This number, n, will be used to select records. Divide this number by 2 to obtain the starting point, m, for selecting records.

- Count from the first patient alphabetically, select the mth patient, and select every nth patient after that. Using the above example, you would select the 4th person and then every 8th person on the list for record review.

The same procedure should be used to select records for discharged patients. Compile a list of patients discharged from the agency within the previous month. Divide the number of patients by five, and use that number (n) to select patients for record review.

In the event that you have fewer than five patients admitted to or discharged from your agency, review all records. It should be noted that many agencies choose to audit a larger sample and some audit 100% of records.

Procedure for Clinical Record Audits: For new admissions, review the start of care (SOC) OASIS items and compare to other admission documentation and two or three subsequent visit notes, if they occur within the first week after SOC. In addition, if care providers from two disciplines perform assessments on the patient within one week of SOC (e.g., registered nurse conducts comprehensive assessment visit and completes OASIS items; the physical therapist visits two days later and evaluates the patient), the documentation should be compared. Reviewers should evaluate whether any discrepancies between the SOC OASIS assessment and the other documentation are sufficiently significant to indicate a data quality problem. For example, if the SOC OASIS items indicate that the patient is fully independent in ambulation, but other documentation indicates that the patient needs assistance when walking, a data quality problem may exist. Assess for any discrepancies between sociodemographic items (e.g., patient ID number or age) in addition to discrepancies in clinical assessments (ICD codes, all clinical assessment OASIS items).

The records for discharged patients should be reviewed in the same manner. All discharge OASIS patient status items should be compared to other discharge information as well as to the previous two or three visit notes (if those visits occur within the same week of discharge). If there are large differences in descriptions of the patient, a potential data quality problem exists.

If differences are found that cannot be explained by other documentation in the clinical record, the care provider who completed the OASIS should be contacted to determine if the discrepancies were real (e.g., the patient did change significantly between the SOC visit and a visit the next day) or if an error was made when recording OASIS data. If data quality problems exist, the problems can be corrected. If clinical documentation must be amended, this should be done according to agency policy. Any corrections to OASIS data in the clinical record must also be reflected in the OASIS database maintained by the agency, and if data submission has already occurred, a correction must be submitted to the State.

Data Entry Audits: Data entry audits allow agencies to monitor the accuracy of data entry. Data entry errors in fields such as birth date or health insurance number are often detected through other agency procedures (e.g., billing -- if the data entry software communicates with other agency systems), while patient status data are not typically subjected to such verification. Such errors, however, can affect outcome analyses and should be

monitored. This type of audit may not be relevant for agencies using electronic health records, as data entry occurs concurrently with the clinical assessment.

To conduct a data entry audit, a small sample of Medicare and/or Medicaid (skilled care) patient records should be checked at monthly intervals. In this evaluation, the clinical documentation is compared to the OASIS data that was entered to assess for data entry errors. This can be done by visual inspection or by double data entry, where the same record is data entered twice.

Procedure for Data Entry Audits: From the monthly list of Medicare and Medicaid patients admitted to the agency, select at least five records. The sample records need not be randomly selected, but if more than one person is responsible for data entry, some records entered by each staff member should be assessed. These may be the same records you use for the clinical audit. Obtain a printout of the information that was data entered or view the data online (the procedure for doing this will vary, depending upon the software you choose). Compare the response to each OASIS item in the clinical documentation with the computer printout or screen display of entered data. An alternative method is to have two staff conduct data entry of the same records independently and to compare the data records item by item.[1]

If discrepancies exist between the data that were entered and the OASIS items in the clinical record or between the OASIS items that were data entered twice, it is important to follow up with appropriate personnel. The agency database should be corrected and if necessary a correction should be submitted to the State. If data entry errors appear to be pervasive, a plan of action to remedy the problems should be developed and implemented.

b. Quarterly Audit Activities

Clinical Audit Visits: Clinical audit visits provide an opportunity to verify the quality of patient status data collected by clinicians. It is recommended that each quarter agencies conduct supervisory (or peer) audit visits to at least three to four patients. These audit visits should occur at the admission comprehensive assessment visit. Within a one-year period, each clinical staff member of an average-sized agency thus can receive an audit visit. The supervisor or peer auditor should complete the SOC OASIS items while observing the care provider conducting the SOC visit. The care provider and auditor should not discuss OASIS items between themselves during the visit. The QI coordinator (or designated person) then compares each item on the SOC OASIS items completed by the care provider to the OASIS items completed by the auditor. Discrepancies should be noted. Any differences between OASIS items should be discussed jointly by the care provider and auditor to determine the reasons for the differences and to ensure that care providers fully understand the OASIS items. It is not necessary to select a random sample of patients for the audit visits, but the QI coordinator or QI team should ensure that a variety of patients and care providers are represented.

[1]The exact mechanism for accomplishing double data entry will depend on the data entry software your agency uses, and may require some database programming at the agency or by your vendor. HAVEN, for example, does not directly support double data entry, although it can be accommodated by a HAVEN user with some expertise in database management.

3. SUMMARIZING AUDIT ACTIVITIES

a. Documentation

Agencies should summarize findings from all audit activities as they are completed. Because these audit activities will be an ongoing quality monitoring activity, it may be helpful to include summaries of findings in quarterly QI reports. If data quality problems are identified from the audit activities, investigations should be conducted into the cause(s) of the problems, and action plans developed and implemented to resolve the problems. Approaches to assure that accurate patient-level data are utilized to describe patient status and to compute outcome measures increase the likelihood that agency-level outcome reports accurately describe the effectiveness of patient care.

b. Chapter 12 Worksheets

Chapter 12 of the OASIS Implementation Manual contains worksheets that may be helpful to you in summarizing your findings, but there are no requirements for their use. Agencies may develop their own summary forms or modify current monitoring forms to include the data quality audit results. These are available at the following link (download Part I Chapters): http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage .

c. Making Corrections To Oasis Data

The following information is posted on the www.qtso.com website for making corrections to OASIS data. For more item-specific questions, refer to CMS posted Q & As on the CMS website (see link in Chapter 5 Resources)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

Ref: S&C-01-12

DATE: **April 20, 2001**

FROM: Director
Survey and Certification Group

SUBJECT: New Outcome and Assessment Information Set (OASIS) Correction Policy for Home Health Agencies (HHAs)—ACTION and INFORMATION

TO: Associate Regional Administrators, DMSO
State Survey Agency Directors

With the scheduled spring 2001 update of the OASIS state-based systems, HHAs will have the ability to electronically correct nearly all errors found in their production OASIS submissions. Currently, the OASIS state-based systems allow HHAs to electronically correct non-key fields in assessments that contain errors. Correcting key field errors and removing assessments that are submitted in error are subject to a process that, until the state system update is in place, can only be corrected by asking state staff to manually make the appropriate corrections or deletions in the state's database. Making such manual deletions has been time consuming and prone to error and many correction and deletion requests have not been fulfilled.

State System and Software Update

We expect the OASIS state-based systems to be updated the week of April 30 - May 4. By May 7, HHAs will be able to correct nearly all erroneous assessments themselves. In order to transition to the automated correction process, state agencies should no longer accept requests for key field changes. Instead, HHAs should be instructed to use the new inactivation procedures that will be available to them beginning May 7 to correct assessments containing key field errors. State agencies should clear up any backlog of requests for key field changes by April 29. The state system update will not change the current process for making non-key field changes.

Concurrent with the update to the OASIS state-based systems, a new version of the Home Assessment Validation Entry (HAVEN) software, HAVEN 5.0, will be distributed to HAVEN users free of charge and will also be available for download from the OASIS website at www.hcfa.gov/medicaid/oasis/havensof.htm. HAVEN 5.0 will give HHAs the ability to electronically correct nearly any kind of assessment errors.

Key Fields and Non-Key Fields

A description of key fields is below. Non-key fields are all other fields making up the OASIS data set that are not key fields.

Key Fields	
Patient Identifiers:	
M0040_PAT_LNAME	Patient last name
M0040_PAT_FNAME	Patient first name
M0064_SSN	Patient social security number
M0066_PAT_BIRTH_DT	Patient date of birth
M0069_PAT_GENDER	Patient gender
HHA Identifiers:	
HHA_AGENCY_ID	Unique Agency ID code
Assessment Event Identifiers:	
M0100_ASSMT_REASON	Reason for completing assessment
M0090_INFO_COMPLETED_DT	Date assessment information completed (This is a key field only on recertification or follow-up assessments where RFA=04 or 05)
M0030_START_CARE_DT	SOC date (This is a key field only on SOC assessments where RFA = 01 or 02)
M0032_ROC_DT	ROC date (This is a key field only on ROC assessments where RFA = 03)
M0906_DC_TRAN_DTH_DT	Discharge, transfer, death date (This is a key field only on transfer to inpatient facility assessments where RFA = 06 or 07, death at home assessments where RFA = 08 and discharge assessments where RFA = 09 or 10)

With the implementation of Version 1.20 of the OASIS data specifications in May, HHAs will be able to electronically correct key field errors in production records in addition to non-key field errors and also remove erroneous records using an automated methodology called inactivation. With the ability to inactivate erroneous OASIS assessments, as described below, HHAs will be able to remove assessments from the state system's active database that have been submitted in error. These records are not actually deleted, but are moved from the active database to a history database that contains records that have been modified or inactivated. This approach keeps an audit trail of modified and inactivated records, but "hides" them from the normal state system reporting procedures.

Determining When to Inactivate an Assessment

If an error has been made in one or more **key fields,** or if an assessment was submitted in error, the HHA will no longer need to notify the state OASIS automation coordinator. The erroneous assessment can and should be inactivated by the HHA. **The inactivation procedure should be used if it is necessary to correct an assessment with errors in key fields. Use of the inactivation procedure is not applicable to correcting assessments with only non-key field errors.** In other words, if an assessment contains errors in only non-key fields, then correction type 3 listed below should be used.

In order to determine whether to submit an inactivation request, the user should apply the following rules:

A. If an assessment was submitted in error (i.e., it should never have been submitted), it must be inactivated. For example, if a discharge assessment was submitted by the therapist; however, the patient is still being visited by the nurse, an inactivation request must be submitted for the erroneous discharge record. Another reason to inactivate an assessment would be if the submitted assessment contained the wrong patient name.

B. If an assessment was submitted which contained an error in any of the key fields listed above, then an inactivation request must be submitted. Normally, the HHA will also submit a new, corrected assessment in this situation. For example, if the HHA discovers that the patient's last name on the start of care (SOC) assessment is spelled "Smyth," while on the follow-up (FU) assessment it is spelled "Smith," it needs to make the appropriate correction. When the HHA determines the discrepancy, the incorrect record must be inactivated and a new corrected record must be submitted.

C. If an assessment was erroneously submitted in a masked format, that is, it was later discovered that the patient was a Medicare or Medicaid patient but was not originally indicated as such at M0150, then an inactivation must be submitted. Normally, the HHA will also submit a new, corrected assessment in this situation. For example, if the value at M0150 for a submitted and accepted assessment is not equal to 1, 2, 3, or 4, *and it should have been*, then an inactivation request should be submitted

Note: There is no automatic mechanism to reactivate a record that has been inactivated. Consider the case where a discharge assessment is submitted to the state system for a patient, but is inadvertently inactivated. There is no means to "undo" the inactivation and thereby "reactivate" this discharge. Instead the HHA must submit the discharge record again. An inactivated record can only be "undone" by the re-submission of the record.

Deleting Assessments

In certain infrequent situations, inactivation is not sufficient to correct assessment errors since inactivation alone does not remove the assessment record from the OASIS state system. Two situations require deletion of an erroneous assessment, rather than inactivation. States will continue to need to submit deletion requests on behalf of HHAs, upon request, to the Iowa Foundation for Medical Care as per current policy outlined in our November 2, 1999 technical memorandum (State Technical Support Office (STSO) Memorandum 1999-075). Described in that memorandum are the following situations requiring deletion.

A. If an assessment exists on the state's database that should never have been stored there, according to current policy it must be deleted. For example, if an assessment was erroneously submitted in an un-masked format (i.e., it was marked at M0150 as 1, 2, 3 or 4) and later it was discovered that the patient was <u>not</u> a Medicare or Medicaid patient because one of these pay sources was incorrectly selected on M0150 (i.e., it should not have marked 1, 2, 3, or 4), the assessment must be deleted from the OASIS state system.

B. If test files and/or batches have been submitted as production files and/or batches in error, they must be deleted.

Types of Corrections an HHA Can Make in HAVEN 5.0

The new version of our data entry software, HAVEN 5.0, will offer the following menu of corrections an HHA can make.

1. Assessment was Submitted to the State and was Rejected. The HHA can unlock the assessment (the lock date changes to reflect the date the correction was made), make the necessary changes, re-lock the assessment, and re-submit it. Because of the built-in edit checks, HHAs using the HAVEN software should not expect records to be rejected by the state system for this reason. Note that the following examples are provided for illustration purposes to troubleshoot HAVEN-like software, but cannot occur in HAVEN.

   EXAMPLE 1: The HHA Agency ID field in one or more assessment records does not match the HHA Agency ID in the header record of the submission file. The entire submission file is rejected and no data is loaded into the state database.

   EXAMPLE 2: The patient=s last name was missing from the assessment file (data record). The HHA may have inadvertently left this field blank. The OASIS state system must have the patient=s last name. The data record in this example would be rejected and no data from this record would be loaded into the state database.

   In these examples, the HHA would make the necessary corrections and re-submit the record. Since the OASIS state system never accepted the original assessment, the correction number field IS NOT incremented in this situation. HHAs may still receive a warning if submission/timing guidelines have been exceeded.

2. Assessment was Submitted to the State and was Accepted. Correction to Key Fields is Necessary. With the implementation of the OASIS state system update, this option will display but will no longer be available and is disabled in the new HAVEN 5.0 software. To correct an assessment with key field errors, first inactivate the assessment, then create a new assessment for re-submission, as applicable. See option 4.

3. Assessment was Submitted to the State and was Accepted. Correction to Non-Key Fields is Necessary. If an HHA determines that a correction(s) must be made to **non-key fields only** (i.e., any fields in the OASIS data set not contained in the key fields listed above), the HHA should re-open the assessment, revise the targeted non-key fields, and re-lock and re-submit the corrected record. The lock date changes to reflect the date the correction was made.

   Note: 'CORRECTION_NUM' is a counter field contained in the programming of the HAVEN software used to track corrections made to an assessment record. The counter field is set to 00 when an assessment record is initially locked. The counter field is incremented in this case. Both the original assessment and the corrected assessment will

be stored in the state database. When this type of correction occurs, the rule requiring the lock date to be within 7 days of the assessment's completion date (M0900) is waived for the corrected record.

4. Assessment was Submitted to the State and was Accepted. Inactivation of the assessment is necessary. This is a new option in HAVEN 5.0 that allows HHAs to correct key field errors by inactivating the assessment(s) containing key field errors and re-submitting a new, corrected assessment. Unlike making non-key field changes, as described in correction type 3 above, the HHA does not simply unlock the assessment record, make the necessary key field changes, re-lock the record, and re-submit it. Instead, the HHA is taken directly to the assessment in question where it can be viewed in a read-only format. While in read-only mode, when the HHA confirms that the assessment should be inactivated, HAVEN will ask the HHA to commit to this selection. The correction number field on the HAVEN Management screen displays an 'X' and the assessment status is set to "Locked (Export Ready)." The 'X' indicates that this assessment has been prepared for inactivation.

   When the HHA selects this correction type, a copy of the original assessment record is created. To re-submit the assessment with the necessary corrections, the HHA first exports the assessment that is being inactivated. From the HAVEN Management screen, the HHA then selects the inactivated record in question and clicks on the 'Correct Assessment' button. A popup box will appear asking if the HHA wants to make any corrections to this assessment. When the HHA clicks on the 'OK' button, a copy of the original assessment appears. The HHA makes the necessary changes and re-submits the assessment. The correction number for this assessment is reset to 00. The lock date changes to reflect the date the correction was made.

The attached flow chart depicts the most common situations necessitating correction.

Documentation of Corrected Assessments

When a comprehensive assessment is corrected, the HHA must maintain the original assessment record as well as all subsequent corrected assessments in the patient's clinical record for five years, or longer, in accordance with the clinical record requirements at 42 CFR 484.48. If maintained electronically, the HHA must be capable of retrieving and reproducing a hard copy of these assessments upon request. It is acceptable to have multiple corrected assessments for an OASIS assessment, as long as the OASIS and the clinical record are documented in accordance with the requirements at 42 CFR 484.48, Clinical records.

Timeliness of Corrections

Currently there are no requirements regarding the timeliness of correcting and inactivating assessment records, either in terms of when they must be completed (locked) or submitted. However, we urge HHAs to make corrections and/or submit inactivations as quickly as possible after errors are identified so the state system will be as current and accurate as possible. This affects the data used to calculate the HHA's Outcome-Based Quality Monitoring reports.

Clinical Implications of Corrected Assessment Records

When corrections are made to an assessment already submitted to the state system, the HHA must determine if there is an impact on the patient's current care plan. If there is an impact, in addition to the correction made to the assessment, the HHA must make corresponding changes to the current care plan. If there are any other records where the correction has an impact, for example, the Home Health Resource Group, the Plan of Treatment (HCFA Form-485), or the Request for Anticipated Payment, the agency should make corresponding changes to that record, as applicable. The agency should establish a procedure to review the impact of any corrections made to assessment records and make corresponding changes to other records that are affected.

Regarding Corrections in Lieu of Required Assessments

Collection and submission of information on SOC (Reason for Assessment (RFA) 1, 2), Resumption of Care (ROC) (RFA 3), FU (RFA 4), Other FU (RFA 5), Transfer (RFA 6, 7) and Discharge (RFA 8, 9, 10) assessments are required by the comprehensive assessment requirements at 42 CFR 484.55. The correction process described here does not preclude the need for accurate patient assessment at the required time points.

The inactivation of an assessment and subsequent correction and re-submission of a new assessment, or a correction to a non-key field cannot be used in lieu of the appropriate OASIS assessment for documenting an unanticipated change in patient condition that was not envisioned in the original plan of care. If there is an unexpected change in the patient's clinical condition due to a major decline or improvement in health status that warrants a change in plan of treatment, the appropriate OASIS assessment is expected to document the change, i.e., the ROC or Other FU assessment, as appropriate. This is in keeping with the regulation at 42 CFR 484.20 (b), accuracy of encoded OASIS data that states, "The encoded OASIS data must accurately reflect the patient's status at the time of assessment." It is necessary to have one document for the patient's assessment, care planning, and payment purposes.

Multiple Corrections in a Record

Correcting assessments with key field errors can only be done by inactivating the incorrect assessments and replacing them with the corrected assessments, as previously described in correction type above. Correcting assessments with non-key field errors can only be done by re-opening the assessment, revising the targeted non-key fields, re-locking and re-submitting the assessment, as previously described in correction type 3 above. 'CORRECTION_NUM' (the counter field) is implemented in non-key field changes. For more specific information concerning the process of correction and inactivation, please refer to the Version 1.20 OASIS data specification notes on the OASIS web page at http://www.hcfa.gov/medicaid/oasis/datasubm.htm.

Questions and Answers Regarding the Automated Correction Policy

Q1. Will HHAs be allowed to change the Reason For Assessment in HAVEN at OASIS data item M0100 if they have submitted the wrong type of assessment?

A1. No. HAVEN will require that the HHA inactivate the erroneous assessment and re-submit a corrected assessment.

Q2. An OASIS transfer assessment (RFA 6) was collected, encoded, and submitted to the state. The resumption of care assessment (RFA 3) was also collected, encoded and submitted. Subsequently it was determined that the assessments were submitted for the wrong patient. Will the submission of an inactivation request for the transfer assessment (RFA 6) also serve to inactivate the incorrect resumption of care assessment (RFA 3), or is it necessary to submit a separate inactivation record for both incorrect assessments?

A2. The submission of an inactivation record for the OASIS transfer assessment (RFA 6) will not inactivate the ROC assessment (RFA 3). It is necessary to submit an inactivation record for both erroneously submitted assessments. It is important to note that an inactivation inactivates only a single record.

Q3. If an HHA makes a correction to a key field after having previously submitted 3 non-key field corrections on the same assessment, will the corrected assessment reflect that the HHA has made 4 changes or 1 change?

A3. If the HHA inactivates the last assessment that had a correction number of 03, then it has inactivated that record (i.e., the original and all 3 correction assessments). Normally, the HHA will also submit a new, corrected assessment to replace the inactivated assessment. When this occurs, the correction number of the new corrected record is 00. Any subsequent corrections to non-key fields using correction type 3 would be reflected in the correction number field as 01 and would increase incrementally from there, as applicable. Note that key field corrections take precedence over non-key fields. Correction to both types of errors in a single assessment cannot be done without the inactivation process. An assessment with only key field errors must be inactivated, corrected, and re-submitted. An assessment with both key field and non-key field errors must first be inactivated, then replaced with the corrected record. An assessment with only non-key field errors does not require inactivation. The HHA can simply re-open the assessment, make the applicable non-key field changes, re-lock the assessment and re-submit it.

Q4. If the HHA identifies that an error was made in a patient's Social Security number after having submitted several assessments on that patient containing the error, will the inactivation process retroactively correct all erroneous submissions?

A4. No. Each assessment submitted to the state system containing the error must be individually inactivated and a corrected assessment submitted in its place. If an HHA inactivates one assessment record, it has inactivated one record. It is important to note that an inactivation request inactivates only a single record.

Q5. An HHA has an assessment with a key field error and will submit a request for inactivation. The HHA will need to submit a new corrected assessment to replace the erroneous record. Can it submit both records in the same submission batch?

A5. Both the inactivation request and the replacement record may be included in the same submission batch.

Q6. Can an HHA submit non-key field corrections, inactivation requests, and new assessments in the same batch?

A6. Yes. An HHA can submit all of these record types in a single batch, if it chooses. The state system follows a sorting algorithm that processes all of the inactivations first, then processes all other records (both originals and corrections) by effective date.

Q7. Will the state system accept assessments created using HAVEN 4.0 once it has been updated?

A7. Yes, but note that HHAs will not be able to inactivate erroneous assessment records with this version of HAVEN.

Q8. Will HAVEN 5.0 allow correction of assessments that were created using HAVEN 4.0?

A8. Yes, HAVEN 5.0 allows correction of assessments created in prior versions of HAVEN. Highlight any assessment that has Locked (Exported) status, then click the Correct Assessment button. The HHA has 3 possible options: correct an assessment that was rejected, create a non-key field correction assessment, or create an inactivation record. Note that in HAVEN 5.0, the key field correction option is disabled. In order to perform a key field correction, it is necessary to inactivate the assessment(s) for the patient and then create replacement assessment(s) with the corrected key field information. It is important to make the key field changes in the Maintain Patient Database screen and update the replacement assessment accordingly before locking and exporting the assessment!

Q9. The HHA inadvertently submitted a bunch of nonsense information that should have been submitted as test data, but was submitted as production (live) data. What should the HHA do?

A9. Inactivation will not solve this problem. The HHA should contact the state's OASIS automation coordinator and request that the erroneous data be deleted from the state system. The coordinator should follow the deletion procedures outlined in STSO memorandum 1999-075.

Q10. Where can I find STSO memorandum 1999-075 concerning deletion requests?

A10. State agency personnel can retrieve this memorandum and all other STSO (now called QIES Technical Support Office (QTSO)) memoranda on the state-specific area of the QTSO website at www.ifmcis.org/stso.

Effective Date

The automated correction policy is effective May 7, 2001. Effective March 30, 2001, state agencies are no longer accepting requests from HHAs for key field corrections. Between now and April 29, 2001, state agencies should complete any key field corrections requested by HHAs prior to March 30.

Training

This policy should be shared with all OASIS Education and Automation coordinators, home health agency surveyors, their managers and the state/regional office training coordinator and

home health providers.

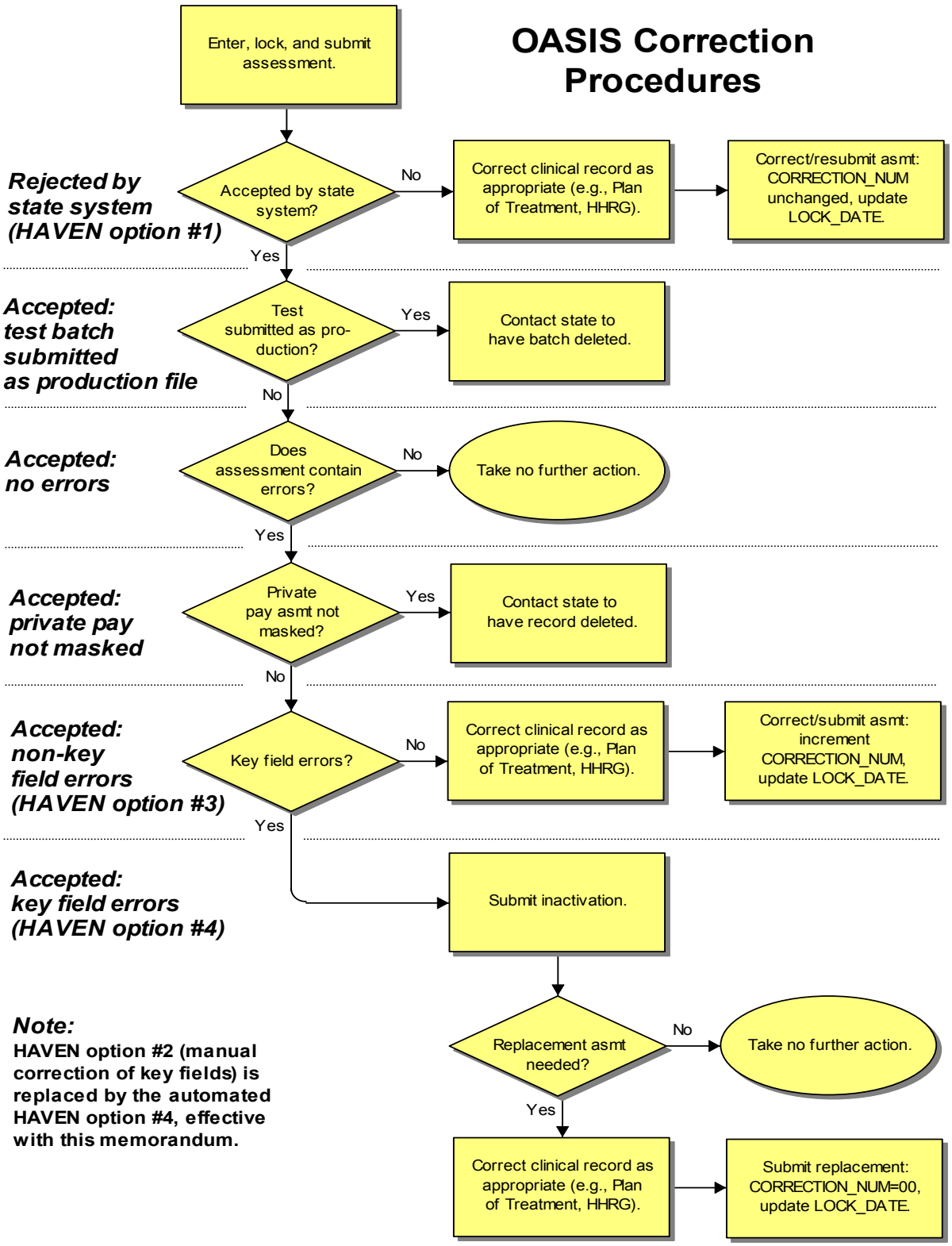
If you have any questions about these instructions, please contact Tracey Mummert at (410) 786-3398 or Mary Weakland at (410) 786-6835.

/s/
Steven A. Pelovitz

Attachment

cc: Regional Office OASIS Coordinators
State Agency OASIS Educational Coordinators
State Agency OASIS Automation Coordinators

Attachment



Note:
HAVEN option #2 (manual correction of key fields) is replaced by the automated HAVEN option #4, effective with this memorandum.

Prepared by:TMUMMERT/CMSO/SCG/CCPB/3-27-01/correct.doc/final 4-5-01//janiel/cmso/scg/released 4-9-01 for review

APPENDIX C – OASIS-C Item Uses

The following key can be used in reading/determining the timepoints and potential uses of OASIS-C data items.

KEY:
S = Item collected on Start of Care (SOC) Assessment
R = Item collected on Resumption of Care (ROC) Assessment
F = Item collected on Follow-up/Recertification (FU) Assessment
T = Item collected on Inpatient Transfer (TRN) Assessment
D = Item collected on Discharge (DC) Assessment
H = Item collected on Death at Home (DAH) Assessment
$ = Item potentially scores points used in assigning case to an HHRG for Medicare payment
C = Consistency - Item is used by Medicare payment grouper software to enforce OASIS-C data consistency specifications
Q = Item used to calculate quality measures
RA = Item under consideration for use in risk adjusting quality measures

OASIS-C (August 2009)		Timepoints						Item Uses		
Item #	Item Description	SOC	ROC	FU	TRN	DC	DAH	Medicare Payment	Quality Measures	Risk* Adjustment
M0010	C M S Certification Number	**S**								
M0014	Branch State	**S**								
M0016	Branch ID Number	**S**								
M0020	Patient ID Number	**S**								
M0030	Start of Care Date	**S**						**C**	**Q**	**RA**
M0032	Resumption of Care Date		**R**						**Q**	**RA**
M0040	Patient Name	**S**								
M0050	Patient State of Residence	**S**								
M0060	Patient Zip Code	**S**								
M0063	Medicare Number	**S**								
M0064	Social Security Number	**S**								
M0065	Medicaid Number	**S**								
M0066	Birth Date	**S**							**Q**	**RA**
M0069	Gender	**S**								**RA**

OASIS-C (August 2009)		Timepoints						Item Uses		
Item #	Item Description	SOC	ROC	FU	TRN	DC	DAH	Medicare Payment	Quality Measures	Risk* Adjustment
M0018	National Provider Identifier (NPI) physician who signed plan of care	S								
M0140	Race/Ethnicity	S								RA
M0150	Current Payment Sources	S								RA
M0080	Discipline of Person Completing Assessment	S	R	F	T	D	H			RA
M0090	Date Assessment Completed	S	R	F	T	D	H	C	Q	RA
M0100	Reason for Assessment	S	R	F	T	D	H	C	Q	RA
M0102	Date of Physician-ordered Start of Care (Resumption of Care)	S	R						Q	RA
M0104	Date Written or Verbal Referral	S	R						Q	RA
M0110	Episode Timing (Early/Later)	S	R	F				C		RA
M1000	Inpatient Facility Discharges, past 14 days	S	R							RA
M1005	Inpatient Discharge Date (most recent)	S	R							RA
M1010	Inpatient Diagnosis, stay within past 14 days	S	R							RA
M1012	Inpatient Procedure(s) relevant to the plan of care	S	R							RA
M1016	Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days	S	R							RA
M1018	Conditions Prior to Regimen Change or Inpatient Stay Within Past 14 Days	S	R							RA
M1020	Primary Diagnosis & Degree of Symptom Control	S	R	F				$		RA
M1022	Other Diagnoses & Degree of Symptom Control	S	R	F				$		RA
M1024	Payment Diagnoses	S	R	F				$		RA
M1030	Therapies patient receives at home	S	R	F				$		RA

OASIS-C (August 2009)		Timepoints						Item Uses		
Item #	Item Description	SOC	ROC	FU	TRN	DC	DAH	Medicare Payment	Quality Measures	Risk* Adjustment
M1032	Risk for Hospitalization	S	R							RA
M1034	Patient's Overall Status	S	R							RA
M1036	Risk Factors	S	R							RA
M1040	Received Influenza Vaccine from agency during episode				T	D			Q	RA
M1045	Reason Influenza Vaccine not received				T	D			Q	RA
M1050	Received Pneumococcal Vaccine from agency during episode				T	D			Q	RA
M1055	Reason PPV not received				T	D			Q	RA
M1100	Patient Living Situation/Availability of Assistance	S	R						Q	RA
M1200	Vision	S	R	F				$		RA
M1210	Ability to hear	S	R							RA
M1220	Understanding of Verbal Content	S	R							RA
M1230	Speech and Oral (Verbal) Expression of Language	S	R			D			Q	RA
M1240	Formal Pain Assessment	S	R						Q	RA
M1242	Frequency of Pain	S	R	F		D		$	Q	RA
M1300	Pressure Ulcer Assessment	S	R						Q	RA
M1302	Risk of Developing Pressure Ulcers	S	R						Q	RA
M1306	Any unhealed Pressure Ulcer at Stage II+ or "unstageable"	S	R	F		D		C	Q	RA
M1307	Oldest Non-epithelialized Stage II Pressure Ulcer					D			Q	RA
M1308	Current Number Unhealed (non-epithelialized) Pressure Ulcers at Stages II-IV (or unstageable)	S	R	F		D		$	Q	RA
M1308	Current Number Unhealed (non-epithelialized) Pressure Ulcers at Stages II-IV (or unstageable) that were present at SOC-ROC			F		D		C		

OASIS-C (August 2009)		Timepoints						Item Uses		
Item #	Item Description	SOC	ROC	FU	TRN	DC	DAH	Medicare Payment	Quality Measures	Risk* Adjustment
M1310	Length of largest unhealed Stage III or IV pressure ulcer	**S**	**R**			**D**		**C**		**RA**
M1312	Width of largest unhealed Stage III or IV pressure ulcer	**S**	**R**			**D**		**C**		**RA**
M1314	Depth of largest unhealed Stage III or IV pressure ulcer	**S**	**R**			**D**		**C**		**RA**
M1320	Status Most Problematic (Observable) Pressure Ulcer	**S**	**R**			**D**		**C**		**RA**
M1322	Current Number Stage I Pressure Ulcers	**S**	**R**	**F**		**D**		$		**RA**
M1324	Stage Most Problematic (Observable) Pressure Ulcer	**S**	**R**	**F**		**D**		$	**Q**	**RA**
M1330	Any Stasis Ulcer?	**S**	**R**	**F**		**D**		$		**RA**
M1332	Current Number (Observable) Stasis Ulcer(s)	**S**	**R**	**F**		**D**		$		**RA**
M1334	Status Most Problematic (Observable) Stasis Ulcer	**S**	**R**	**F**		**D**		$		**RA**
M1340	Any Surgical Wound?	**S**	**R**	**F**		**D**		**C**	**Q**	**RA**
M1342	Status Most Problematic (Observable) Surgical Wound	**S**	**R**	**F**		**D**		$	**Q**	**RA**
M1350	Other Skin Lesion or Open Wound receiving intervention by agency	**S**	**R**	**F**		**D**		**C**		**RA**
M1400	When dyspneic	**S**	**R**	**F**		**D**		$	**Q**	**RA**
M1410	Respiratory Treatments Received	**S**	**R**			**D**				**RA**
M1500	Symptoms in Heart Failure Patients				**T**	**D**			**Q**	**RA**
M1510	Heart Failure Symptom Follow-up				**T**	**D**			**Q**	**RA**
M1600	Urinary Tract Infection treatment in past 14 days	**S**	**R**			**D**			**Q**	**RA**
M1610	Urinary Incontinence or Urinary Catheter Presence	**S**	**R**	**F**		**D**		$	**Q**	**RA**
M1615	When Urinary Incontinence occurs	**S**	**R**			**D**			**Q**	**RA**
M1620	Bowel Incontinence Frequency	**S**	**R**	**F**		**D**		$	**Q**	**RA**

OASIS-C (August 2009)		Timepoints						Item Uses		
Item #	Item Description	SOC	ROC	FU	TRN	DC	DAH	Medicare Payment	Quality Measures	Risk* Adjustment
M1630	Ostomy for Bowel Elimination	S	R	F				$		RA
M1700	Cognitive Functioning	S	R			D			Q	RA
M1710	When Confused (Reported or Observed Within the Last 14 Days)	S	R			D			Q	RA
M1720	When Anxious (Reported or Observed Within the Last 14 Days)	S	R			D			Q	RA
M1730	Depression Screening	S	R						Q	RA
M1740	Cognitive, behavioral, and psychiatric symptoms	S	R			D			Q	RA
M1745	Frequency of Disruptive Behavior Symptoms (Reported or Observed)	S	R			D			Q	RA
M1750	Receipt of Psychiatric Nursing Services	S	R							RA
M1800	Grooming	S	R			D			Q	RA
M1810	Ability to Dress Upper Body	S	R	F		D		$	Q	RA
M1820	Ability to Dress Lower Body	S	R	F		D		$	Q	RA
M1830	Bathing	S	R	F		D		$	Q	RA
M1840	Toilet Transferring	S	R	F		D		$	Q	RA
M1845	Toileting Hygiene	S	R			D			Q	RA
M1850	Bed Transferring	S	R	F		D		$	Q	RA
M1860	Ambulation/Locomotion	S	R	F		D		$	Q	RA
M1870	Feeding or Eating	S	R			D			Q	RA
M1880	Plan and Prepare Light Meals	S	R			D			Q	RA
M1900	Prior Functioning ADL/IADL	S	R							RA
M1890	Ability to Use Telephone	S	R			D			Q	RA
M1910	Multi-factor Fall Risk Assessment	S	R						Q	RA
M2000	Drug Regimen Review	S	R					C		RA
M2002	Medication Follow-up	S	R						Q	RA

OASIS-C (August 2009)		Timepoints						Item Uses		
Item #	Item Description	SOC	ROC	FU	TRN	DC	DAH	Medicare Payment	Quality Measures	Risk* Adjustment
M2004	Medication Intervention				T	D			Q	RA
M2010	Patient/Caregiver High Risk Drug Education	S	R						Q	RA
M2015	Patient/Caregiver Drug Education Intervention				T	D			Q	RA
M2020	Management of Oral Medications – Current Ability	S	R			D			Q	RA
M2030	Management of Injectable Medications – Current Ability	S	R	F		D		$		RA
M2040	Prior Medication Management Ability	S	R							RA
M2100	Types of Assistance Needed and Sources/Availability	S	R			D				RA
M2110	Frequency receipt of ADL or IADL assistance (other than agency staff)	S	R			D				RA
M2200	Therapy Need	S	R	F				$		RA
M2250	Plan of Care Synopsis (Patient-specific parameters for notifying physician, Diabetic foot care, Falls prevention, Depression intervention(s), Intervention(s) to monitor and mitigate pain, Intervention(s) to prevent pressure ulcers, Pressure ulcer treatment)	S	R						Q	RA
M2300	Used Emergent Care				T	D			Q	RA
M2310	Reason for Emergent Care				T	D			Q	RA
M2400	Intervention Synopsis (Diabetic foot care, Falls prevention interventions, Depression intervention(s), Intervention(s) to monitor and mitigate pain, Intervention(s) to prevent pressure -ulcers, Pressure ulcer treatment)				T	D			Q	RA
M2410	Type Inpatient Facility to which patient admitted				T	D			Q	RA
M2420	Discharge Disposition					D			Q	RA

OASIS-C (August 2009)		Timepoints						Item Uses		
Item #	Item Description	SOC	ROC	FU	TRN	DC	DAH	Medicare Payment	Quality Measures	Risk* Adjustment
M2430	Reason for Hospitalization				T				Q	RA
M2440	Reason(s) Admitted to a Nursing Home				T					RA
M0903	Date of Last (Most Recent) Home Visit				T	D	H			RA
M0906	Discharge/Transfer/Death Date				T	D	H		Q	RA

* Since the risk-adjustment models for OASIS-C-based quality measures have not yet been developed, the possible role of each OASIS-C item in risk adjustment is not yet known. The flagged variables are considered to have potential and will be tested for their value in risk adjustment.

APPENDIX D – SELECTION AND ASSIGNMENT OF OASIS DIAGNOSIS

A. INTRODUCTION

Appendix D, previously known as Attachment D, was initially published to facilitate the introduction of V-code diagnosis reporting on the OASIS, (see OASIS-B1, 12/2002), effective October 1, 2003. The appendix was designed to clarify HHA implementation of the Official ICD-9-C M Coding Guidelines of 2002. The changes in OASIS diagnosis reporting in 2003 allowed HHAs the ability to assign V-codes to M1020/M1022 and comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA, Title II).

We are reissuing this document to promote accurate selection and assignment of the patient's diagnosis on the current OASIS-C. This document addresses the OASIS diagnoses items that pertain to the home health episode (i.e., M1020/M1022/M1024 and will clarify CMS' expectations specific to the assignment of V-codes to the OASIS as dictated by the revised ICD-9-C M coding guidelines effective October 2008.

Additionally, with (HH PPS) refinements in January 2010, the HH PPS grouper was revised. If a V-code assigned to M1020/M1022 replaces a case mix diagnosis code, HHAs no longer must always code a numeric diagnosis code in the optional case mix diagnosis M1024. ICD-9-C M coding guidelines state that certain rehabilitation and aftercare V-codes need a secondary diagnosis code in M1022 to describe a resolving condition or sequelae. If the diagnoses codes representing the underlying condition displaced by the V-code are case mix codes, the HH PPS grouper will look to M1022 to award appropriate points.

HHA diagnosis selection and assignment is expected to be performed in compliance with Medicare's rules and regulations for coverage and payment to ensure provider compliance with Section 1862(a)(1)(A) of the Social Security Act. Section 1862(a)(1)(A) excludes provider services from Medicare coverage and payment that are not reasonable and necessary for the patient's diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

B. OASIS INTEGRITY

Appropriate coding practices will ensure the integrity of the home health diagnoses assigned to the OASIS. Due to the nature and significance of accurate HHA diagnosis selection and assignment, CMS expects providers to comply with the following:

- Avoid assigning excessive numbers of V-codes to OASIS M1020 and M1022. CMS expects HHAs to limit the reporting of V-codes on the OASIS. V-codes are less specific to the clinical condition of the patient than are numeric diagnosis codes.
- Limit the number of diagnoses assigned to M1024.
- Avoid the practice of allowing the case mix status of a diagnosis to influence the diagnosis selection process. HHAs are expected to prevent "Coding for Payment" from occurring.
- HHAs are expected to report any indication of fraudulent coding directly to the administrator of the HHA. If appropriate action is not taken, then the clinician is expected to report this activity to the appropriate RHHI hotline and/or to the State Surveyor hotline.

C. COMPREHENSIVE ASSESSMENT MUST PRECEDE DIAGNOSIS CODING

HHAs are expected to understand the patient's specific clinical status before selecting and assigning the diagnosis. Each patient's overall medical condition and care needs must be comprehensively assessed before the HHA selects and assigns the OASIS diagnoses. CMS expects HHAs to complete the patient's comprehensive assessment before assigning the home health diagnoses to M1020/M1022 and M1024 (optional) to the OASIS-C.

D. CRITERIA FOR OASIS DIAGNOSIS REPORTING

1. General Diagnosis Selection Criteria

If a diagnosis under consideration fails to comply with the criteria described below, then the diagnosis is not acceptable and should not be assigned to the OASIS. However, if the diagnosis under consideration complies with the criteria described below, the diagnosis decision process continues to determine if the diagnosis will qualify as the patient's primary or secondary diagnosis.

- HHA clinician/coders are expected to comply with ICD-9-C M coding guidelines when assigning primary and secondary diagnoses to the OASIS items M1020 and M1022. Refer to the *ICD-9-C M Official Guidelines for Coding and Reporting*, which can be found at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf.
- Code only those diagnoses that are unresolved. If a patient has a resolved condition, which has no impact on the patient's current plan of care, then the condition does not meet the criteria for a home health diagnosis, and should not be coded.
- Code only the relevant medical diagnoses. For example, if a patient is admitted for surgical aftercare (e.g., the surgery eliminated the disease or the acute phase has ended), the acute diagnosis should not be coded in M1020 and M1022. Note: if a V-code is under consideration as diagnosis, refer to Section D.5, Criteria for Coding V-codes as a Diagnosis for additional criteria and coding instructions.
- Code only the diagnoses supported by the patient's medical record documentation (i.e., the home health plan of care and clinical comprehensive assessment). If the diagnosis under consideration is not supported by the patient's medical condition and clinical care needs, then the diagnosis must not be reported on the OASIS.
- Ensure compliance with ICD-9-C M sequencing requirements. If the diagnosis code is not compliant with ICD-9-C M sequencing requirements, then it must not be reported on the OASIS.
- If a condition under consideration calls for multiple diagnosis coding (such as an etiology/manifestation pair), refer to Section D.6, Criteria for Coding Etiology and Manifestation Pairs, for additional criteria and coding instructions.
- Avoid selecting a diagnosis with the following characteristics for assignment to the OASIS:
  - Non-specific or ambiguous diagnosis;
  - Symptom diagnosis (general symptomatic complaint in the elderly population);
  - Diagnosis lacking consensus for clear diagnostic criteria within the medical community;
  - Surgical procedure.

If the diagnosis under consideration meets the above criteria as an acceptable home health diagnosis, continue to analyze the diagnosis to determine if it qualifies as a primary or secondary diagnosis.

2. Primary Diagnosis Selection Criteria (M1020)

The patient's primary diagnosis is defined as the diagnosis most related to the current home health plan of care. The primary diagnosis may or may not relate to the patient's most recent hospital stay, but must relate to the services rendered by the HHA. If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be assigned to M1020 of the OASIS. If the diagnosis under consideration does not meet the criteria below, it cannot be coded as the primary diagnosis in M1020, and should be considered for coding as a potential secondary diagnosis in M1022.

- Ensure the diagnosis under consideration is acceptable for assignment to the OASIS. The diagnosis meets all criteria listed in Section D.1, General Diagnosis Selection Criteria.
- Ensure that the diagnosis is the one most related to the patient's current plan of care, is the chief reason home care is needed, and is the most acute.
- Ensure that of all the diagnoses under consideration for this patient, this is the diagnosis requiring the most intensive skilled services.
- If the primary diagnosis is a V-code, refer to Section D.5, Criteria for Coding V-codes as a Diagnosis, for additional criteria and coding instructions.
- If the primary diagnosis is a multiple diagnosis situation (such as an etiology/manifestation pair), refer to Section D.6, Criteria for Coding Etiology and Manifestation Pairs, for additional criteria and coding instructions.

3. Secondary Diagnosis Selection Criteria M1022

Secondary diagnoses, or other diagnoses, are defined as all conditions that coexisted with the primary diagnosis at the time the plan of care was established, or which developed subsequently, or affect the treatment or care of the patient.

a. If a diagnosis meets the general diagnosis criteria for assignment on the OASIS, but does not meet the criteria for coding as a primary diagnosis, the HHA must consider whether the diagnosis can be coded as a secondary diagnosis in M1022 under ICD-9-C M guidelines. For example, certain V-codes may not be eligible for assignment as a secondary diagnosis. If the diagnosis does not meet the criteria for primary diagnosis, and does not comply with ICD-9-C M requirements as a secondary diagnosis, the diagnosis cannot be coded on the OASIS. Otherwise, if a diagnosis meets the general diagnosis criteria for assignment on the OASIS, but does not meet the criteria for a primary diagnosis, the diagnosis must be coded as a secondary diagnosis in M1022. If the secondary diagnosis is a V-code, or is part of an etiology/manifestation pair, additional coding criteria must be followed (refer to Section D.5, Criteria for Coding V-codes as a Diagnosis, and Section D.6, Criteria for Coding Etiology and Manifestation Pairs, for additional criteria and coding instructions associated with etiology/manifestation pair coding).

b. Additionally, the following criteria apply to all diagnoses under consideration as a secondary diagnosis:

- Ensure that the secondary diagnosis under consideration includes not only conditions actively addressed in the patient's home health plan of care but also any comorbidity

affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself.

- Ensure that the secondary diagnoses assigned to the OASIS are listed in the order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided.
- When the secondary diagnosis assigned to M1022 is a V-code, then it is appropriate to report the numeric diagnosis that the V-code is replacing. HHAs must usually report the numeric diagnosis that is being replaced by the V-code as a secondary diagnosis in M1022 also. Refer to Section D.5, Criteria for Coding V-codes as a Diagnosis, for a more thorough discussion concerning V-codes.
- If a secondary diagnosis under consideration is part of a multiple diagnosis situation (such as an etiology/manifestation pair), both codes must be reported in M1022, coding first the etiology code followed by the manifestation code. Refer to Section D.6, Criteria for Coding Etiology and Manifestation Pairs, for additional criteria and coding instructions.

4. Coding Optional Case Mix Diagnosis M1024

a. History of M0245

OASIS instructions from the inception of HH PPS in October 2000 until October 2003 did not permit HHAs to assign V-codes to the primary or secondary diagnoses (M1020/M1022). During that time, HH PPS grouper software was structured to award points only for the patient's primary diagnosis in M1020, or the first secondary diagnosis in M1022 in certain situations. To comply with the HIPAA Act of 1996, which required OASIS to become compliant with ICD-9-C M coding guidelines, the OASIS instructions were changed to allow HHAs the ability to assign V-codes to M1020 and M1022, effective Oct. 1, 2003. To ensure that HH PPS grouper software awarded the appropriate points to an assessment when a V-code was coded in M1020, a new field was added to the OASIS, M0245. Clinicians were instructed to code a numeric diagnosis code in M0245 if the V-code assigned to M1020 was used "in place of" a case mix diagnosis code. If the V-code replaced a case mix diagnosis that was part of an etiology/manifestation pair then clinicians were instructed to code both the etiology code and the manifestation code in M0245.

b. Protocol for M1024

Effective January 2008, the structure for the OASIS diagnosis section changed, and M0246 replaced M0245. Additionally, effective with the January 2008 HH case mix refinements, the HH PPS grouper was revised.

HHAs no longer must always code a numeric diagnosis code in M1024 if a V-code assigned to M1020/M1022 replaces a case mix diagnosis code. The reason is that ICD-9-C M coding guidelines state that certain rehabilitation and aftercare V-codes need a secondary diagnosis code in M1022 to describe a resolving condition or sequelae. In some cases, such underlying or associated diagnoses are case mix codes representing the underlying condition displaced by the V-code. In these cases, the HH PPS grouper will look to M1022 to award appropriate points. HHAs optionally may code M1024 when a V-code in M1020/M1022 replaces a numeric case mix code. However, CMS expects that HHA coding of M1024 will be infrequent, limited to the scenarios described in Section D.4.c, *M1024 Coding to prevent loss of case mix points,* and to those scenarios where the V-code is displacing a case mix diagnosis that is inappropriate to report as an underlying or associated code in M1022

Additional information on case mix diagnoses can be found in the Diagnosis Tables, located in the "Downloads" section of the HH PPS web site.

http://www.cms.hhs.gov/HomeHealthPPS/05_CaseMixGrouperSoftware.asp#TopOfPage

c. M1024 coding to prevent loss of case mix points

To prevent the loss of case mix points when an underlying case mix diagnosis is associated with the primary V-code diagnosis, HHAs should code the numeric diagnosis case mix code to the primary diagnosis line (a) of M1024 when the following three conditions apply:

1) The primary diagnosis M1020 is a V-code
2) The V-code displaces a numeric diagnosis that is a case mix diagnosis
3) The numeric case mix diagnosis is contained within one of the following three HH PPS diagnosis groups:
   - Diabetes
   - Skin 1-Traumatic wounds, burns, and post-operative complications
   - Neuro 1-Brain Disorders and Paralysis.

Note: In the situation above, to comply with ICD-9-C M coding guidelines, ensure that a secondary diagnosis--if needed to support the primary, V-code diagnosis and if appropriate for ICD-9-C M reporting in the home health setting--is reported in M1022 sequenced immediately following the V-code.

Additionally, ICD-9-C M coding guidelines stipulate that the acute fracture code only may be used for the initial, acute episode of care, which is why the acute fracture code is no longer appropriate once the patient has been discharged from the hospital to home health care. In this scenario, if a V-code replaces the fracture code in either M1020 or M1022, the HHA can code the acute fracture code in the corresponding occurrence of M1024.

d. General criteria for M1024 diagnoses coding

The following are general criteria required for assigning a diagnosis to M1024:

- Code M1024 if a V-code is reported in M1020 or M1022 and the V-code is replacing a case mix diagnosis that is inappropriate to report as an underlying or associated code in M1022.
- Surgical codes must not be assigned to M1024. Instead, assign the underlying diagnosis to M1020 or M1022 only if the surgery did not eliminate the disease or the acute phase of the disease has not ended.
- E-codes must not be assigned to M1024. Instead, code the relevant medical diagnosis in M1020.
- V-codes must not be assigned to M1024.

5. Criteria for Coding V-codes

CMS expects HHAs to avoid assigning excessive V-codes to the OASIS. V-code reporting on the OASIS became effective in October 2003 in compliance with HIPAA; however, V-codes are less specific to the clinical condition of the patient than are numeric diagnosis codes. The logic for determining V-code assignment to OASIS M1020/M1022 remains unchanged with the CY 2008 HH PPS final rule with comment period (located at http://edocket.access.gpo.gov/2007/pdf/07-4184.pdf).

In the home health setting, V-codes are appropriately assigned to M1020 or M1022 when a patient with a resolving disease or injury requires specific aftercare of that disease or injury (e.g., surgical aftercare or aftercare for rehabilitation).

Sometimes in the home health setting, reporting of V-codes in either M1020 or M1022 requires reporting of the replaced numeric case mix diagnosis in M1022 also. The reason is that certain aftercare and rehabilitation V-code categories require an underlying or associated diagnosis to be coded in order to describe the resolving condition or sequelae. In some circumstances, the condition will be a case mix diagnosis; other times, reporting of a V-code in M1020 or M1022 does not require reporting of an underlying or associated diagnosis. Refer to ICD-9-C M coding guidance for a complete discussion of V-code reporting.

Examples:

- The code category V57, Care involving use of rehabilitation procedures, requires the use of an additional numeric code following the V-code to identify the patient's underlying or associated condition. Refer to Case Scenario #1 in Section F, Case Scenarios, for a more detailed example.

- In other V-code situations such as surgical aftercare V-codes, it is not appropriate to code a secondary numeric diagnosis code in M1022. If the acute diagnosis is no longer applicable (e.g., the surgery eliminated the disease or the acute phase has ended, or the acute code is a fracture code), then no numeric code should be coded in M1022.

HHAs are expected to understand each of the following V-code limitations and consider a V-code assignment to the OASIS as an "assignment of last resort." Additional, specific criteria for assigning V-codes are as listed below. Further information related to coding can be found in the ICD-9-C M Official Guidelines for Coding and Reporting at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf.

- V-codes may be used as the primary or secondary diagnosis unless ICD-9-C M coding guidelines stipulate otherwise. OASIS V-code assignment is governed by the *ICD-9-C M Official Guidelines for Coding and Reporting*.

- A single V-code could be related to various underlying or associated numeric codes, each of which describes a specific different clinical condition.

- HHAs are expected to report the accurate underlying diagnosis in M1022, as stipulated in the *ICD-9-C M Official Guidelines for Coding and Reporting,* to support the assignment of certain V-codes.

- If the patient has an acute condition relevant to the plan of care, continue to report the code for the acute condition. V-codes are intended to deal with circumstances other than a disease or injury, or recorded as a diagnosis or problem.

– If there is a complication of medical or surgical care, such as infection or wound dehiscence, select a code specific to either complication rather than a V-code. For example, codes for surgical complications are available within Chapter 17, Injury and Poisoning, of the ICD-9-C M Coding Manual.

6. Criteria for Coding Etiology and Manifestation Pairs

In certain cases, ICD-9-C M guidelines require more than one code to report a condition. The use of two codes in such a prescribed way is referred to as "mandatory multiple coding," "dual classification," "dual coding," or "mandatory dual coding." One specific example of such mandatory dual coding is termed "etiology/manifestation conventions" and involves the reporting of both a disease and one of its manifestations. The ICD-9-C M manual clearly identifies the instances where etiology/manifestation coding is required in the "Tabular List of Diseases" (see Volume One of the ICD-9-C M manual) and in the "Alphabetic Index to Diseases and Injuries" (see Volume Two of the ICD-9-C M manual). Criteria associated with etiology/manifestation pairs coding are listed below:

– The etiology code is the underlying disease and must be sequenced first, before the code for a related manifestation.

– When a diagnosis is under consideration as an etiology diagnosis, the HHA is expected to ensure that a valid manifestation code is sequenced immediately following the assignment of the etiology code.

– The manifestation diagnosis is the relevant condition caused by the underlying disease. It is never assigned as the patient's primary diagnosis.

– Additional instructions referencing manifestation and etiology diagnoses in the ICD-9-C M coding manual include:

    1) In the Alphabetic Index of the ICD-9-C M Manual, both conditions are listed together with the etiology code listed first and the manifestation code listed second [and in slanted brackets].

    2) In the Tabular Index of the ICD-9-C M Manual, the manifestation code may be listed in italics.

<u>An example: How to Code Diabetes Mellitus</u>:

– The ICD-9-C M Official Guidelines for Coding and Reporting, effective October 1, 2008, issued the following sequencing guidance specific to the most commonly used multiple coding situation, Diabetes Mellitus. The codes for Diabetes Mellitus are located under category 250. The diabetes codes and the secondary codes that correspond to them are paired codes that follow the etiology/manifestation convention of the classification. Several codes under category 250 have an instruction note to "use additional code" to identify manifestation. The diabetes code should be sequenced first followed by the manifestation code.

– There are some codes that include the associated condition within the diabetes code, for example, 250.1, Diabetes with ketoacidosis and 250.2 Diabetes with hyperosmolarity. An additional code is not required for these codes.

– Should a patient have more than one manifestation of diabetes, more than one code from category 250 may be used with as many manifestation codes as are needed to fully describe the patient's complete diabetic condition.

E. FLOW CHARTS

1. Purpose of Flow Charts

In these flow charts, each chart is designed to assist HHA clinicians and coders to identify information required to complete each step of the diagnosis selection criteria. The charts should be utilized to analyze the process of assigning a diagnosis to the OASIS. The following flow charts are contained in this section:

Chart A: General Selection and Assignment of the HH Diagnosis

Chart B: Selection and Assignment of the Primary Diagnosis

Chart C: Selection and Assignment of the Secondary Diagnosis

2. Selection & Assignment of the HH Diagnosis

Chart A provides a visual representation of the logical process related to the selection and assignment of all home health diagnoses. This chart identifies a starting point for the decisions that must be made before HHA clinicians and coders are permitted to proceed and it serves to explain how decisions related to the patient's diagnosis will conclude. Please note that Chart A is the official starting point for Chart B and Chart C.

3. M1024 Discussion

The flow charts were designed to concentrate on the selection of the patient's primary and secondary diagnosis and assignment to the OASIS. For reasons discussed in Section D.4, Coding Optional Case Mix Diagnosis, M1024 is an optional payment item that is expected to have limited utilization by HHAs. Refer to the HH PPS Payment Rule if the M1020 Aftercare V-code assignment will result in a loss of points due to compliance with ICD-9-C M Coding Guidelines (see Section D.4.c, M1024 coding to prevent loss of case mix points of this document for further detail).

Chart A - Home Health Correct Coding Protocol:
General Selection and Assignment of HH Diagnoses

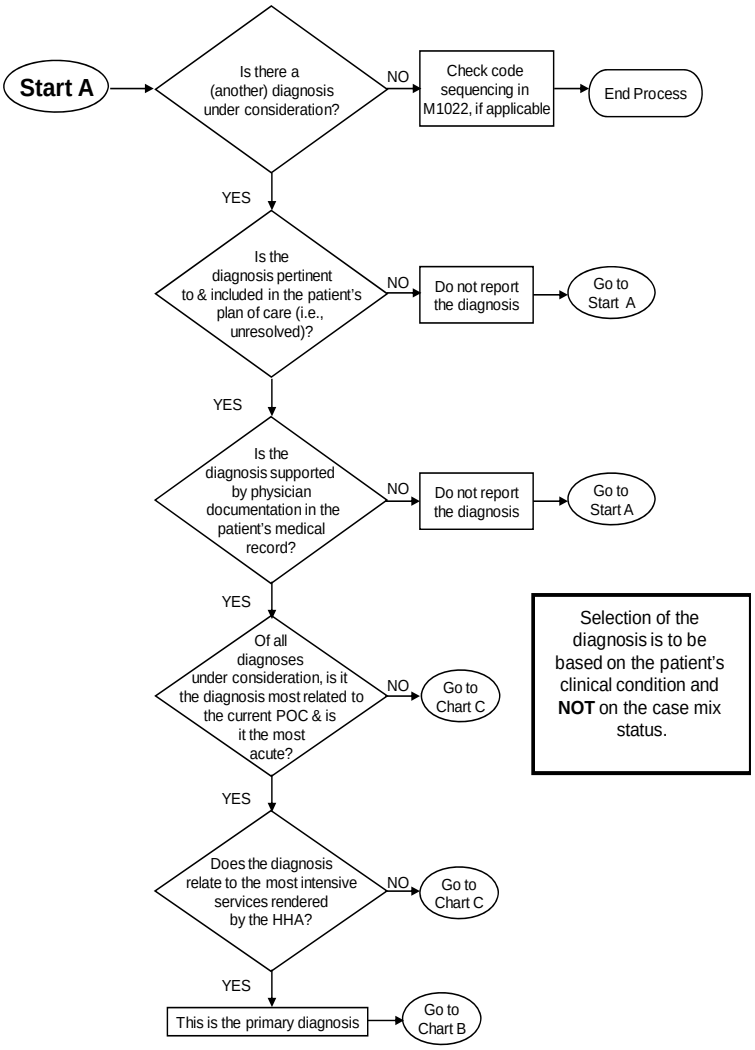


Chart A - Home Health Correct Coding Protocol: General Selection and Assignment of HH Diagnoses is a flowchart used to identify the proper primary or secondary diagnosis codes. The flowchart is a series of questions with "Yes" and "No" responses along with actions associated with each response.

General directions for Chart A

1. Selection of the diagnosis is to be based on the patient's clinical condition and NOT on the case mix status.

Start A

Question 1: Is there a (another) diagnosis under consideration?

If no, check the code sequencing in M1022, if applicable, and end process.
If yes, go to Question 2.

Question 2: Is the diagnosis pertinent to and included in the patient's plan of care (i.e., unresolved)?

If no, do not report the diagnosis and return to Start A.
If yes, go to Question 3.

Question 3: Is the diagnosis supported by physician documentation in the patient's medical record?

If no, do not report the diagnosis and return to Start A.
If yes, go to Question 4.

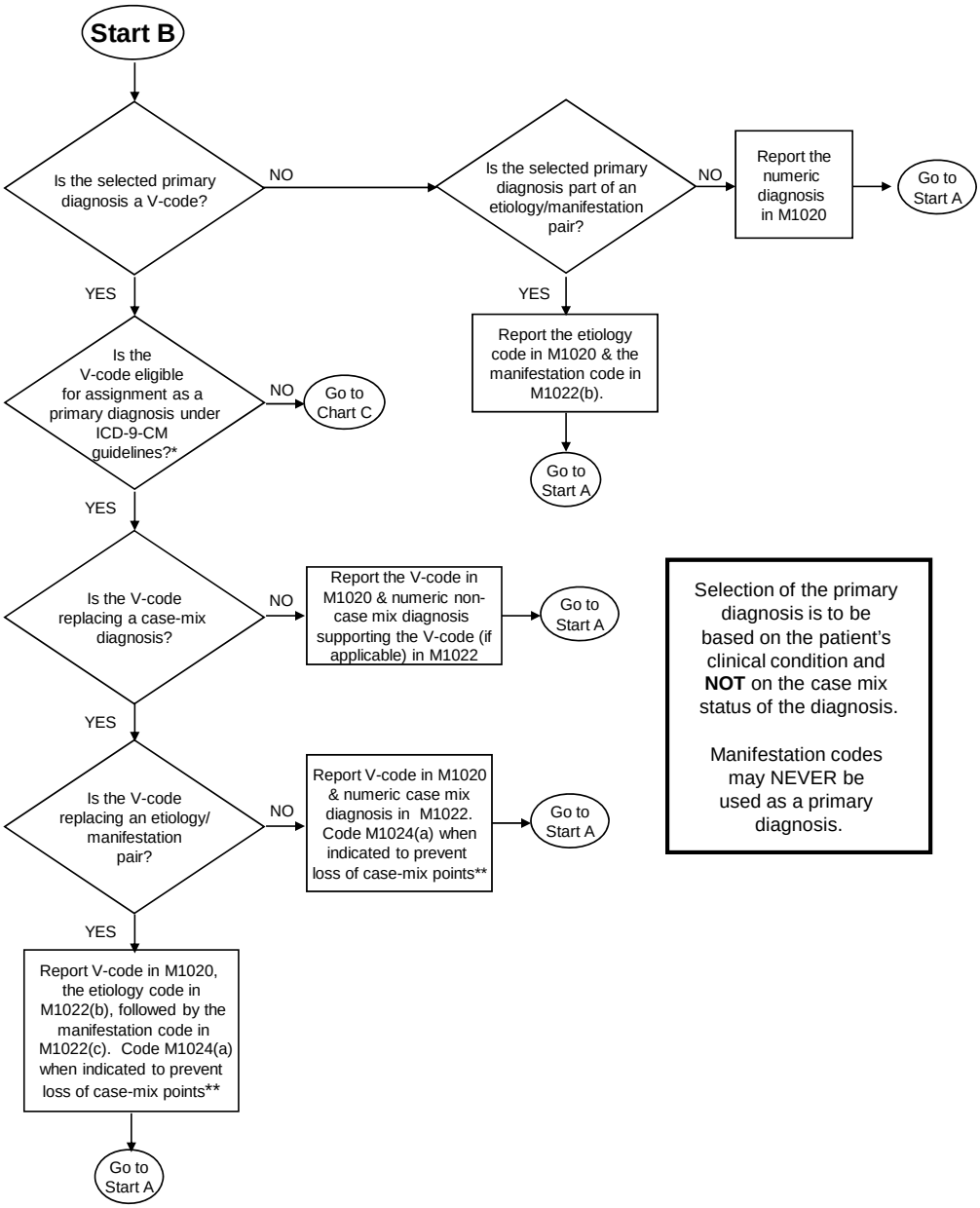
Question 4: Of all diagnoses under consideration, is it the diagnosis most related to the current POC and is it the most acute?

If no, go to Chart C.
If yes, go to Question 5.

Question 5: Does the diagnosis relate to the most intensive services rendered by the HHA?

If no, go to Chart C.
If yes, this is the primary diagnosis and go to Chart B.

Chart B - Home Health Correct Coding Protocol:
Selection and Assignment of the Primary Diagnosis



* See V-code Table in the "ICD-9-C M Official Guidelines for Coding and Reporting" at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm

** Refer to M1024 coding to prevent loss of case-mix points if the M1020 Aftercare V-code assignment will result in a loss of points due to compliance with ICD-9-C M Coding Guidelines (see Section D4(c) of this document for further detail).

Chart B - Home Health Correct Coding Protocol: Selection and Assignment of Primary Diagnosis is a flowchart used to select the proper primary diagnosis code, i.e., a V-code or an ICD-9-C M code that is not a V-code. The flowchart is a series of questions with "Yes" and "No" responses along with actions associated with each response.

General directions for Chart B

1. Selection of the primary diagnosis is to be based on the patient's clinical condition and NOT on the case mix status of the diagnosis.
2. Manifestation codes may NEVER be used as a primary diagnosis.

Start B

Question 1: Is the selected primary diagnosis a V-code?

If no, answer Follow-up Question: Is the selected primary diagnosis part of an etiology or manifestation pair?

If no, report the numeric diagnosis in M1020 and return to Start A.

If yes, report the etiology code in M1020, report the manifestation code in M1022(b), and return to Start A.

If the answer to Question 1 "Is the selected primary diagnosis a V-code?" was "yes," then go Question 2.

Question 2: Is the V-code eligible for assignment as a primary diagnosis under ICD-9-C M guidelines? (See V-code Table in the ICD-9-C M Official Guidelines for Coding and Reporting at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm.)

If no, go to Chart C.

If yes, go to Question 3.

Question 3: Is the V-code replacing a case-mix diagnosis?

If no, report the V-code in M1020, report the numeric non-case mix diagnosis support the V-code (if applicable) in M1022, and return to Start A.

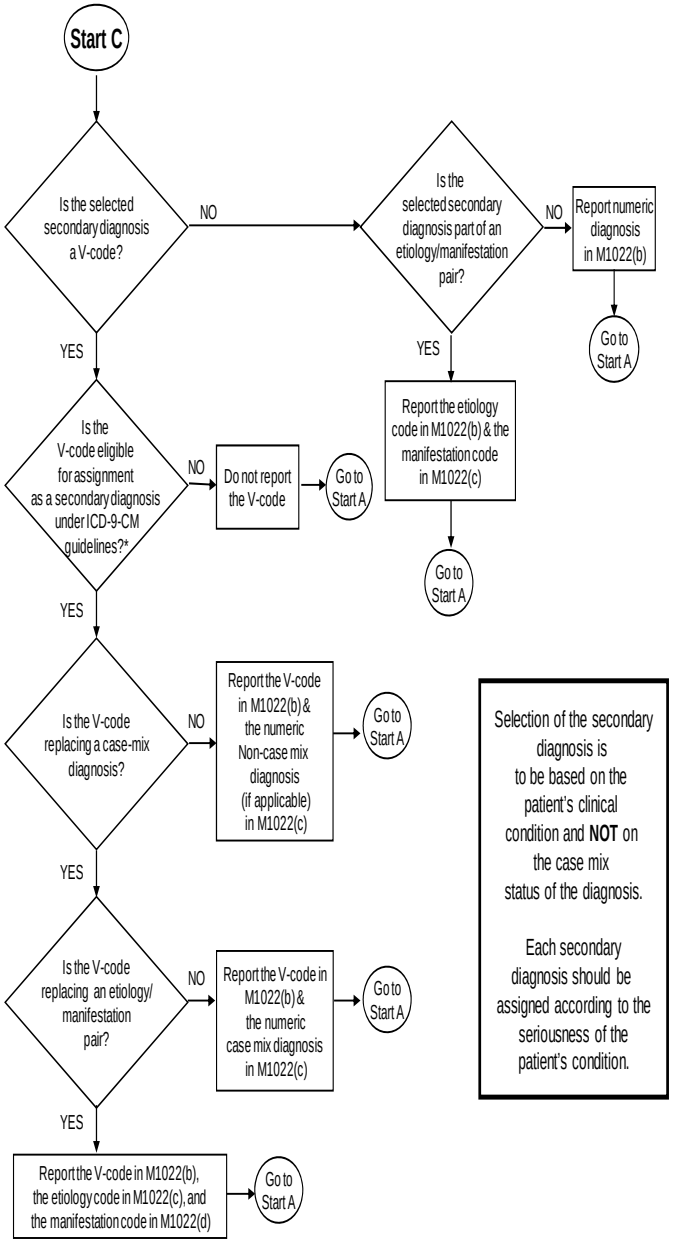
If yes, go to Question 4.

Question 4: Is the V-code replacing an etiology or manifestation pair?

If no, report V-code in M1020 and numeric case mix diagnosis in M1022. Code M1024(a) when indicated to prevent loss of case-mix points. (Refer to M1024 coding to prevent loss of case-mix points if the M1020 Aftercare V-code assignment will result in a loss of points due to compliance with ICD-9-C M Coding Guidelines, see Section D4(c) of this document for further detail.) Return to Start A.

If yes, report V-code in M1020, report the etiology code in M1022(b), report the manifestation code in M1022(c). Code M1024(a) when indicated to prevent loss of case-mix points. (Refer to M1024 coding to prevent loss of case-mix points if the M1020 Aftercare V-code assignment will result in a loss of points due to compliance with ICD-9-C M Coding Guidelines, see Section D4(c) of this document for further detail.) Return to Start A.

Chart C - Home Health Correct Coding Protocol:
Selection and Assignment of the Secondary Diagnosis



* See V-code Table in the "ICD-9-C M Official Guidelines for Coding and Reporting" at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm

Chart C - Home Health Correct Coding Protocol: Selection and Assignment of the Secondary Diagnosis is a flowchart used to select the proper secondary diagnosis code, i.e., a V-code or an ICD-9-C M code that is not a V-code. The flowchart is a series of questions with "Yes" and "No" responses along with actions associated with each response.

General directions for Chart C

1. Selection of the primary diagnosis is to be based on the patient's clinical condition and NOT on the case mix status of the diagnosis.
2. Each secondary diagnosis should be assigned according to the seriousness of the patient's condition.

Start C

Question 1: Is the selected secondary diagnosis a V-code?

If no, answer Follow-up Question: Is the selected secondary diagnosis part of an etiology or manifestation pair?

If no, report the numeric diagnosis in M1022(b) and return to Start A.

If yes, report the etiology code in M1022(b), report the manifestation code in M1022(c), and return to Start A.

If the answer to Question 1 "Is the selected secondary diagnosis a V-code?" was "yes," then go Question 2.

Question 2: Is the V-code eligible for assignment as a secondary diagnosis under ICD-9-C M guidelines? (See V-code Table in the ICD-9-C M Official Guidelines for Coding and Reporting at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm.)

If no, do not report the V-code and return to Start A.

If yes, go to Question 3.

Question 3: Is the V-code replacing a case-mix diagnosis?

If no, report the V-code in M1022(b), report the numeric non-case mix diagnosis (if applicable in M1022(c), and return to Start A.

If yes, go to Question 4.

Question 4: Is the V-code replacing an etiology or manifestation pair?

If no, report the V-code in M1022(b), report the numeric case mix diagnosis in M1022(c), and return to Start A.

If yes, report the V-code in M1022(b), report the etiology code in M1022(c), and report the manifestation code in M1022(d). Return to Start A.

F. CASE SCENARIOS

1. Purpose and Design

The purpose of this section is to provide case scenario examples of the guidance given in previous sections of this attachment. HHAs are responsible for consistently accurate diagnosis reporting to ensure compliance with Medicare's rules and regulations for coverage and payment. Section 1862(a)(1)(A) of the Social Security Act excludes from Medicare coverage and payment provider services that are not reasonable and necessary for the patient's diagnosis.

Each Case Scenario includes the following subsections:

- M1020/M1022 Discussion/Assignment: Implements guidance provided within Section D of this attachment.
- M1024 Discussion: Throughout this subsection, Tables 2A and 2B are tables located in the HH PPS Final Rule with Comment, dated August 29, 2007 (see CMS-1541-FC in the Federal Register or http://www.cms.hhs.gov/HomeHealthPPS/HHPPSRN/itemdetail.asp?filterType=dual,%20keyword&filterValue=1541&filterByDID=0&sortByDID=4&sortOrder=ascending&itemID=CMS1202451&intNumPerPage=10)
- OASIS Coding: Instruction is provided specific to the line and column assignment for each diagnosis assigned to M1020/M1022/M1024.

Case Scenario #1: V-code used to Designate Specific Aftercare.

An 85-year-old independent female sustained a left hip fracture resulting in a hospital stay for an open reduction with internal fixation. Following her discharge from the hospital, she was admitted to a skilled nursing facility (SNF). She is scheduled to be discharged from the SNF to her home where she will receive home health skilled therapy services. Her physician ordered non-weight bearing activity to her left lower extremity with supervised pivot transfers and contact guard assist in and out of bed.

Skilled Nursing: The HHA did not receive an order from the patient's physician to provide skilled nursing services. The initial assessment visit by the HHA did NOT identify a skilled nursing need.

Therapy Need: The physician ordered physical therapy (PT) for gait evaluation/training and strengthening exercises three times per week for four weeks. The patient's ambulation is limited due to the non-weight bearing status of her left leg. This is her first episode of home health care. Twelve therapy visits are ordered by her physician for this episode of care.

M1020 Discussion/Assignment

Code V57.1, Other physical therapy, is selected as the patient's primary diagnosis and assigned to M1020. The rehabilitation code V57.1, Other physical therapy, qualifies as the patient's primary diagnosis because the focus of the patient's current home health plan of care is to provide rehabilitation through therapeutic physical therapy.

Specific Coding Considerations:

- Coding guidelines for V57 instructs the HHA to use an additional code to identify the patient's underlying condition. Code 781.2, Abnormality of gait, is identified as the patient's underlying condition.
- Codes under category V57 are expected to be assigned as a primary diagnosis unless there are multiple reasons for the patient's admission (not applicable to this scenario).

M1022 Discussion/Assignment

Abnormality of gait, code 781.2, is selected as the secondary diagnosis and assigned to M1022. This diagnosis most accurately describes the patient's current condition and supports the patient's need for PT services.

Specific Coding Considerations: The patient's acute hip fracture, code 820.8, Unspecified part of neck of femur, closed fracture, should not be assigned as a home health diagnosis to M1020/M1022. Acute fracture codes, according to ICD-9-C M Coding Guidelines, must be used only for the patient's initial, acute episode of care. In case scenario #1, the patient's treatment is directed at rehabilitation following hip fracture and surgery. The physical therapy services ordered by the patient's physician are not treating the fracture but rather the gait abnormality, which occurred as a result of the fracture.

M1024 Discussion

Primary diagnosis: Other physical therapy, code V57.1, could potentially be considered to replace code 781.2, Abnormality of gait; however, it is not an option in this case because of the patient's clinical status. Code 781.2 does not qualify as a case mix diagnosis and M1024 (optional) is blank.

Secondary Diagnosis: Abnormality of gait, 781.2, does not qualify as a case mix diagnosis because the patient in this scenario does not have a pressure ulcer (clinical interaction required in line item 19 of Table 2A is NOT present in this scenario). Note: To qualify as a case mix diagnosis, the diagnosis must be listed in Table 2B and meet the criteria stipulated in Table 2A. Acute hip fracture, code 820.8, is contained in the "Ortho-1-Leg Disorders" diagnosis group in Table 2B however this diagnosis does not qualify as a case mix diagnosis because the patient in this scenario does not have a pressure ulcer and is not receiving intravenous, parenteral nutrition or enteral nutrition therapy at home, (clinical interactions required in line items 19 and 20 of Table 2A).

OASIS Coding

Primary Diagnosis:	M1020a	Column 1, Other Physical Therapy
	M1020a	Column 2, V57.1
Secondary Diagnosis:	M1022b	Column 1, Abnormality of Gait
	M1022b	Column 2, 781.2
Optional Payment Diagnosis	M1024a	Column 3, is blank
Optional Payment Diagnosis	M1024b	Column 3, is blank

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

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

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 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 in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		**(M1024) Case Mix Diagnoses (OPTIONAL)**	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete **only if** the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-C M / Symptom Control Rating	Description/ ICD-9-C M	Description/ ICD-9-C M
(M1020) Primary Diagnosis a. **Other physical therapy**	**(V-codes are allowed)** a. (V 5 7 . 1) ☐0 ☐1 ☒2 ☐3 ☐4	**(V- or E-codes NOT allowed)** a. _____ (.)	**(V- or E-codes NOT allowed)** a. _____ (.)
(M1022) Other Diagnoses b. **Abnormality of gait**	**(V- or E-codes are allowed)** b. (7 8 1 . 2) ☐0 ☐1 ☒2 ☐3 ☐4	**(V- or E-codes NOT allowed)** b. _____ (.)	**(V- or E-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. _____ (.)

Case Scenario #2: Multidisciplinary Case Involving Total Hip Replacement

An 83-year-old female is admitted by the HHA following discharge from the hospital. The patient is seven days status post left total hip replacement due to osteoarthritis in both hips. She developed a mildly exudated wound infection (Staph. aureus) of her surgical incision and was discharged from the hospital with IV antibiotics. This is the patient's initial episode of home health care.

Skilled Nursing Need: The patient's physician ordered daily skilled nursing visits for three weeks to treat her infected left hip surgical wound. The specific skilled nursing services ordered by the physician include the following:

- monitor the wound for signs and symptoms of infection;
- administer IV antibiotics daily for 21 days; and
- teach the patient's daughter to perform IV administration and wound care.

Therapy Need: The patient's physician ordered physical therapy services for gait training and strengthening exercises two times a week for four weeks. Ambulation is limited due to non-weight-bearing status of her left lower extremity. The patient can perform supervised pivot transfers with contact guard assistance in and out of bed. Her daughter will be staying with her until her mobility improves.

M1020 Discussion/Assignment

This is a multidisciplinary case directed at providing post-op care following a total hip replacement. Code 998.59, Other post-operative infection, is selected as the patient's primary diagnosis and assigned to M1020. The surgical wound infection represents the most acute condition and requires the most intensive skilled services.

M1022 Discussion/Assignment

Code 041.11, Methicillin susceptible staphylococcus aureus in conditions classified elsewhere and of unspecified site; V54.81, Aftercare following joint replacement; V43.64, Hip joint replaced; 715.35, Osteoarthrosis, localized, not specified whether primary or secondary, pelvic region and thigh; and 781.2, Abnormality of Gait are selected as the patient's secondary diagnoses. Each diagnosis is assigned to the OASIS in the order that reflects the seriousness of the patient's condition and to justify the disciplines and services provided (see Section D.3, Secondary Diagnosis Criteria, of this attachment).

M1022b - 041.11, Methicillin susceptible staphylococcus aureus in conditions classified elsewhere and of unspecified site, is assigned as the first diagnosis in M1022. Coding guidelines for ICD-9-C M code 998.59, which is the primary diagnosis, requires assignment of an additional code to identify the infection.

M1022c - V54.81, Aftercare following joint replacement, is assigned as the second diagnosis in M1022. ICD-9-C M coding guidelines require an additional code to identify the joint replacement site, left hip V43.64.

M1022d - V43.64, Hip joint replaced, is the additional "Status V-Code" required per ICD-9-C M coding guidelines to identify the joint replacement site of the V54.81 Aftercare code. It is the third diagnosis assigned to M1022.

M1022e - 715.35, Osteoarthrosis, localized, not specified whether primary or secondary, pelvic region and thigh, is assigned as the fourth secondary diagnosis in M1022.
M1022f - 781.2, Abnormality of gait is assigned as the fifth secondary diagnosis in M1022.

M1024 Discussion

Primary diagnosis: Other post-operative Infection, code 998.59, qualifies as a case mix diagnosis based on the clinical status of the patient. Note: M1024a, column 3 is blank because a V-code is not replacing the case mix diagnosis. The Grouper will identify the diagnosis assigned to M1020 as a point bearing diagnosis qualifying for case mix points.

Secondary Diagnoses: Osteoarthrosis, localized, not specified whether primary or secondary, pelvic region and thigh, code 715.35, qualifies as a case mix diagnosis based on the clinical status of the patient. Although code V54.81, Aftercare following joint replacement, could replace case mix diagnosis code 715.35, and 715.35 could be coded to M1024 (optional), this is not the preferred way to code. It is preferable for osteoarthrosis to be assigned to M1022 rather than M1024 because osteoarthrosis is an ongoing condition of the patient. Note: M1024c, column 3 is blank, the Grouper will identify diagnoses assigned to M1022 that qualify for case mix points.

Code 781.2, Abnormality of gait, does not qualify as a case mix diagnosis. To qualify as a case mix diagnosis, the diagnosis must be listed in Table 2B and meet the criteria stipulated in Table 2A. Code 781.2, Abnormality of gait, does not qualify as a case mix diagnosis because the patient in this scenario does not have a pressure ulcer (clinical interaction required in line item 19 of Table 2A is NOT present in this scenario).

OASIS Coding

Primary Diagnosis:	M1020a	Column 1, Other postoperative Infection
	M1020a	Column 2, 998.59
Secondary Diagnosis:	M1022b	Column 1, Methicillin susceptible staphylococcus aureus in conditions classified elsewhere and of unspecified site
	M1022b	Column 2, 041.11
Secondary Diagnosis:	M1022c	Column 1, Aftercare following joint replacement
	M1022c	Column 2, V54.81
Secondary Diagnosis:	M1022d	Column 1, Hip joint replaced
	M1022d	Column 2, V43.64
Secondary Diagnosis:	M1022e	Column 1, Osteoarthrosis, localized, not specified whether primary or secondary, pelvic region and thigh
	M1022e	Column 2, 715.35
Secondary Diagnosis:	M1022f	Column 1, Abnormality of Gait
	M1022f	Column 2, 781.2
Optional Payment Diagnosis	M1024a-f	Column 3, is blank

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

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

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 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 in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		**(M1024) Case Mix Diagnoses (OPTIONAL)**	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete **only if** the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM / Symptom Control Rating	Description/ ICD-9-CM	Description/ ICD-9-CM
(M1020) Primary Diagnosis a. **Other post-operative infection**	**(V-codes are allowed)** a. (9 9 8 . 5 9) ☐0 ☐1 ☐2 ☒3 ☐4	**(V- or E-codes NOT allowed)** a. _____ (.)	**(V- or E-codes NOT allowed)** a. _____ (.)
(M1022) Other Diagnoses b. **Methicillin susceptible Staph. Aureus**	**(V- or E-codes are allowed)** b. (0 4 1 . 1 1) ☐0 ☐1 ☐2 ☒3 ☐4	**(V- or E-codes NOT allowed)** b. _____ (.)	**(V- or E-codes NOT allowed)** b. _____ (.)
c. **Aftercare following joint replacement**	c. (V 5 4 . 8 1) ☐0 ☐1 ☒2 ☐3 ☐4	c. _____ (.)	c. _____ (.)
d. **Hip Joint replaced**	d. (V 4 3 . 6 4) ☐0 ☐1 ☒2 ☐3 ☐4	d. _____ (.)	d. _____ (.)
e. **Osteoarthrosis, localized, not spec. whether primary or secondary, pelvic region & thigh**	e.(7 1 5 . 3 5) ☐0 ☐1 ☒2 ☐3 ☐4	e. _____ (.)	e. _____ (.)
f. **Abnormality of gait**	f. (7 8 1 . 2) ☐0 ☐1 ☒2 ☐3 ☐4	f. _____ (.)	f. _____ (.)

Case Scenario #3: Malignant Neoplasm of the Breast

A 66-year-old left-handed, left dominant woman who lives alone is discharged from the hospital three days after a right, modified radical mastectomy for breast cancer. The patient has a right surgical breast wound and lymphedema of the right arm. She also has residual weakness of her left arm, due to H/O stroke. The patient is unable to care for her breast wound. Her medications include Tamoxifen for estrogen receptor positive breast cancer chemotherapy and pain medications. Her physician reports that the patient's breast cancer is not resolved and the surgical drain is scheduled to be removed in several days.

Skilled Nursing Need: The patient's physician ordered skilled nursing visits daily for 10 days until the surgical drain is removed, then three times a week for four weeks to provide surgical wound care and supervision of the exercises ordered to improve her right shoulder range of motion and to monitor her arm lymphedema.

Skilled Therapy Need: Skilled therapy services are not required or ordered by the patient's physician. The nurse will supervise the patient's performance of the exercises ordered to improve her shoulder range of motion on the affected side.

M1020 Discussion/Assignment

V58.42, Aftercare following surgery for neoplasm, is selected as the primary diagnosis and assigned to M1020. The skilled nursing services rendered by the HHA to care for the patient's surgical wound and monitor the wound for signs and symptoms of infection is the chief reason for providing home care. ICD-9-C M Coding Guidelines require the use of an additional aftercare code in conjunction with code V58.42 to fully identify the reason for the aftercare services. Therefore, code V58.31, Encounter for change or removal of surgical wound dressing, is assigned as the first secondary diagnosis.

M1022 Discussion/Assignment

Code V58.31, Encounter for change or removal of surgical wound dressing; Code 174.9, Malignant neoplasm of breast (female), unspecified; V86.0, Estrogen receptor positive status; Code 457.0, Post-mastectomy lymphedema syndrome and Code 438.31, Monoplegia of upper limb affecting dominant side, are selected as the patient's secondary diagnoses. Each diagnosis is assigned to the OASIS in the order that reflects the seriousness of the patient's condition and to justify the services provided, (see Section D.3, Secondary Diagnosis Selection Criteria, of this attachment).

M1022b - Code V58.31, Encounter for change or removal of surgical wound dressing is coded as the first secondary diagnosis in M1022. The assignment of this code complies with ICD-9-C M coding guidelines and identifies the skilled nursing wound care services provided to the patient.

M1022c - Code 174.9, Malignant neoplasm of breast (female) unspecified, is coded as the second diagnosis in M1022. Note: It is preferable for code 174.9 to be coded as a secondary diagnosis because malignant cancer is an ongoing condition that justifies/supports the assignment of V58.42 and V58.31. ICD-9-C M coding guidelines require the use of an additional code to identify the estrogen receptor status when assigning code 174.9.

M1022d - Code V86.0, Estrogen receptor positive status, is coded as the third diagnosis in M1022 in compliance with ICD-9-C M coding guidelines.

M1022e - Code 457.0, Post mastectomy lymphedema syndrome, is coded as the fourth diagnosis in M1022. Lymphedema is actively addressed in the patient's plan of care and affects her responsiveness to treatment and rehabilitative prognosis.

M1022f - Code 438.31, Monoplegia of upper limb affecting dominant side, is coded as the fifth diagnosis in M1022. This condition is a residual dysfunction of her left arm (the patient's dominant side), due to a stroke that occurred one year ago. Code 438.31, is a co-morbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis.

M1024 Discussion

Primary Diagnosis: M1024a, Column 3 is blank. Although code V58.42, Aftercare following surgery for neoplasm, could replace case mix diagnosis code 174.9, Malignant Neoplasm of breast (female) unspecified, and 174.9 could be coded to M1024a, Column 3, this is not the preferred way to code this case. It is preferable for code 174.9 to be assigned as a secondary diagnosis rather than coded to M1024a, Column 3, because the malignant cancer is an ongoing condition.

Secondary Diagnoses: Code 174.9, Malignant neoplasm breast (female), unspecified, qualifies as a case mix diagnosis. Note: M1024c, Column 3, is blank; the Grouper will identify diagnoses assigned to M1022 that qualify for case mix points.

Code 457.0, Post mastectomy lymphedema syndrome does not qualify as a case mix diagnosis.

Code 438.31, Monoplegia of upper limb affecting dominant side, qualifies as a case mix diagnosis, M1024f, Column 3, is blank, the Grouper will identify diagnoses assigned to M1022 that qualify for case mix points.

OASIS Coding

Primary Diagnosis:	M1020a	Column 1, Aftercare Following Surgery for Neoplasm
	M1020a	Column 2, V58.42
Secondary Diagnosis:	M1022b	Column 1, Encounter for change or removal of surgical wound dressing
	M1022b	Column 2, V58.31
Secondary Diagnosis:	M1022c	Column 1, Malignant neoplasm breast (female), unspecified
	M1022c	Column 2, 174.9
Secondary Diagnosis:	M1022d	Column 1, Estrogen receptor positive status
	M1022d	Column 2, V86.0
Secondary Diagnosis:	M1022e	Column 1, Post mastectomy lymphedema syndrome
	M1022e	Column 2, 457.0
Secondary Diagnosis:	M1022f	Column 1, Monoplegia of upper limb affecting dominant side
	M1022f	Column 2, 438.31
Optional Payment Diagnosis	M1024a-f	Column 3, is blank

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

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

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 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 in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		**(M1024) Case Mix Diagnoses (OPTIONAL)**	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete **only if** the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM / Symptom Control Rating	Description/ ICD-9-CM	Description/ ICD-9-CM
(M1020) Primary Diagnosis a. **Aftercare following surgery for neoplasm**	**(V-codes are allowed)** a. (V 5 8 . 4 2) ☐0 ☐1 ☒2 ☐3 ☐4	**(V- or E-codes NOT allowed)** a._____ (____.__)	**(V- or E-codes NOT allowed)** a._____ (____.__)
(M1022) Other Diagnoses b. **Encounter for change or removal of surgical wound dressing**	**(V- or E-codes are allowed)** b. (V 5 8 . 3 1) ☐0 ☐1 ☐2 ☒3 ☐4	**(V- or E-codes NOT allowed)** b._____ (____.__)	**(V- or E-codes NOT allowed)** b._____ (____.__)
c. **Malig Neo. (female) Breast Unspecified**	c. (1 7 4 . 9) ☐0 ☐1 ☐2 ☒3 ☐4	c._____ (____.__)	c._____ (____.__)
d. **Estrogen Receptor Positive**	d. (V 8 6 . 0) ☐0 ☐1 ☐2 ☒3 ☐4	d._____ (____.__)	d._____ (____.__)
e. **Lymphedema syndrome**	e. (4 5 7 . 0) ☐0 ☐1 ☒2 ☐3 ☐4	e._____ (____.__)	e._____ (____.__)
f. **Monoplegia of upper limb affecting dominant side**	f.(4 3 8 . 3 1) ☐0 ☐1 ☒2 ☐3 ☐4	f._____ (____.__)	f._____ (____.__)

Case Scenario #4: Cerebral Contusion

Note: This scenario provides an example of acceptable M1024 documentation. (Refer to Section D.4.c, M1024 coding to prevent loss of case mix points, within this document for additional information.)

A 70-year-old male is admitted to home health following discharge from a three- day hospitalization for cerebral contusion, code 851.02. He accidentally fell at home with brief loss of consciousness, confusion (resolved), and resolving right leg weakness and unsteady gait (dominant side). CT revealed a focal left cortex contusion. The patient received physical therapy and occupational therapy while in the hospital. Although his functional ability is improved, he is unable to ambulate and requires a manual wheelchair for mobility. The patient requires physical therapy to regain his normal gait. His physician orders home health skilled therapy due to residual effects of his intracranial injury, code 907.0, Late effect of intracranial injury without mention of skull fracture.

Skilled Nursing: The HHA did not receive an order from the patient's physician to provide skilled nursing services. The patient's initial comprehensive assessment visit by the HHA did NOT identify a skilled nursing need.

Therapy Need: The patient's physician orders physical therapy for gait evaluation/training and strengthening exercises three times per week for four weeks. The patient is currently wheelchair dependent (chairfast). He is unable to ambulate but he is able to wheel independently in his wheel chair. This is his first episode of home health care.

M1020 Discussion/Assignment

The rehabilitation code V57.1, Other physical therapy, qualifies as the patient's primary diagnosis because the focus of the patient's current home health plan of care is to provide rehabilitation through therapeutic physical therapy.

Specific Coding Considerations:

- Coding guidelines for V57 instructs HHAs to use an additional code to identify the patient's underlying condition. Code, 907.0, Late effect of intracranial injury without mention of skull fracture, is identified as the patient's underlying condition.
- In the home health setting, V-codes are appropriately assigned to M1020 when a patient with a resolving disease or injury requires specific aftercare of that disease or injury.

M1022 Discussion/Assignment

Code 907.0, Late effect of intracranial injury without mention of skull fracture, is identified as the as the first secondary diagnosis because it is the condition that best reflects the seriousness of the patient's condition and justifies the therapy services provided.

Abnormality of gait, code 781.2, is selected as the second diagnosis assigned to M1022. This diagnosis most accurately describes the patient's current condition and supports the patient's need for PT services.

Specific Coding Considerations:

In this case scenario the patient received treatment for his acute condition, cerebral contusion, code 851.02 in the hospital. The patient's cerebral contusion is the cause of his acute injury and Code 907.0, Late effect of intracranial injury without mention of skull fracture is identified as the late effect of the patient's injury. Under ICD-9-CM coding guidelines, the code for the acute phase of an illness or injury that led to the patient's late effect is never used with a code for the late effect. To comply with ICD-9-CM Official Guidelines for Coding and Reporting, code 851.02 must not be assigned as the patient's primary and or secondary diagnosis.

M1024 Discussion

Specific HH PPS payment rules and documentation considerations apply to the primary diagnosis in this scenario.

- The patient's primary diagnosis is a V-code, V57.1, Other physical therapy. The first secondary diagnosis is Code 907.0, Late effect of intracranial injury without mention of skull fracture is a case mix diagnosis contained within the Neuro 1-Brain Disorders and Paralysis Diagnosis Group, (Refer to Section D.4.c of this document, M1024 coding to prevent loss of case mix points for additional information.).
- To qualify as a case mix diagnosis, the diagnosis must be listed in Table 2B and the patient's condition meets the criteria stipulated in Table 2A.

Documentation Guidance: To avoid receiving secondary points for case mix diagnosis code, 907.0, Late effect of intracranial injury without mention of skull fracture, report this code in the case mix section of the OASIS, the primary diagnosis line (a) of M1024.

OASIS Coding

Primary Diagnosis:	M1020a	Column 1, Other Physical Therapy
	M1020a	Column 2, V57.1
Secondary Diagnosis:	M1022b	Column 1, Late effect of intracranial injury without mention of skull fracture.
	M1022b	Column 2, 907.0
Secondary Diagnosis:	M1022c	Column 1, Abnormality of gait
	M1022c	Column 2, 781.2
Optional Payment Diagnosis	M1024a	Column 3, Late effect of intracranial injury without mention of skull fracture 907.0
Optional Payment Diagnosis	M1024b	Column 3, is blank

(M1020/1022/1024) Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare P P S case mix group. Do not assign symptom control ratings for V- or E-codes.

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

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1;

Rate the degree of symptom control for the condition listed in Column 1 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 in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

(M1020) Primary Diagnosis & (M1022) Other Diagnoses		**(M1024) Case Mix Diagnoses (OPTIONAL)**	
Column 1	Column 2	Column 3	Column 4
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-9-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses	Complete if a V-code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis.	Complete **only if** the V-code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).
Description	ICD-9-CM / Symptom Control Rating	Description/ ICD-9-CM	Description/ ICD-9-CM
(M1020) Primary Diagnosis a. **Other physical therapy**	**(V-codes are allowed)** a. (V 5 7 . 1) ☐0 ☐1 ☒2 ☐3 ☐4	**(V- or E-codes NOT allowed)** a. Late effect of intracranial injury without mention of skull fracture (9 0 7 . 0)	**(V- or E-codes NOT allowed)** a. _____ (.)
(M1022) Other Diagnoses b. **Late effect of intracranial injury without mention of skull fracture**	**(V- or E-codes are allowed)** b. (9 0 7 . 0) ☐0 ☐1 ☒2 ☐3 ☐4	**(V- or E-codes NOT allowed)** b. _____ (.)	**(V- or E-codes NOT allowed)** b. _____ (.)
c. **Abnormality of gait**	c. (7 8 1 . 2) ☐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. _____ (.)

APPENDIX E – DATA REPORTING REGULATIONS

DATA REPORTING REGULATION

Section 4602(e) of the Balanced Budget Act of 1997 authorizes the Secretary of the Department of Health and Human Services (HHS) to require that home health agencies (HHAs) submit any information that the Secretary considers necessary to develop a reliable case mix system for the purposes of implementing a prospective payment system for HHAs. To fulfill this mandate, CMS implemented a regulation requiring electronic reporting of OASIS data for Medicare and Medicaid patients to the State Agency (or other entity designated by CMS) as a condition of participation for HHAs. This rule provides guidelines for HHAs for the electronic transmission of the OASIS data as well as responsibilities of the State Agency or contractor in collecting and transmitting this information to CMS. Rules concerning the privacy of patient identifiable information generated by the OASIS were also set forth.

The reporting regulation focuses on two Conditions of Participation (CoP) for the HHA at Code of Federal Regulations (CFR):

- CFR Title 42 §484.20 - Reporting OASIS information and CFR Title 42 §484.11 - Release of patient identifiable OASIS information, and

- CFR Title 42 §488.68 outlining the State Agency responsibilities for OASIS collection and database requirements.

42 CFR 484.20 Condition of Participation: Reporting OASIS Information

There are four standards in the Reporting OASIS Information CoP. In these standards, we address the following requirements:

a. §484.20(a) Standard: Encoding OASIS Data

Once the comprehensive assessment has been completed and OASIS data collected, HHAs enter the OASIS information into the computer system, which we call “encoding.” All the time points of the OASIS assessments have a uniform time frame of thirty days from the date the assessment is completed (M0090— Date Assessment Completed) for encoding and submitting the data. Once the OASIS data are encoded (in software available from CMS or other software that conforms to the CMS standard electronic record layout, edit specifications, and data dictionary), the agency will review each assessment and edit it for transmission to the State Agency. During this preparation period, the HHA must run a software application that subjects each patient data set to the CMS edit specifications and makes it transmission-ready. The agency must correct any information that does not pass the CMS-specified edits (e.g., data is missing, incorrect, or inconsistent). Staff entering data may need to contact the qualified clinician who assessed the patient for assistance in making those corrections. The clinician’s recall of the patient assessment and clinical notes, which document the assessment, are better at a point in time closer to the assessment activity than if the edits and corrections are delayed.

HHAs have flexibility in the method used to encode their data. Data can be encoded directly by the skilled professional who conducts the assessment into a laptop or hand-

held computer, by a clerical staff member from a hard copy of the completed assessment, or by a data entry operator or service with whom the HHA may contract to enter the data. Any of these are acceptable methods of meeting the regulatory reporting requirements for OASIS. However, the HHA is ultimately responsible for meeting the reporting requirements as well as maintaining patient confidentiality.

Non-clinical staff may not assess patients or complete assessment items; however, clerical staff or data entry operators may enter into the computer the OASIS data collected by the skilled professional. In entering the data, HHAs must comply with all requirements for safeguarding the confidentiality of protected health (patient-identifiable) information.

Once the OASIS data are encoded, HHAs use their software to review and edit the data prior to transmission to the State Agency. When editing the data prior to transmission, it is important to remember that the edits include an electronic safety net to preclude the transmission of erroneous or inconsistent information and enforce the required formatting for the data set items. When transmitted, the patient assessment data are stabilized at the time point of the assessment, preventing the override of current assessment information with future or past information.

b. §484.20(b) Standard: Accuracy of Encoded OASIS Data

The encoded OASIS data must accurately reflect the patient's status at the time the information is collected. Before transmission, the HHA must ensure that data items on its own clinical record match the encoded data that are sent to the State. We expect that once the qualified skilled professional completes the assessment, the HHA will develop a means to ensure that the OASIS data input into the computer and transmitted to the State Agency (or CMS contractor) exactly reflect the data collected by the skilled professional. Appendix B contains recommendations for conducting data quality audits on a routine basis and includes information from the original *OASIS Implementation Manual* (Chapter 12) (available at the following link (download Part I Chapters: http://www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp#TopOfPage). In addition, the State survey process for HHAs may include review of OASIS data collected versus data encoded and transmitted to the State.

c. §484.20(c) Standard: Transmittal of OASIS Data

CMS requires that the HHA electronically transmit the accurate, completed, and encoded OASIS data to the State Agency (or CMS contractor) within 30 days of the completion of the assessment (M0090 Date Assessment Completed). Data must be transmitted in a format that meets the requirements specified in the data format standard (i.e., conforming to the CMS standard electronic record layouts, edit specifications, and data dictionary). CMS believes that this time frame for transmitting the data will minimize the burden on the HHA associated with frequency of transmission, maintain uniform assessment reporting time frames, and maintain a clear reporting time frame that eliminates the variation of days in a month. Therefore, HHAs are free to develop schedules for transmitting the data that best suit their needs. HHAs must use CMS-specified electronic communications protocols to contact the State Agency or CMS contractor, transmit the export file, and receive validation information. HHAs required to submit OASIS data must do so using browser software to access the State system via the Medicare Data Communications Network, which provides a direct telephone connection for submission and interim reports. Once

transmitted, the State Agency or CMS contractor validates the information while the HHA remains on-line to ensure that some basic elements such as format and HHA information conform to CMS requirements. Once these file checks are completed, a message indicating whether the file has been accepted or rejected is sent back to the HHA's terminal and appears on its computer screen and is reported on the initial validation report displaying all Fatal File and Warning messages in relation to the submission file as a whole. If the submission passes the initial validation check, each individual record is then checked for errors or exceptions to the data specifications, and a Final Validation Report is generated. If the individual record is rejected, a message is sent to the HHA along with the rejected submission file for correction. A file or individual record may be rejected for a variety of reasons, (e.g., the provider identification name or number submitted may be incorrect, the number of records indicated in the trailer record does not match the actual number of records submitted). The HHA must make the corrections and resubmit the file to the State.

HHAs must use a CMS-assigned branch identification number (where applicable) to identify branch-specific assessment information in a uniform fashion nationwide. This procedure finalized a process that began in January 2004, uniquely identifying every branch of every HHA certified to participate in the Medicare home health program. The system links the parent to the branch HHA and gives CMS the capability of monitoring the quality of care delivered by agencies down to the HHA branch level.

For Medicare fee-for-service patients, the transmitted OASIS data also are utilized for billing. The HHA can submit a Request for Anticipated Payment (RAP) to their Regional Home Health Intermediary (RHHI) when all of the four following conditions are met:

- The OASIS assessment is complete and transmitted to the State,
- A physician's verbal orders for home care have been received and documented,
- A plan of care has been established and sent to the physician, and
- The first service visit under that plan has been delivered.

An episode will be opened on Common Working File (CWF) with the receipt and processing of the RAP. RAPs, or in special cases claims, must be submitted for initial HH PPS episodes, subsequent HH PPS episodes, or in transfer situations to start a new HH PPS episode when another episode is already open at a different agency. HHAs should submit the RAP as soon as possible after care begins to assure they are established as the primary HHA for the beneficiary.

d. §484.20(d) Standard: Data Format

To meet the data format requirements, HHAs may use software developed by CMS, the Home Assessment Validation Entry (HAVEN) system, or other vendor's software that conforms to CMS standardized electronic record formats, edit specifications, and data dictionaries. The HAVEN software can be used for several purposes. HHAs can use HAVEN to encode OASIS data, maintain agency and patient-specific OASIS information, and create export files to submit OASIS data. HAVEN provides comprehensive on-line help to users in encoding, editing, and transmitting these data sets. HAVEN can also be

used as a core program by HHAs and software vendors for developing their own software that supports OASIS reporting requirements, while also supporting or developing programs that meet other agency needs. Additionally, CMS maintains a toll-free help line to support this software product. The number for home health providers is 800-339-9313, available 7AM to 7PM, Central Time.

HAVEN alerts the individual who is encoding the data to use the correct screens for the specific type of assessment record required. HHAs using paper copies of assessment instruments must differentiate among the various subsets of OASIS data, i.e., specialized forms for particular assessment time points. HHAs are cautioned that the HAVEN system provides only the minimum requirements to encode data, transmit the data, and receive validation reports. CMS will support these functions and applications; however, we do not intend to provide any other applications related to care planning, financial information, durable medical equipment, medications, or personnel issues. Software developers are encouraged to use the HAVEN software to meet minimum requirements until they can ensure that their own software will accommodate CMS specifications and other applications useful for HHAs. If the HHA uses software other than HAVEN, it must conform to CMS standardized electronic record formats, edit specifications, and data dictionaries. The software must also include the various OASIS data sets.

The required OASIS data set is available on our OASIS website located at http://www.cms.hhs.gov/oasis; click on "Data Set." HHAs can download the required OASIS data set for each data collection time point, i.e., start of care; resumption of care following an inpatient facility stay; follow-up; discharge (not to an inpatient facility); transfer to inpatient facility (with or without agency discharge); and death at home. In addition, CMS provides the HAVEN software on the same website, which can be downloaded at no charge to HHAs and used to report OASIS data. In addition to the software and the OASIS data set documentation available, this website includes the data specifications, data dictionaries, user's manual for the OASIS data set, HAVEN manual, HHA data submission manual, contact information for each state's OASIS Education Coordinator and OASIS Automation Coordinator, and access to OASIS Questions and Answers. Other educational materials for HHAs will be posted on the website. The site is intended to provide direct access for HHAs, State agencies, CMS contractors, software vendors, professional organizations, and consumers. Vendors and agencies are encourage to regularly review the website for information related to the computerization of OASIS and other CMS-related home health issues. CMS will continue to promote processes for ensuring accuracy in the software. In the future, as OASIS is revised, HHAs will be directed to the CMS OASIS website for the current version of the OASIS data set. HHAs may also obtain hard copies from the National Technical Information Service at 1-800-553-6847.

42.CFR 484.11 Condition of Participation: Release of Patient Identifiable OASIS Information

The HHA or an agent acting on behalf of the HHA must ensure that all protected health (patient-identifiable) information in the clinical record, including OASIS data, remains confidential and is not released to the public. The data, whether in hard copy or in electronic format, must be secured and controlled. In addition to the provisions of this Condition of Participation, all HHAs must adhere to the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to ensure patient confidentiality and the security of patient information. (Further information on these requirements is provided on-line at http://www.cms.hhs.gov/hipaa.)

CMS specifies that the HHA who chooses to secure the services of an agent to complete the OASIS regulatory reporting requirements must secure a written contract between the HHA and the agent to not use or disclose the information. The agent may only release data to the extent the HHA itself is permitted to do so. It is believed that this CoP will act as a safeguard against the unauthorized use of a patient's clinical record information, regardless of the form or storage method.

State Agency Responsibilities for OASIS Collection and Database Requirements

Under section 1891(b) of the Social Security Act, the Secretary of the Department of Health and Human Services must assure that processes are in place to protect the health and safety of individuals under the care of an HHA and to promote the effective and efficient use of public monies. Section 1864 of the Act authorizes the use of State health agencies to determine a provider's compliance with the CoPs. State responsibilities in ensuring compliance with the CoPs are set forth at Part 488, Survey, Certification, and Enforcement Procedures.

State Agency OASIS collection and database responsibilities have been added to the other State responsibilities at 42 CFR §488. This section provides that the overall responsibility for fulfilling requirements to operate the OASIS system rests with the State Agency or other entity under direct contract with CMS. The State may enter into an agreement with the State Medicaid agency, another State component, or a private contractor to perform day-to-day operations of the system, or CMS may directly contract with an authorized entity. These "CMS contractors" perform the duties on behalf of CMS or the State Agency.

While these entities may actually perform all OASIS-related functions, the ultimate responsibility of the OASIS program rests with the State Agency or authorized entity under contract directly to CMS. If the standard State system is operated by an entity other than the State Agency, the State must ensure that it has suitable access to this system to fully support all OASIS-driven functions required of the State Agency (for example, outcome-based quality improvement reports and survey specific data). The regulation specifies State Agency and CMS contractor responsibilities with regard to the OASIS system.

As part of State Agency survey responsibilities, the State Agency or other entity designated by CMS has overall responsibility for fulfilling the following requirements for operating the OASIS system. The State Agency or other entity designated by CMS must establish and maintain an OASIS database on the standard system developed or approved by CMS to collect, store, and analyze data; conduct basic system management activities including hardware and software maintenance, system back-up, and database monitoring; and analyze and report OASIS data to CMS. The State Agency must edit the data on receipt from the HHA, as specified by CMS, and ensure that the HHA resolves errors within the limits specified by CMS. At least monthly, all edited OASIS records received during that period must be made available for retrieval by CMS.

The State Agency must ensure that access to data is restricted (except for the transmission of data and reports to CMS) to the State Agency component that conducts surveys for purposes related to this function, and to other entities if authorized by CMS. The State Agency must ensure that patient identifiable OASIS data are released only to the extent permitted under the Privacy Act of 1974 and the Administrative Simplification provision of the HIPAA Act of 1996. The System of Records supports the HHA/OASIS database.

The State Agency provides training and technical support for HHAs. The State Agency or other entity designated by CMS must instruct each HHA on the administration of and integration of the

OASIS data set into the facility's own record keeping system; instruct each HHA on the use of software to encode and transmit OASIS data to the State; monitor each HHA's ability to transmit OASIS data; provide ongoing technical assistance and general support to HHAs in implementing the OASIS reporting requirements specified in the Conditions of Participation for HHAs; and carry out any other functions as designated by CMS necessary to maintain OASIS data on the standard State system.

Privacy Act System of Records Notice

The Privacy Act System of Records (SOR) Notice was first published in the *Federal Register*, Vol. 64, No. 117, June 18, 1999, and was updated in the Vol. 66, No. 248 *Federal Register*, published on December 27, 2001 and Vol. 72, No. 218 *Federal Register,* published November 13, 2007. The original notice describes the purpose of the new SOR (a national database) and identifies the statutory authority for creation and maintenance of the system and appropriate routine uses of the data. Clinical assessment information for all Medicare or Medicaid patients receiving the services of a Medicare- or Medicaid-approved HHA except for those receiving HHA services for pre- and post-partum conditions, patients less than 18 years of age, and patients receiving exclusively personal care or non-health care services (i.e., chore or homemaker services) is included in the System of Records (SOR). The assessment information contained in the SOR are OASIS data. These data are obtained through a patient assessment that SOR conducted by a registered nurse or qualified therapist. To determine the type of care needed by a patient, HHAs perform an assessment of each patient's physical and emotional status. HHAs will continue to do these assessments, but now they will report a portion of that assessment to CMS to perform several critical functions, such as calculating the appropriate amount to pay for home health services, and to ensure that HHAs are providing the highest quality of care for the entire agency and for each individual patient. Home health patients are one of the most vulnerable populations because services are provided in the home where it is difficult to oversee the quality of services provided. OASIS data allow CMS to measure how well HHAs care for their patients through the development of performance profiles for each agency.

Consistent with the HIPAA Privacy and Security Rules, the Privacy Act permits CMS to disclose information without an individual's consent if the information is to be used for a purpose that is compatible with the stated purpose(s) for which the information was collected. This disclosure is known as "routine use." Several routine use disclosures have been identified for OASIS data. These data may be disclosed only to:

- The Department of Justice, court, or adjudicatory body when CMS is involved in litigation or when CMS' policies or operations could be affected by the outcome of the litigation.

- A third party with whom CMS has contracted to assist in accomplishing CMS functions relating to purposes of the System of Records.

- Another Federal or State Agency, agency of a State Government, or established by State law, for purposes of evaluating and monitoring the quality of home health care and contributing to the accuracy of CMS' health insurance operations.

- A Quality Improvement Organization (QIO), to assist in performing specific functions relating to assessing and improving HHA quality of care.

- An individual or organization for research, evaluation, or epidemiological activities related to health.

- A member of Congress or a Congressional staff member in response to an inquiry of the Congressional Office made at the written request of the constituent about whom the record is maintained.

The December 27, 2001, *Federal Register* notice added a seventh use disclosure:

- National accrediting organizations with approval for deeming authority for Medicare requirements for home health services, allowing these organizations to target potential or identified problems during the accreditation review process.

The June 18, 1999 *Federal Register* notice also identified the specific safeguards in place to ensure confidentiality of patient-level data. Please refer to this announcement for details.

Deficit Reduction Act of 2005 Requirement for Reporting Quality Data and Public Reporting for Quality Measures

In 2005, the Deficit Reduction Act (DRA) Section 5201(c) (2) was passed by Congress and added section 1895(b) (3) (ii) (V) to the Social Security Act requiring each HHA to submit to the Secretary such data that the Secretary determines are appropriate for the measurement of health care quality for 2007 and each subsequent year. Section 5201 (c)(v) requires a payment adjustment if an HHA does not submit data for the reporting year, "the home health market basket percentage increase applicable for such year shall be reduced by 2 percentage points." The two percent reduction would begin to apply to annual payment updates beginning on January 2007 and each year thereafter. For calendar year (CY) 2010, the data will be will based on OASIS submissions from 7/1/2008 through 6/30/2009.

The law also requires the Secretary to establish procedures for making data submitted available to the public and ensures the HHA has the opportunity to review the data prior to the data being made public. HHAs currently have pre-publication access to their own agency's quality data (which the contractor updates periodically). CMS proposes to continue this process, to enable each agency to know how it is performing before public posting of data on the Home Health Compare website. CMS also publishes an annual Preview Report in the fall of each year (available to home health agencies on the Casper Reporting system and posted the QTSO memorandum in the OASIS State Welcome Page in their folders to advise agencies of the preview reports and how to access them). See the Reporting Home Health Quality Data for Annual Payment Update website at the following link: http://www.cms.hhs.gov/HomeHealthQualityInits/08_HHQIReportingforAPU.asp and refer to QTSO Memorandum 2006-122, published November 17, 2006 in the **Downloads** section of that website. Also see Pay for Reporting Implementation Links and **Downloads** for the original DRA, Rule and Press Release.

The Secretary of the Department of HHS has determined that the OASIS information collection best meets the requirements of this statutory mandate. Continuing to use the OASIS instrument ensures that providers will not have an additional burden of reporting through a separate mechanism and that the costs associated with the development and testing of a new reporting mechanism can be avoided.

Therefore, OASIS assessment episodes submitted by home health agencies to CMS for Condition of Participation compliance for dates of service beginning July 1 and ending June 30 of each year will count as meeting the reporting requirement for CY as listed in the rules for annual payment update. (This reporting time period would allow 12 full months of data and would provide CMS the time necessary to analyze and make any necessary payment adjustments.) CMS proposes to reconcile the OASIS submissions with claims data every year in order to verify full compliance with the quality reporting.

HHAs that meet the reporting requirements would be eligible for the full home health market basket percentage increase. CMS has proposed that HHAs certified on or after May 1 each year for payments to be made in the next calendar year to be excluded from the quality reporting requirement data for use in that CY, as data submission and analysis would not be possible for an agency certified this late in the reporting time period. At the soonest time possible after obtaining the CMS Certification Number (CCN), reporting is mandated. We note these exclusions only affect quality reporting requirements and do not affect the agency's OASIS reporting responsibilities under the CoP submission requirement. The data elements will not require additional reporting or burden to HHAs.

The reporting requirement is to transmit during the reporting year (between 7/1/2008 and 6/30/2009) to get complete payment the following payment year, 2010. If a new HHA is approved for operation between 5/1/2009 and 6/30/2009, they do not have to meet the reporting (transmission) requirement by 6/30/2009 because their paperwork would not be completed in time for them to transmit by 6/30/2009 (would not have tie-in notice for CMS Certification Number (CCN) and password to transmit to the OASIS system). They would not be subject to the market basket decrease in the CY (calendar year) that follows, 2010.

Additionally, section 1895(b) (3) (B) (v) (II) of the Act provides the Secretary of the Department of HHS with the discretion to submit appropriate health care quality data in form, manner, and a specified time frame. Such measures would be evidence-based, clearly linked to improved outcomes, and able to be reliably captured with the least burden to the provider.

The OASIS Version C has undergone final revisions based on OMB public comment period and the NQF steering committee process. The implementation of OASIS Version C is anticipated to begin collection in 2010 with HH Compare display of new and refined measures in 12/2010 for a 2011 Pay for Reporting (P4R) impact. There will be a transition of measure requirements as the data elements and quality measures change. CMS will indicate in rulemaking the transition of measures it plans to post on Home Health Compare. Some measures may continue to be reported, while others will be new and refined, and others retired. Measure priorities are determined with each annual payment update.

APPENDIX F – OASIS AND OBQI

CMS provides several reports to HHAs generated from OASIS data. These include reports on agency-patient related characteristics (case mix), potentially avoidable events (adverse event outcomes), and end-result and utilization outcomes. Agency case mix data are derived from OASIS data provided at Start or Resumption of Care (SOC/ROC). Outcomes are calculated from both discharge or transfer OASIS data, and SOC/ROC data. These outcomes can be used to identify focus areas as part of an Outcome-Based Quality Improvement (OBQI) program. OASIS-C incorporates measures of process quality that should also be considered within quality improvement programs. Process measures will be reported as the percentage of patients for whom specific care processes were completed, as specified in OASIS-C.

Process items represent actions taken by home health care providers that are designed to improve patient outcomes. An example of a process measure is the percentage of patients for whom drug education on all medications was provided during the episode (defined as "since the previous OASIS assessment"). The process items in OASIS-C have been carefully chosen to represent "evidence-informed" practice. However, not every process item will apply to every patient. There is no expectation that agencies attain 100% performance on the process items. Two examples may help to demonstrate:

Example: The US Preventive Services Task Force recommends that men ages 45 to 79 use aspirin for primary prevention of cardiovascular disease.

http://www.annals.org/cgi/content/full/150/6/396

However, there are strong clinical reasons where this recommendation would not be appropriate (e.g., allergy to aspirin, history of GI bleeding).

Example: OASIS-C includes a process item to screen for depressive symptoms (M1730). However, a home health care patient with moderate to severe cognitive impairment would not be easily screened with the standard screening instruments.

With respect to OASIS-based outcome measurement and OBQI, it is important to clarify what we mean by patient outcomes and risk adjustment.

What outcomes are:

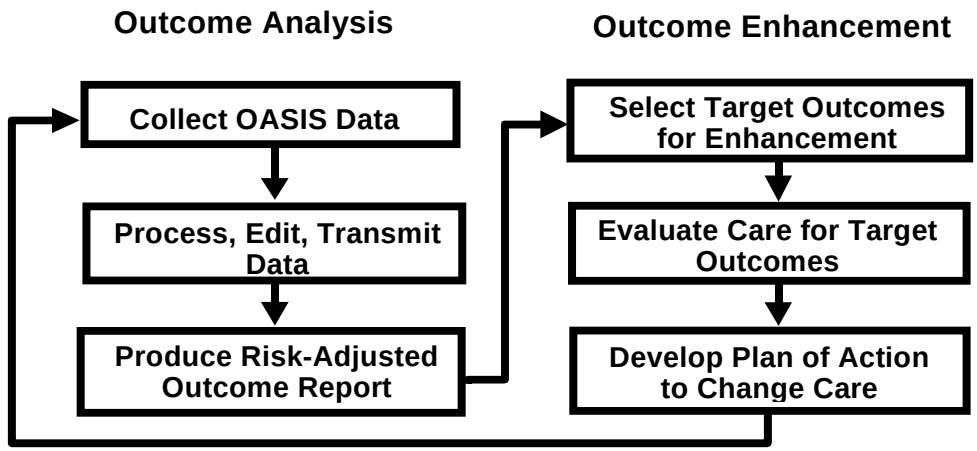
- Outcomes are health status changes between two or more time points, where the term "health status" encompasses physiologic, functional, cognitive, emotional, and behavioral health.
- Outcomes are changes that are intrinsic to the patient.
- Outcomes are positive, negative, or neutral changes in health status.
- Outcomes are changes that result from care provided, or natural progression of disease and disability, or both.

An **outcome** is a health status change that occurs over time, where the change is intrinsic to the patient. Thus, a change in the patient's environment, such as the provision of a walker or handrails in the patient's residence, is not considered an outcome according to this definition — such changes are services or processes of care. Because the nature of the change can be positive, negative, or neutral, the actual change in patient health status can correspond to improvement, decline, or stabilization (i.e., no change) in patient condition. The definition of an outcome does not include a presumed direction; therefore, any deviation (or nondeviation) in health status between the initial time point and the follow-up time point constitutes an outcome. An **end-result outcome** is a change in patient health status, such as physiologic, functional, cognitive, emotional, or behavioral health, between two or more time points. Examples of end-result outcomes are: Improvement in Ambulation/Locomotion and Stabilization in Bathing. A **utilization outcome** is a type of health care utilization (or non-utilization) that reflects (typically a substantial) change in patient health status over time. Examples of utilization outcomes are hospital admission, use of hospital emergency department services, and discharge to the community.

Change in health status over a time interval during which care is provided (e.g., a care episode) can occur either as a result of the care provided or the natural progression of disease and disability. The challenge in outcome analysis is to attempt to somehow separate changes due to care from those due to natural progression. Statistical **risk adjustment** refers to a collection of analytic methods designed to separate the relationships of outcomes with care provided from the relationship of outcomes with natural progression of disease and disability, which is critical to accurate outcome analysis. One of the major purposes of OASIS is to provide data items needed for risk adjustment. In essence, the general intent of risk adjustment is to compensate or adjust for differences in case mix or risk factors (between agency and a comparison sample) that should be taken into consideration if outcomes are to be compared validly. *Risk adjustment compensates or controls for the potential influence of case mix variables (i.e., risk factors) that can affect outcomes.*

OASIS data items and OASIS data do not represent an end in themselves. Rather, they are the means to achieve outcome measurement and OBQI. The OBQI approach is fundamentally a two-stage process as shown in Figure F.1. The first stage is outcome analysis. For the outcome analysis to be conducted for a given agency, it is necessary to collect uniform OASIS data for all patients in the agency — or those patients with conditions of interest. The result of the first stage is an agency-level report showing the agency's present performance in terms of patient outcomes relative to a national sample of home care patients. This is the first outcome report that an agency receives. The second, and subsequent, outcome reports contain comparisons of an agency's present performance in terms of patient outcomes relative to the preceding time period for the agency and relative to a national sample of home care patients. These outcome comparisons constitute the outcome analysis portion of OBQI. This first stage should incorporate risk adjustment through grouping or statistical methods, as appropriate. As noted earlier, risk adjustment refers to the process of compensating or controlling for the potential influence of risk factors or case mix variables that can affect outcomes.

FIGURE F.1: TWO-STAGE OBQI FRAMEWORK.



The outcome report produced from the first-stage analysis helps to determine which outcomes are clearly inferior and which are clearly superior relative either to the prior time period or to the national sample. Therefore, the second stage (that of outcome enhancement) *starts* with those outcomes, termed target outcomes, identified for further investigation. By selecting target outcomes, providers can focus their attention and energies for quality improvement on those care behaviors that produced the target outcomes. Evaluating or investigating processes of care entails reviewing the care provided for those patients who contributed to the target outcomes. This review can take several forms, ranging from informal discussions and brainstorming with agency care providers to structured clinical record reviews.

The review process results in findings, which in turn must be translated into recommendations for changing or reinforcing certain aspects of care provision. These need to be systematically documented in a written plan of action for each target outcome (usually only a few target outcomes are chosen because this can be an intensive effort). The plan of action needs to be thoroughly implemented and continually monitored, which requires a strong agency commitment to changing care behaviors for each target outcome.

Subsequent outcome reports will allow evaluation of how well the care behavior changes have worked — in terms of patient outcomes. Thus, in reviewing its next outcome report, the agency should examine its target outcomes and the changes in those outcomes for their agency between the prior and current outcome reporting periods. Once OBQI is successfully implemented in an agency and becomes a "steady-state" activity, it emerges as a powerful agency tool to continuously improve care for the benefit of patients. Detailed information on the OASIS reports and the OBQI process is provided in the CMS Outcome-based Quality Improvement Manual, available at http://www.cms.hhs.gov/HomeHealthQualityInits/16_HHQIOASISOBQI.asp.

APPENDIX G – COMPARISON OF OASIS-B1 TO OASIS-C

Appendix G includes the following tables that highlight the changes between OASIS-B1 and OASIS-C:

- Table G.1: Comparison of OASIS-B1 to OASIS-C
  (Table G.1 was revised and replaced 12/18/2009)

- Table G.2: OASIS-B1 and OASIS-C – Items Unchanged, Items Modified, Items Dropped, and New Items Added.

Table G.1 was revised and replaced 12/18/2009

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

OASIS-B1 (1/2008)		***OASIS-C (8/2009)***	
Item #	***Item Text***	***Item #***	***Item Text***
M0010	(M0010) Agency Medicare Provider Number	M0010	C M S Certification Number __ __ __ __ __ __
M0012	(M0012) Agency Medicaid Provider Number		ITEM DROPPED on OASIS-C
M0014	Branch State: __ __	M0014	Branch State: __ __
M0016	Branch I D Number: __ __ __ __ __ __ __ __ __ __	M0016	Branch I D Number: __ __ __ __ __ __ __ __ __ __
M0020	Patient I D Number: __	M0020	Patient I D Number: __
M0030	Start of Care Date: month/ day /year	M0030	Start of Care Date: month/ day /year
M0032	Resumption of Care Date: month/day/year/ NA	M0032	Resumption of Care Date: month/day/year/ NA
M0040	Patient Name: __ __ __ __ __ __ __ __ __ __ __ __ __ (First) (MI) __ (Last) (Suffix)	M0040	Patient Name: __ __ __ __ __ __ __ __ __ __ __ __ __ (First) (MI) __ (Last) (Suffix)
M0050	Patient State of Residence: __ __	M0050	Patient State of Residence: __ __
M0060	Patient Zip Code: __ __ __ __ __ __ __ __ __	M0060	Patient Zip Code: __ __ __ __ __ __ __ __ __
M0063	Medicare Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ (including suffix) • NA – No Medicare	M0063	Medicare Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ (including suffix) • NA – No Medicare
M0064	Social Security Number: __ __ __ - __ __ - __ __ __ __ • UK – Unknown or Not Available	M0064	Social Security Number: __ __ __ - __ __ - __ __ __ __ • UK – Unknown or Not Available
M0065	Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ • NA – No Medicaid	M0065	Medicaid Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ • NA – No Medicaid
M0066	(M0066) Birth Date: month/day/year	M0066	Birth Date: month/day/year
M0069	(M0069) Gender: • 1 - Male • 2 - Female	M0069	Gender: • 1 - Male • 2 – Female
M0072	(M0072) Primary Referring Physician id: (UPIN#) __ __ __ __ __ __ __ __ __ __ • UK - Unknown or Not Available	M0018	National Provider identifier (NPI) for the attending physician who has signed the plan of care: __ __ __ __ __ __ __ __ __ __ • UK – Unknown or Not Available

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0140	(M0140) Race/Ethnicity (as identified by patient): (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 • UK – Unknown	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	(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) • 3 - Medicaid (traditional fee-for-service) • 4 - Medicaid (HMO/managed care) • 5 - Workers' compensation • 6 - Title programs (e.g., Title III, V, or XX) • 7 - Other government (e.g., CHAMPUS, VA, etc.) • 8 - Private insurance • 9 - Private HMO/managed care • 10 - Self-pay • 11 - Other (specify) • UK – Unknown	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 (e.g., Title III, V, or XX) • 7 - Other government (e.g., TriCare, VA, etc.) • 8 - Private insurance • 9 - Private HMO/managed care • 10 - Self-pay • 11 - Other (specify) • UK – Unknown
M0080	(M0080) Discipline of Person Completing Assessment: • 1-RN • 2-PT • 3-SLP/ST • 4-OT	M0080	Discipline of Person Completing Assessment: • 1-RN • 2-PT • 3-SLP/ST • 4-OT
M0090	(M0090) Date Assessment Completed: month/day /year	M0090	Date Assessment Completed: month/day/year
M0100	(M0100) This Assessment is Currently Being Completed for the Following Reason: Start/Resumption of Care 1 – Start of care—further visits planned 3 – Resumption of care (after inpatient stay) Follow-Up 4 – Recertification (follow-up) reassessment [Go to M0110] 5 – Other follow-up [Go to M0110] Transfer to an Inpatient Facility 6 – Transferred to an inpatient facility—patient not discharged from agency [Go to M0830] 7 – Transferred to an inpatient facility—patient discharged from agency [Go to M0830] Discharge from Agency — Not to an Inpatient Facility 8 – Death at home [Go to M0906] 9 – Discharge from agency [Go to M0200]	M0100	This Assessment is Currently Being Completed for the Following Reason: Start/Resumption of Care 1 – Start of care—further visits planned 3 – Resumption of care (after inpatient stay) Follow-Up 4 – Recertification (follow-up) reassessment [Go to M0110] 5 – Other follow-up [Go to M0110] Transfer to an Inpatient Facility 6 – Transferred to an inpatient facility—patient not discharged from agency [Go to M1040] 7 – Transferred to an inpatient facility—patient discharged from agency [Go to M1040] Discharge from Agency — Not to an Inpatient Facility 8 – Death at home [Go to M0903] 9 – Discharge from agency [Go to M1040]
	New item on OASIS-C	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. __ __ /__ __ /__ __ __ __ month / day / year (Go to M0110, if date entered) NA –No specific SOC date ordered by physician
	/New item on OASIS-C	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

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0110	(M0110) Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes? • 1 - Early • 2 - Later • UK - Unknown • NA - Not Applicable: No Medicare case mix group to be defined by this assessment.	M0110	Episode Timing: Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes? • 1 - Early • 2 - Later • UK - Unknown • NA - Not Applicable: No Medicare case mix group to be defined by this assessment.
M0175	(M0175) From which of the following Inpatient Facilities was the patient discharged during the past 14 days? (Mark all that apply.) • 1 - Hospital • 2 - Rehabilitation facility • 3 - Skilled nursing facility • 4 - Other nursing home • 5 - Other (specify) • NA - Patient was not discharged from an inpatient facility [If NA, go to M0200]	M1000	From which of the following Inpatient Facilities was the patient discharged during the past 14 days? (Mark all that apply.) 1 - Long-term nursing facility (N F) 2 - Skilled nursing facility (S N F / T C U) 3 - Short-stay acute hospital (I P P S) 4 - Long-term care hospital (L T C H) 5 - Inpatient rehabilitation hospital or unit (I R F) 6 - Psychiatric hospital or unit 7 - Other (specify) NA - Patient was not discharged from an inpatient facility [Go to M1016]
M0180	(M0180) Inpatient Discharge Date (most recent): month/day/year • UK - Unknown	M1005	Inpatient Discharge Date (most recent): month/day/year • UK – Unknown
M0190	(M0190) List each Inpatient Diagnosis and ICD 9 CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no surgical, E codes, or V codes): Inpatient Facility Diagnosis ICD-9-CM a. (__ __ __ • __ __) b. (__ __ __ • __ __)	M1010	List each Inpatient Diagnosis and ICD-9-CM code at the level of highest specificity for only those conditions treated during an inpatient stay within the last 14 days (no E codes, or V codes): Inpatient Facility Diagnosis ICD-9-CM Code a. _____ __ __ __ . __ __ b. _____ __ __ __ . __ __ c. _____ __ __ __ . __ __ d. _____ __ __ __ . __ __ e. _____ __ __ __ . __ __ f. _____ __ __ __ . __ __
	New item on OASIS-C	M1012	List each Inpatient Procedure and the associated ICD-9-CM procedure code relevant to the plan of care. Inpatient Procedure Procedure Code a. _____ __ __ . __ __ b. _____ __ __ . __ __ c. _____ __ __ . __ __ d. _____ __ __ . __ __ NA - Not applicable UK - Unknown
M0200	(M0200) Medical or Treatment Regimen Change Within Past 14 Days: Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days? • 0 - No [If No, go to M0220; if No at Discharge, go to M0250] • 1 – Yes		ITEM DROPPED on OASIS-C (incorporated as NA in M1016)

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0210	(M0210) List the patient's Medical Diagnoses and ICD 9 CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical, E codes, or V codes):: Changed Medical Regimen Diagnosis ICD-9-CM a. (__ __ __ • __ __) b. (__ __ __ • __ __) c. (__ __ __ • __ __) d. (__ __ __ • __ __)	M1016	Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient's Medical Diagnoses and ICD-9-CM codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days. (no surgical, E codes, or V codes): Changed Medical Regimen Diagnosis ICD-9-CM Code a. _____ __ __ __ . __ __ b. _____ __ __ __ . __ __ c. _____ __ __ __ . __ __ d. _____ __ __ __ . __ __ e. _____ __ __ __ . __ __ f. _____ __ __ __ . __ __ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)
M0220	(M0220) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. (Mark all that apply.) • 1 - Urinary incontinence • 2 - Indwelling/suprapubic catheter • 3 - Intractable pain • 4 - Impaired decision-making • 5 - Disruptive or socially inappropriate behavior • 6 - Memory loss to the extent that supervision required • 7 - None of the above • NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days • UK - Unknown	M1018	Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days: If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. (Mark all that apply.) 1 - Urinary incontinence 2 - Indwelling/suprapubic catheter 3 - Intractable pain 4 - Impaired decision-making 5 - Disruptive or socially inappropriate behavior 6 - Memory loss to the extent that supervision required 7 - None of the above NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days UK - Unknown
M0230	M0230/240/246 Diagnoses, Severity Index, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2) . Rate each condition (Column 2) using the severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) V codes (for M0230 or M0240) or E codes (for M0240 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V code is reported in place of a case mix diagnosis, then optional item M0246 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group.	M1020, 1022, 1024	Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-CM code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V codes (for M1020 or M1022) or E codes (for M1022 only) may be used. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group. Do not assign symptom control ratings for V or E codes.

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M230, cont.	Code each row as follows: Column 1: Enter the description of the diagnosis. Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1; Rate the severity of the condition listed in Column 1 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 Column 3: (OPTIONAL) If a V code reported in any row in Column 2 is reported in place of a case mix diagnosis, list the appropriate case mix diagnosis (the description and the ICD-9-CM code) in the same row in Column 3. Otherwise, leave Column 3 blank in that row. Column 4: (OPTIONAL) If a V code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.	M1020, 1022, 1024 cont.	Code each row according to the following directions for each column: Column 1: Enter the description of the diagnosis. Column 2: Enter the ICD-9-CM code for the diagnosis described in Column 1; Rate the degree of symptom control for the condition listed in Column 1 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 &dose monitoring 4 - Symptoms poorly controlled; history of re-hospitalizations - Note that in Column 2 the rating for symptom control of each diagnosis should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided. Column 3: (OPTIONAL) If a V code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS C Guidance Manual. Column 4: (OPTIONAL) If a V code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-CM coding guidelines, enter the diagnosis descriptions and the -ICD-9-CM codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-CM code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-CM code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0240	COLUMN HEADINGS Column 2 - ICD-9-CM and severity rating for each condition - ICD-9-CM / Severity Rating Column 3 - Complete only if a V code in Column 2 is reported in place of a case mix diagnosis. - Description/ ICD-9-CM Column 4 - Complete only if the V code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).- Description/ICD-9-CM	M1020, 1022, 1024 cont.	COLUMN HEADINGS for (M1020) Primary Diagnosis, (M1022) Other Diagnoses, & (M1024) Payment Diagnoses (OPTIONAL) Column 1 - Diagnoses - (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.) - Description Column 2 - ICD-9-CM and symptom control rating for each condition (Note that the sequencing of these ratings may not match the sequencing of the diagnoses.) ICD-9-CM / Symptom Control Rating Column 3 - Complete if a V code is assigned under certain circumstances to Column 2 in place of a case mix diagnosis. - Description/ICD-9-CM Column 4 - Complete only if the V code in Column 2 is reported in place of a case mix diagnosis that is a multiple coding situation (e.g., a manifestation code).- Description/ICD-9-CM
M0246	-see M0230	M1020, 1022, 1024 cont.	See above
M0250	(M0250) Therapies the patient receives at home: (Mark all that apply.) 1 - Intravenous or infusion therapy (excludes TPN) 2 - Parenteral nutrition (TPN or lipids) 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal) 4 - None of the above	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
M0260	(M0260) Overall Prognosis: BEST description of patient's overall prognosis for recovery from this episode of illness. • 0 - Poor: little or no recovery is expected and/or further decline is imminent • 1 - Good/Fair: partial to full recovery is expected • UK – Unknown		ITEM DROPPED on OASIS-C
M0270	(M0270) Rehabilitative Prognosis: BEST description of patient's prognosis for functional status. • 0 - Guarded: minimal improvement in functional status is expected; decline is possible • 1 - Good: marked improvement in functional status is expected • UK - Unknown		ITEM DROPPED on OASIS-C
M0280	(M0280) Life Expectancy: (Physician documentation is not required.) • 0 - Life expectancy is greater than 6 months • 1 - Life expectancy is 6 months or fewer		ITEM DROPPED on OASIS-C

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
	New item on OASIS-C	M1032	Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.) 1 - Recent decline in mental, emotional, or behavioral status 2 - Multiple hospitalizations (2 or more) in the past 12 months 3 - History of falls (2 or more falls - or any fall with an injury - in the past year) 4 - Taking five or more medications 5 - Frailty indicators, e.g., weight loss, self-reported exhaustion 6 - Other 7 - None of the above
	New item on OASIS-C	M1034	Overall Status: Which description best fits the patient's overall status? (Check one) 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient's age). 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death. 3 - The patient has serious progressive conditions that could lead to death within a year. UK - The patient's situation is unknown or unclear.
M0290	(M0290) High Risk Factors characterizing this patient: (Mark all that apply.) • 1 - Heavy smoking • 2 - Obesity • 3 - Alcohol dependency • 4 - Drug dependency • 5 - None of the above • UK – Unknown	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
	New item on OASIS-C	M1040	Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year's influenza season (October 1 through March 31) during this episode of care? 0 - No 1 - Yes [Go to M1050] NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [Go to M1050]
	New item on OASIS-C	M1045	Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason: 1 - Received from another health care provider (e.g., physician) 2 - Received from your agency previously during this year's flu season 3 - Offered and declined 4 - Assessed and determined to have medical contraindication(s) 5 - Not indicated; patient does not meet age/ condition guidelines for influenza vaccine 6 - Inability to obtain vaccine due to declared shortage 7 - None of the above
	New item on OASIS-C	M1050	Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)? 0 - No 1 - Yes [Go to M1500 at TRN; Go to M1230\\ at DC]

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
	New item on OASIS-C	M1055	Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason: 1 - Patient has received PPV in the past 2 - Offered and declined 3 - Assessed and determined to have medical contraindication(s) 4 - Not indicated; patient does not meet age/condition guidelines for PPV 5 - None of the above
M0300	(M0300) Current Residence: • 1 - Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/significant other) • 2 - Family member's residence • 3 - Boarding home or rented room • 4 - Board and care or assisted living facility • 5 - Other (specify)		ITEM DROPPED on OASIS-C
M0340	(M0340) Patient Lives With: (Mark all that apply.) • 1 - Lives alone • 2 - With spouse or significant other • 3 - With other family member • 4 - With a friend • 5 - With paid help (other than home care agency staff) • 6 - With other than above		ITEM DROPPED on OASIS-C
M0350	(M0350) Assisting Person(s) Other than Home Care Agency Staff: (Mark all that apply.) • 1 - Relatives, friends, or neighbors living outside the home • 2 - Person residing in the home (EXCLUDING paid help) • 3 - Paid help • 4 - None of the above [If None of the above, go to M0390] • UK - Unknown [If Unknown, go to M0390]		ITEM DROPPED on OASIS-C
M0360	(M0360) Primary Caregiver taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff): • 0 - No one person [If No one person, go to M0390] • 1 - Spouse or significant other • 2 - Daughter or son • 3 - Other family member • 4 - Friend or neighbor or community or church member • 5 - Paid help • UK - Unknown [If Unknown, go to M0390]		ITEM DROPPED on OASIS-C
M0370	(M0370) How Often does the patient receive assistance from the primary caregiver? • 1 - Several times during day and night • 2 - Several times during day • 3 - Once daily • 4 - Three or more times per week • 5 - One to two times per week • 6 - Less often than weekly • UK - Unknown		ITEM DROPPED on OASIS-C

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0380	(M0380) Type of Primary Caregiver Assistance: (Mark all that apply.) • 1 - ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding) • 2 - IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances) • 3 - Environmental support (housing, home maintenance) • 4 - Psychosocial support (socialization, companionship, recreation) • 5 - Advocates or facilitates patient's participation in appropriate medical care • 6 - Financial agent, power of attorney, or conservator of finance • 7 - Health care agent, conservator of person, or medical power of attorney • UK - Unknown		ITEM DROPPED on OASIS-C
	New item on OASIS-C	M1100	Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? (Check one box only). MATRIX ROWS: Living Arrangement 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 (e.g., assisted living) • 11 • 12 • 13 • 14 • 15 BY COLUMNS: Availability of Assistance: - Around the clock 01-06-11 - Regular daytime 02-07-12 - Regular nighttime 03-08-13 - Occasional / short-term assistance 04-09-14 - No assistance available 05-10-15
M0390	(M0390) Vision with corrective lenses if the patient usually wears them: • 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint. • 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length. • 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.	M1200	Vision (with corrective lenses if the patient usually wears them): 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint. 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length. 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.
M0400	(M0400) Hearing and Ability to Understand Spoken Language in patient's own language (with hearing aids if the patient usually uses them): • 0 - No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation. • 1 - With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice. • 2 - Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance. • 3 - Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, additional time. • 4 - Unable to hear and understand familiar words or common expressions consistently, or patient nonresponsive.	M1210	Ability to hear (with hearing aid or hearing appliance if normally used): 0 - Adequate: hears normal conversation without difficulty. 1 - Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly. 2 - Severely Impaired: absence of useful hearing. UK - Unable to assess hearing.

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
	New item on OASIS-C	M1220	Understanding of Verbal Content in patient's own language (with hearing aid or device if used): 0 - Understands: clear comprehension without cues or repetitions. 1 - Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand. 2 - Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand. 3 - Rarely/Never Understands UK - Unable to assess understanding.
M0410	(M0410) Speech and Oral (Verbal) Expression of Language (in patient's own language): • 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. • 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance). • 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences. • 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases. • 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible). • 5 - Patient nonresponsive or unable to speak.	M1230	Speech and Oral (Verbal) Expression of Language (in patient's own language): 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment. 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance) 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences. 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases. 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible). 5 - Patient nonresponsive or unable to speak.
	New item on OASIS-C	M1240	Has this patient had a formal Pain Assessment using a standardized pain assessment tool (appropriate to the patient's ability to communicate the severity of pain)? • 0 - No standardized assessment conducted • 1 - Yes, and it does not indicate severe pain • 2 - Yes, and it indicates severe pain
M0420	(M0420) Frequency of Pain interfering with patient's activity or movement: • 0 - Patient has no pain or pain does not interfere with activity or movement • 1 - Less often than daily • 2 - Daily, but not constantly • 3 - All of the time	M1242	Frequency of Pain Interfering with patient's activity or movement: 0/ - Patient has no pain 1 - Patient has pain that does not interfere with activity or movement 2 - Less often than daily 3 - Daily, but not constantly 4 - All of the time
M0430	(M0430) Intractable Pain: Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity? • 0 - No • 1 – Yes		ITEM DROPPED on OASIS-C
	New item on OASIS-C	M1300	Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers? 0 - No assessment conducted [Go to M1306] 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool 2 - Yes, using a standardized tool, e.g., Braden, Norton, other

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
	New item on OASIS-C	M1302	Does this patient have a Risk of Developing Pressure Ulcers? 0 - No 1 – Yes
M0445	(M0445) Does this patient have a Pressure Ulcer? • 0 - No [If No, go to M0468] • 1 - Yes	M1306	Does this patient have at least one unhealed Pressure Ulcer at Stage II or higher or designated as "unstageable"? 0 - No [Go to M1322] 1 – Yes
	New item on OASIS-C	M1307	(M1307) The Oldest Non-epithelialized Stage II Pressure Ulcer that is present at discharge 1-Was present at the most recent SOC/ROC assessment 2-Developed since the most recent SOC/ROC assessment: record date pressure ulcer first identified: __ __ /__ __ /__ __ __ __ month / day / year NA - No non-epithelialized Stage II pressure ulcers are present at discharge
M0450 b-e (M0450 a: see below)	(M0450 b-e) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.) Pressure Ulcer Stages - Number of Pressure Ulcers b) Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. 0 1 2 3 4 or more c) Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. 0 1 2 3 4 or more d) Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.) 0 1 2 3 4 or more e) In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? • 0 - No • 1 - Yes	M1308	Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage: (MATRIX) (Enter "0" if none; excludes Stage I pressure ulcers) ROWS: Stage description - unhealed pressure ulcers a. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. b. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. c. Stage IV: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. d.1 Unstageable: Known or likely but unstageable due to non-removable dressing or device d.2 Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar. d.3 Unstageable: Suspected deep tissue injury in evolution. BY COLUMNS: COLUMN 1: Complete at SOC/ROC/FU & DC, Number Currently Present COLUMN 2: Complete at FU and DC – Number of those listed in column 1 that were present on admission (most recent SOC/ROC)
	New item on OASIS-C	M1310	Directions for M1310, M1312 and M1314: If the patient has one or more unhealed (non-epithelialized) Stage III or IV pressure ulcers, identify the pressure ulcer with the largest surface dimension (length x width) and record in centimeters. If no Stage III or Stage IV pressure ulcers, go to M1320. Pressure Ulcer Length: Longest length "head-to-toe" | ___ | ___ | . | ___ | (cm)
	New item on OASIS-C	M1312	Pressure Ulcer Width: Width of the same pressure ulcer; greatest width perpendicular to the length | ___ | ___ | . | ___ | (cm)
	New item on OASIS-C	M1314	Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area | ___ | ___ | . | ___ | (cm)

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0464	(M0464) Status of Most Problematic (Observable) Pressure Ulcer: • 1 - Fully granulating • 2 - Early/partial granulation • 3 - Not healing • NA - No observable pressure ulcer	M1320	Status of Most Problematic (Observable) Pressure Ulcer: 0 – Newly epithelialized 1 - Fully granulating 2 - Early/partial granulation 3 - Not healing NA - No observable pressure ulcer
M0450a (stage 1) (M0450 b-e: see above)	(M0450) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.) a) Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators. 0, 1, 2, 3, 4 or more	M1322	Current Number of Stage I Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. • 0 • 1 • 2 • 3 • 4 or more
M0460	[At follow-up, skip to M0470 if patient has no pressure ulcers] (M0460) Stage of Most Problematic (Observable) Pressure Ulcer: • 1 - Stage 1 • 2 - Stage 2 • 3 - Stage 3 • 4 - Stage 4 • NA - No observable pressure ulcer	M1324	Stage of Most Problematic (Observable) Pressure Ulcer: • 1 - Stage I • 2 - Stage II • 3 - Stage III • 4 - Stage IV • NA - No observable pressure ulcer or unhealed pressure ulcer
M0468	(M0468) Does this patient have a Stasis Ulcer? 0 - No [If No, go to M0482] 1 - Yes	M1330	Does this patient have a Stasis Ulcer? • 0 - No [Go to M1340] • 1 - Yes, patient has BOTH observable and unobservable stasis ulcers • 2 - Yes, patient has observable stasis ulcers ONLY • 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing) [Go to M1340]
M0470	(M0470) Current Number of Observable Stasis Ulcer(s): 0 - Zero 1 - One 2 - Two 3 - Three 4 - Four or more	M1332	Current Number of (Observable) Stasis Ulcer(s): • 1 - One • 2 - Two • 3 - Three • 4 - Four or more
M0474	(M0474) Does this patient have at least one Stasis Ulcer that Cannot be Observed due to the presence of a nonremovable dressing? • 0 - No • 1 - Yes		ITEM DROPPED on OASIS-C (incorporated as responses in M1330)
M0476	[At follow-up, skip to M0488 if patient has no stasis ulcers] (M0476) Status of Most Problematic (Observable) Stasis Ulcer: 1 - Fully granulating 2 - Early/partial granulation 3 - Not healing NA - No observable stasis ulcer	M1334	Status of Most Problematic (Observable) Stasis Ulcer: • 0 – Newly epithelialized • 1 - Fully granulating • 2 - Early/partial granulation • 3 - Not healing
M0482	(M0482) Does this patient have a Surgical Wound? 0 - No [If No, go to M0490] 1 - Yes	M1340	Does this patient have a Surgical Wound? • 0 - No [Go to M1350] • 1 - Yes, patient has at least one (observable) surgical wound • 2 - Surgical wound known but not observable due to non-removable dressing [Go to M1350]

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0484	(M0484) Current Number of (Observable) Surgical Wounds: (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.) • 0 - Zero • 1 - One • 2 - Two • 3 - Three • 4 - Four or more		ITEM DROPPED on OASIS-C
M0486	(M0486) Does this patient have at least one Surgical Wound that Cannot be Observed due to the presence of a nonremovable dressing? • 0 - No • 1 - Yes		ITEM DROPPED on OASIS-C
M0488	(M0488) [At follow-up, skip to M0490 if patient has no surgical wounds] Status of Most Problematic (Observable) Surgical Wound: 1 - Fully granulating 2 - Early/partial granulation 3 - Not healing NA - No observable surgical wound	M1342	Status of Most Problematic (Observable) Surgical Wound: 0 - Newly epithelialized 1 - Fully granulating 2 - Early/partial granulation 3 - Not healing
M0440	(M0440) Does this patient have a Skin Lesion or an Open Wound? This excludes "OSTOMIES." • 0 - No [If No, go to M0490] • 1 - Yes	M1350	Does this patient have a Skin Lesion or Open Wound, excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency? 0 - No 1 – Yes
M0490	(M0490) When is the patient dyspneic or noticeably Short of Breath? 0 - Never, patient is not short of breath 1 - When walking more than 20 feet, climbing stairs 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet) 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation 4 - At rest (during day or night)	M1400	When is the patient dyspneic or noticeably Short of Breath? 0 - Patient is not short of breath 1 - When walking more than 20 feet, climbing stairs 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet) 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation 4 - At rest (during day or night)
M0500	(M0500) Respiratory Treatments utilized at home: (Mark all that apply.) • 1 - Oxygen (intermittent or continuous) • 2 - Ventilator (continually or at night) • 3 - Continuous positive airway pressure • 4 - None of the above	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
	New item on OASIS-C	M1500	Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at any point since the previous OASIS assessment? 0 - No [Go to M2004 at TRN; Go to M1600 at DC] 1 - Yes 2 - Not assessed [Go to M2004 at TRN; Go to M1600 at DC] NA - Patient does not have diagnosis of heart failure [Go to M2004 at TRN; Go to M1600 at DC]

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
	New item on OASIS-C	M1510	Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? (Mark all that apply.) 0 - No action taken 1 - Patient's physician (or other primary care practitioner) contacted the same day 2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room) 3 - Implement physician-ordered patient-specific established parameters for treatment 4 - Patient education or other clinical interventions 5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)
M0510	(M0510) Has this patient been treated for a Urinary Tract Infection in the past 14 days? • 0 - No • 1 - Yes • NA - Patient on prophylactic treatment • UK - Unknown	M1600	Has this patient been treated for a Urinary Tract Infection in the past 14 days? 0 - No 1 - Yes NA - Patient on prophylactic treatment UK – Unknown [Omit UK option at DC]
M0520	(M0520) Urinary Incontinence or Urinary Catheter Presence: 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [If No, go to M0540] 1 - Patient is incontinent 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) [Go to M0540]	M1610	Urinary Incontinence or Urinary Catheter Presence: 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620] 1 - Patient is incontinent 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) [Go to M1620]
M0530	(M0530) When does Urinary Incontinence occur? 0 - Timed-voiding defers incontinence 1 - During the night only 2 - During the day and night	M1615	When does Urinary Incontinence occur? 0 - Timed-voiding defers incontinence 1 - Occasional stress incontinence 2 - During the night only 3 - During the day only 4 - During the day and night
M0540	(M0540) Bowel Incontinence Frequency: 0 - Very rarely or never has bowel incontinence 1 - Less than once weekly 2 - One to three times weekly 3 - Four to six times weekly 4 - On a daily basis 5 - More often than once daily NA - Patient has ostomy for bowel elimination UK - Unknown	M1620	Bowel Incontinence Frequency: 0 - Very rarely or never has bowel incontinence 1 - Less than once weekly 2 - One to three times weekly 3 - Four to six times weekly 4 - On a daily basis 5 - More often than once daily NA - Patient has ostomy for bowel elimination UK – Unknown [Omit UK option at FU, DC]
M0550	(M0550) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen? 0 - Patient does not have an ostomy for bowel elimination. 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen. 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.	M1630	Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen? 0 - Patient does not have an ostomy for bowel elimination. 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen. 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0560	(M0560) Cognitive Functioning: (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.) • 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. • 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions. • 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility. • 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time. • 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.	M1700	Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands. 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently. 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions. 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility. 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time. 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.
M0570	(M0570) When Confused (Reported or Observed): • 0 - Never • 1 - In new or complex situations only • 2 - On awakening or at night only • 3 - During the day and evening, but not constantly • 4 - Constantly • NA - Patient nonresponsive	M1710	When Confused (Reported or Observed Within the Last 14 Days): 0 - Never 1 - In new or complex situations only 2 - On awakening or at night only 3 - During the day and evening, but not constantly 4 - Constantly NA – Patient nonresponsive
M0580	(M0580) When Anxious (Reported or Observed): • 0 - None of the time • 1 - Less often than daily • 2 - Daily, but not constantly • 3 - All of the time • NA - Patient nonresponsive	M1720	When Anxious (Reported or Observed Within the Last 14 Days): 0 - None of the time 1 - Less often than daily 2 - Daily, but not constantly 3 - All of the time NA – Patient nonresponsive
	New item on OASIS-C	M1730	Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool? 0 - No 1 - Yes, patient was screened using the PHQ-2©* scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems") (Matrix) ROWS: a) Little interest or pleasure in doing things b) Feeling down, depressed, or hopeless? by COLUMNS: - Not at all (0 - 1 day) (0) - Several days (2 - 6 days) (1) - More than half of the days (7 – 11 days) (2) - Nearly every day (12 – 14 days) (3) - N/A - Unable to respond 2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression. 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression. **Copyright© Pfizer Inc. All rights reserved. Reproduced with permission.*

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0590	(M0590) Depressive Feelings Reported or Observed in Patient: (Mark all that apply.) • 1 - Depressed mood (e.g., feeling sad, tearful) • 2 - Sense of failure or self reproach • 3 - Hopelessness • 4 - Recurrent thoughts of death • 5 - Thoughts of suicide • 6 - None of the above feelings observed or reported		ITEM DROPPED on OASIS-C
M0610	(M0610) Behaviors Demonstrated at Least Once a Week (Reported or Observed): (Mark all that apply.) • 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required • 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions • 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. • 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects) • 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions) • 6 - Delusional, hallucinatory, or paranoid behavior • 7 - None of the above behaviors demonstrated	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 (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects) 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions) 6 - Delusional, hallucinatory, or paranoid behavior 7 - None of the above behaviors demonstrated
M0620	(M0620) Frequency of Behavior Problems (Reported or Observed) (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.): • 0 - Never • 1 - Less than once a month • 2 - Once a month • 3 - Several times each month • 4 - Several times a week • 5 - At least daily	M1745	Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety. 0 - Never 1 - Less than once a month 2 - Once a month 3 - Several times each month 4 - Several times a week 5 - At least daily
M0630	(M0630) Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse? • 0 - No • 1 - Yes	M1750	Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse? 0 – No 1 - Yes
M0640	(M0640) Grooming: Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care). Prior 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1 - Grooming utensils must be placed within reach before able to complete grooming activities. 2 - Someone must assist the patient to groom self. 3 - Patient depends entirely upon someone else for grooming needs UK - Unknown Current 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1 - Grooming utensils must be placed within reach before able to complete grooming activities. 2 - Someone must assist the patient to groom self. 3 - Patient depends entirely upon someone else for grooming needs	M1800	Grooming: Current ability to tend safely to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care). PRIOR STATUS NO LONGER COLLECTED 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.

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0650	(M0650) Ability to Dress Upper Body (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps: Prior 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2 - Someone must help the patient put on upper body clothing. 3 - Patient depends entirely upon another person to dress the upper body. UK - Unknown Current 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2 - Someone must help the patient put on upper body clothing. 3 - Patient depends entirely upon another person to dress the upper body.	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: PRIOR STATUS NO LONGER COLLECTED 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance. 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient. 2 - Someone must help the patient put on upper body clothing. 3 - Patient depends entirely upon another person to dress the upper body.
M0660	(M0660) Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes: Prior 0 - Able to obtain, put on, and remove clothing and shoes without assistance. 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3 - Patient depends entirely upon another person to dress lower body. UK - Unknown Current 0 - Able to obtain, put on, and remove clothing and shoes without assistance. 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient. 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes. 3 - Patient depends entirely upon another person to dress lower body.	M1820	Current Ability to Dress Lower Body safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes: PRIOR STATUS NO LONGER COLLECTED 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.

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0670	(M0670) Bathing: Ability to wash entire body. Excludes grooming (washing face and hands only). Prior 0 - Able to bathe self in shower or tub independently. 1 - With the use of devices, is able to bathe self in shower or tub independently. 2 - Able to bathe in shower or tub with the assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3 - Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4 - Unable to use the shower or tub and is bathed in bed or bedside chair. 5 - Unable to effectively participate in bathing and is totally bathed by another person. UK - Unknown Current 0 - Able to bathe self in shower or tub independently. 1 - With the use of devices, is able to bathe self in shower or tub independently. 2 - Able to bathe in shower or tub with the assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3 - Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4 - Unable to use the shower or tub and is bathed in bed or bedside chair. 5 - Unable to effectively participate in bathing and is totally bathed by another person.	M1830	Bathing: Current ability to wash entire body safely. Excludes grooming (washing face, washing hands and shampooing hair) PRIOR STATUS NO LONGER COLLECTED 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2 - Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4 - Unable to use the shower or tub, but able to bathe self independently, with or without the use of devices, at the sink, in chair, or on commode. 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath. 6 - Unable to participate effectively in bathing and is bathed totally by another person.

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0680	(M0680) Toileting: Ability to get to and from the toilet or bedside commode. Prior 0 - Able to get to and from the toilet independently with or without a device. 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet. 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance). 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. 4 - Is totally dependent in toileting. UK - Unknown Current 0 - Able to get to and from the toilet independently with or without a device. 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet. 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance). 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently. 4 - Is totally dependent in toileting.	M1840	Toilet Transferring: Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode. PRIOR STATUS NO LONGER COLLECTED 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.
	New item on OASIS-C	M1845	Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment. 0 - Able to manage toileting hygiene and clothing management without assistance. 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient. 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing. 3 - Patient depends entirely upon another person to maintain toileting hygiene.

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0690	(M0690) Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast. Prior • 0 - Able to independently transfer. • 1 - Transfers with minimal human assistance or with use of an assistive device. • 2 - Unable to transfer self but is able to bear weight and pivot during the transfer process. • 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person. • 4 - Bedfast, unable to transfer but is able to turn and position self in bed. • 5 - Bedfast, unable to transfer and is unable to turn and position self. • UK - Unknown Current • 0 - Able to independently transfer. • 1 - Transfers with minimal human assistance or with use of an assistive device. • 2 - Unable to transfer self but is able to bear weight and pivot during the transfer process. • 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person. • 4 - Bedfast, unable to transfer but is able to turn and position self in bed. • 5 - Bedfast, unable to transfer and is unable to turn and position self.	M1850	Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast. PRIOR STATUS NO LONGER COLLECTED 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.
M0700	(M0700) Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces. Prior 0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device). 1 - Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 2 - Able to walk only with the supervision or assistance of another person at all times. 3 - Chairfast, unable to ambulate but is able to wheel self independently. 4 - Chairfast, unable to ambulate and is unable to wheel self. 5 - Bedfast, unable to ambulate or be up in a chair. UK - Unknown Current 0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device). 1 - Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 2 - Able to walk only with the supervision or assistance of another person at all times. 3 - Chairfast, unable to ambulate but is able to wheel self independently. 4 - Chairfast, unable to ambulate and is unable to wheel self. 5 - Bedfast, unable to ambulate or be up in a chair.	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. PRIOR STATUS NO LONGER COLLECTED 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device). 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. 3 - Able to walk only with the supervision or assistance of another person at all times. 4 - Chairfast, unable to ambulate but is able to wheel self independently. 5 - Chairfast, unable to ambulate and is unable to wheel self. 6 - Bedfast, unable to ambulate or be up in a chair

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0710	(M0710) Feeding or Eating: Ability to feed self meals and snacks. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten. Prior 0 - Able to independently feed self. 1 - Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet. 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack. 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. 5 - Unable to take in nutrients orally or by tube feeding. UK - Unknown Current 0 - Able to independently feed self. 1 - Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet. 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack. 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy. 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. 5 - Unable to take in nutrients orally or by tube feeding.	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. PRIOR STATUS NO LONGER COLLECTED 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.
M0720	(M0720) Planning and Preparing Light Meals (e.g., cereal, sandwich) or reheat delivered meals: Prior 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission). 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. 2 - Unable to prepare any light meals or reheat any delivered meals. UK - Unknown Current 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission). 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. 2 - Unable to prepare any light meals or reheat any delivered meals.	M1880	Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely: PRIOR STATUS NO LONGER COLLECTED 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission). 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. 2 - Unable to prepare any light meals or reheat any delivered meals.

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
	New item on OASIS-C	M1900	Prior Functioning ADL/IADL: Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only one box in each row. MATRIX: ROWS - Functional Area a. Self-Care (e.g., grooming, dressing, and bathing) b. Ambulation c. Transfer d. Household tasks (e.g., light meal preparation, laundry, shopping) by COLUMNS - Independent - Needed Some Help - Dependent
M0730	(M0730) Transportation: Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway). Prior • 0 - Able to independently drive a regular or adapted car; OR uses a regular or handicap-accessible public bus. • 1 - Able to ride in a car only when driven by another person; OR able to use a bus or handicap van only when assisted or accompanied by another person. • 2 - Unable to ride in a car, taxi, bus, or van, and requires transportation by ambulance. • UK – Unknown Current • 0 - Able to independently drive a regular or adapted car; OR uses a regular or handicap-accessible public bus. • 1 - Able to ride in a car only when driven by another person; OR able to use a bus or handicap van only when assisted or accompanied by another person. • 2 - Unable to ride in a car, taxi, bus, or van, and requires transportation by ambulance.		ITEM DROPPED on OASIS-C

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0740	(M0740) Laundry: Ability to do own laundry to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand. Prior • 0 - (a) Able to independently take care of all laundry tasks; OR (b) Physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this home care admission). • 1 - Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry. • 2 - Unable to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation. • UK - Unknown Current • 0 - (a) Able to independently take care of all laundry tasks; OR (b) Physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this home care admission). • 1 - Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry. • 2 - Unable to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.		ITEM DROPPED on OASIS-C
M0750	(M0750) Housekeeping: Ability to safely and effectively perform light housekeeping and heavier cleaning tasks. Prior • 0 - (a) Able to independently perform all housekeeping tasks; OR (b) Physically, cognitively, and mentally able to perform all housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this home care admission). • 1 - Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently. • 2 - Able to perform housekeeping tasks with intermittent assistance or supervision from another person. • 3 - Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process. • 4 - Unable to effectively participate in any housekeeping tasks. • UK - Unknown Current • 0 - (a) Able to independently perform all housekeeping tasks; OR (b) Physically, cognitively, and mentally able to perform all housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this home care admission). • 1 - Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently. • 2 - Able to perform housekeeping tasks with intermittent assistance or supervision from another person. • 3 - Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process. • 4 - Unable to effectively participate in any housekeeping tasks.		ITEM DROPPED on OASIS-C

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0760	(M0760) Shopping: Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery. Prior • 0 - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; OR (b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission). • 1 - Able to go shopping, but needs some assistance: (a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; OR (b) Unable to go shopping alone, but can go with someone to assist. • 2 - Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery. • 3 - Needs someone to do all shopping & errands. • UK - Unknown Current • 0 - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; OR (b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission). • 1 - Able to go shopping, but needs some assistance: (a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; OR (b) Unable to go shopping alone, but can go with someone to assist. • 2 - Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery. • 3 - Needs someone to do all shopping & errands.		ITEM DROPPED on OASIS-C

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0770	(M0770) Ability to Use Telephone: Ability to answer the phone, dial numbers, and effectively use the telephone to communicate. Prior • 0 - Able to dial numbers and answer calls appropriately and as desired. • 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers. • 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. • 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation. • 4 - Unable to answer the telephone at all but can listen if assisted with equipment. • 5 - Totally unable to use the telephone. • NA - Patient does not have a telephone. • UK - Unknown Current • 0 - Able to dial numbers and answer calls appropriately and as desired. • 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers. • 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. • 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation. • 4 - Unable to answer the telephone at all but can listen if assisted with equipment. • 5 - Totally unable to use the telephone. • NA - Patient does not have a telephone.	M1890	Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate. PRIOR STATUS NO LONGER COLLECTED 0 - Able to dial numbers and answer calls appropriately and as desired. 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers. 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls. 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation. 4 - Unable to answer the telephone at all but can listen if assisted with equipment. 5 - Totally unable to use the telephone. NA - Patient does not have a telephone.
	New item on OASIS-C	M1910	Has this patient had a multi-factor Fall Risk Assessment (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)? 0 - No multi-factor falls risk assessment conducted. 1 - Yes, and it does not indicate a risk for falls. 2 - Yes, and it indicates a risk for falls.
	New item on OASIS-C	M2000	Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance? 0 - Not assessed/reviewed [Go to M2010] 1 - No problems found during review [Go to M2010] 2 - Problems found during review NA - Patient is not taking any medications [Go to M2040]
	New item on OASIS-C	M2002	Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation? 0 - No 1 – Yes

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
	New item on OASIS-C	M2004	Medication Intervention: If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation? 0 - No 1 - Yes NA - No clinically significant medication issues identified since the previous OASIS assessment
	New item on OASIS-C	M2010	Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur? 0 - No 1 - Yes NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications
	New item on OASIS-C	M2015	Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur? 0 - No 1 - Yes NA - Patient not taking any drugs

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0780	(M0780) Management of Oral Medications: Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.) Prior 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) given daily reminders; OR (c) someone develops a drug diary or chart. 2 - Unable to take medication unless administered by someone else. NA - No oral medications prescribed. UK - Unknown Current 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) given daily reminders; OR (c) someone develops a drug diary or chart. 2 - Unable to take medication unless administered by someone else. NA - No oral medications prescribed.	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.) PRIOR STATUS NO LONGER COLLECTED 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.
M0790	(M0790) Management of Inhalant/Mist Medications: Patient's ability to prepare and take all prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes all other forms of medication (oral tablets, injectable and IV medications). Prior Current • 0 - Able to independently take the correct medication and proper dosage at the correct times. • 1 - Able to take medication at the correct times if: (a) individual dosages are prepared in advance by another person, OR (b) given daily reminders. • 2 - Unable to take medication unless administered by someone else. • NA - No inhalant/mist medications prescribed. • UK - Unknown		ITEM DROPPED on OASIS-C

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0800	(M0800) Management of Injectable Medications: Patient's 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. Prior 0 - Able to independently take the correct medication and proper dosage at the correct times. 1 - Able to take injectable medication at correct times if: (a) individual syringes are prepared in advance by another person, OR (b) given daily reminders. 2 - Unable to take injectable medications unless administered by someone else. NA - No injectable medications prescribed. UK - Unknown Current 0 - Able to independently take the correct medication and proper dosage at the correct times. 1 - Able to take injectable medication at correct times if: (a) individual syringes are prepared in advance by another person, OR (b) given daily reminders. 2 - Unable to take injectable medications unless administered by someone else. NA - No injectable 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. PRIOR STATUS NO LONGER COLLECTED 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.
	New item on OASIS-C	M2040	Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only one box in each row. MATRIX: ROWS - Functional Area a. Oral medications b. Injectable medications by COLUMNS - Independent - Needed Some Help - Dependent - Not Applicable

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0810	(M0810) Patient Management of Equipment (includes ONLY oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies): Patient's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. (NOTE: This refers to ability, not compliance or willingness.) • 0 - Patient manages all tasks related to equipment completely independently. • 1 - If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment. • 2 - Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task. • 3 - Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment. • 4 - Patient is completely dependent on someone else to manage all equipment. • NA - No equipment of this type used in care [If NA, go to M0826]		ITEM DROPPED on OASIS-C (see M2100, row "e")
M0820	(M0820) Caregiver Management of Equipment (includes ONLY oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies): Caregiver's ability to set up, monitor, and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. (NOTE: This refers to ability, not compliance or willingness.) • 0 - Caregiver manages all tasks related to equipment completely independently. • 1 - If someone else sets up equipment, caregiver is able to manage all other aspects. • 2 - Caregiver requires considerable assistance from another person to manage equipment, but independently completes significant portions of task. • 3 - Caregiver is only able to complete small portions of task (e.g., administer nebulizer treatment, clean/store/dispose of equipment or supplies). • 4 - Caregiver is completely dependent on someone else to manage all equipment. • NA - No caregiver • UK – Unknown		ITEM DROPPED on OASIS-C (see M2100, row "e")

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
	New item on OASIS-C	M2100	Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only one box in each row.) MATRIX ROWS: Type of Assistance a. ADL assistance (e.g., transfer/ ambulation, bathing, dressing, toileting, eating/feeding) b. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances) c. Medication administration (e.g., oral, inhaled or injectable) d. Medical procedures/ treatments (e.g., changing wound dressing) e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies) f. Supervision and safety (e.g., due to cognitive impairment) g. Advocacy or facilitation of patient's participation in appropriate medical care (includes transportation to or from appointments) BY COLUMNS: - No assistance needed in this area - Caregiver(s) currently provides assistance - Caregiver(s) need training/ supportive services to provide assistance - Caregiver(s) not likely to provide assistance - Unclear if Caregiver(s) will provide assistance - Assistance needed, but no Caregiver(s) available
	New item on OASIS-C	M2110	How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)? 1 - At least daily 2 - Three or more times per week 3 - One to two times per week 4 - Received, but less often than weekly 5 - No assistance received UK - Unknown* [*at discharge, omit Unknown response.]
M0826	(M0826) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero [“000”] if no therapy visits indicated.) (__ __ __) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined). • NA - Not Applicable: No case mix group defined by this assessment.	M2200	Therapy 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.

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
	New item on OASIS-C	M2250	Plan of Care Synopsis: (Check only one box in each row.) Does the physician-ordered plan of care include the following: MATRIX: ROWS - Plan / Intervention a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings COLUMNS = no, yes, 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 COLUMNS = no, yes, NA - Patient is not diabetic or is bilateral amputee c. Falls prevention interventions COLUMNS = no, yes, NA - Patient is not assessed to be at risk for falls d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment COLUMNS = no, yes, NA - Patient has no diagnosis or symptoms of depression e. Intervention(s) to monitor and mitigate pain COLUMNS = no, yes, NA - No pain identified f. Intervention(s) to prevent pressure ulcers COLUMNS = no, yes, NA - Patient is not assessed to be at risk for pressure ulcers g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician COLUMNS = no, yes, NA - Patient has no pressure ulcers with need for moist wound healing
M0830	(M0830) Emergent Care: Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? (Mark all that apply.) • 0 - No emergent care services [If no emergent care, go to M0855] • 1 - Hospital emergency room (includes 23-hour holding) • 2 - Doctor's office emergency visit/house call • 3 - Outpatient department/clinic emergency (includes urgicenter sites) • UK - Unknown [If UK, go to M0855]	M2300	Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation) 0 - No [Go to M2400] 1 - Yes, used hospital emergency department WITHOUT hospital admission 2 - Yes, used hospital emergency department WITH hospital admission UK - Unknown [Go to M2400]

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0840	(M0840) Emergent Care Reason: For what reason(s) did the patient/family seek emergent care? (Mark all that apply.) • 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis • 2 - Nausea, dehydration, malnutrition, constipation, impaction • 3 - Injury caused by fall or accident at home • 4 - Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction) • 5 - Wound infection, deteriorating wound status, new lesion/ulcer • 6 - Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain) • 7 - Hypo/Hyperglycemia, diabetes out of control • 8 - GI bleeding, obstruction • 9 - Other than above reasons • UK - Reason unknown	M2310	Reason for Emergent Care: For what reason(s) did the patient receive emergent care (with or without hospitalization)? (Mark all that apply.) 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis 2 - Injury caused by fall 3 - Respiratory infection (e.g. pneumonia, bronchitis) 4 - Other respiratory problem 5 - Heart failure (e.g., fluid overload) 6 - Cardiac dysrhythmia (irregular heartbeat) 7 - Myocardial infarction or chest pain 8 - Other heart disease 9 - Stroke (CVA) or TIA 10 - Hypo/Hyperglycemia, diabetes out of control 11 - GI bleeding, obstruction, constipation, impaction 12 - Dehydration, malnutrition 13 - Urinary tract infection 14 - IV catheter-related infection or complication 15 - Wound infection or deterioration 16 - Uncontrolled pain 17 - Acute mental/behavioral health problem 18 - Deep vein thrombosis, pulmonary embolus 19 - Other than above reasons UK - Reason unknown
	New item on OASIS-C	M2400	Intervention Synopsis: (Check only one box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented? MATRIX ROWS - Plan / Intervention a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care COLUMNS: yes, no, NA - Patient is not diabetic or is bilateral amputee b. Falls prevention interventions COLUMNS: yes, no, NA - Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment COLUMNS: yes, no, NA - Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment d. Intervention(s) to monitor and mitigate pain COLUMNS: yes, no, NA - Formal assessment did not indicate pain since the last OASIS assessment e. Intervention(s) to prevent pressure ulcers COLUMNS: yes, no, NA - Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment f. Pressure ulcer treatment based on principles of moist wound healing COLUMNS: yes, no, NA - Dressings that support the principles of moist wound healing not indicated for this patient's pressure ulcers OR patient has no pressure ulcers with need for moist wound healing

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0855	(M0855) To which Inpatient Facility has the patient been admitted? 1 - Hospital [Go to M0890] 2 - Rehabilitation facility [Go to M0903] 3 - Nursing home [Go to M0900] 4 - Hospice [Go to M0903] NA - No inpatient facility admission	M2410	To which Inpatient Facility has the patient been admitted? 1 - Hospital [Go to M2430] 2 - Rehabilitation facility [Go to M0903] 3 - Nursing home [Go to M2440] 4 - Hospice [Go to M0903] NA - No inpatient facility admission (OMIT NA AT TRN)
M0870	(M0870) Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.) 1 - Patient remained in the community (not in hospital, nursing home, or rehab facility) 2 - Patient transferred to a noninstitutional hospice [Go to M0903] 3 - Unknown because patient moved to a geographic location not served by this agency [Go to M0903] UK - Other unknown [Go to M0903]	M2420	Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.) 1 - Patient remained in the community (without formal assistive services) 2 - Patient remained in the community (with formal assistive services) 3 - Patient transferred to a noninstitutional hospice 4 - Unknown because patient moved to a geographic location not served by this agency UK - Other unknown [Go to M0903]
M0880	(M0880) After discharge, does the patient receive health, personal, or support Services or Assistance? (Mark all that apply.) • 1 - No assistance or services received • 2 - Yes, assistance or services provided by family or friends • 3 - Yes, assistance or services provided by other community resources (e.g., meals-on-wheels, home health services, homemaker assistance, transportation assistance, assisted living, board and care)		ITEM DROPPED on OASIS-C (see M2420)
M0890	(M0890) If the patient was admitted to an acute care Hospital, for what Reason was he/she admitted? • 1 - Hospitalization for emergent (unscheduled) care • 2 - Hospitalization for urgent (scheduled within 24 hours of admission) care • 3 - Hospitalization for elective (scheduled more than 24 hours before admission) care • UK – Unknown		ITEM DROPPED on OASIS-C

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

OASIS-B1 (1/2008)		*OASIS-C (8/2009)*	
Item #	***Item Text***	***Item #***	***Item Text***
M0895	(M0895) Reason for Hospitalization: (Mark all that apply.) • 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis • 2 - Injury caused by fall or accident at home • 3 - Respiratory problems (SOB, infection, obstruction) • 4 - Wound or tube site infection, deteriorating wound status, new lesion/ulcer • 5 - Hypo/Hyperglycemia, diabetes out of control • 6 - GI bleeding, obstruction • 7 - Exacerbation of CHF, fluid overload, heart failure • 8 - Myocardial infarction, stroke • 9 - Chemotherapy • 10 - Scheduled surgical procedure • 11 - Urinary tract infection • 12 - IV catheter-related infection • 13 - Deep vein thrombosis, pulmonary embolus • 14 - Uncontrolled pain • 15 - Psychotic episode • 16 - Other than above reasons	M2430	Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.) 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis 2 - Injury caused by fall 3 - Respiratory infection (e.g. pneumonia, bronchitis) 4 - Other respiratory problem 5 - Heart failure (e.g., fluid overload) 6 - Cardiac dysrhythmia (irregular heartbeat) 7 - Myocardial infarction or chest pain 8 - Other heart disease 9 - Stroke (CVA) or TIA 10 - Hypo/Hyperglycemia, diabetes out of control 11 - GI bleeding, obstruction, constipation, impaction 12 - Dehydration, malnutrition 13 - Urinary tract infection 14 - IV catheter-related infection or complication 15 - Wound infection or deterioration 16 - Uncontrolled pain 17 - Acute mental/behavioral health problem 18 - Deep vein thrombosis, pulmonary embolus 19 - Scheduled treatment or procedure 20 - Other than above reasons UK - Reason unknown [Go to M0903]
M0900	(M0900) For what Reason(s) was the patient Admitted to a Nursing Home? (Mark all that apply.) • 1 - Therapy services • 2 - Respite care • 3 - Hospice care • 4 - Permanent placement • 5 - Unsafe for care at home • 6 - Other • UK - Unknown	M2440	For what Reason(s) was the patient Admitted to a Nursing Home? (Mark all that apply.) 1 - Therapy services 2 - Respite care 3 - Hospice care 4 - Permanent placement 5 - Unsafe for care at home 6 - Other UK - Unknown [Go to M0903]
M0903	(M0903) Date of Last (Most Recent) Home Visit: __ __ /__ __ / __ __ __ __ month day year	M0903	Date of Last (Most Recent) Home Visit: __ __ /__ __ / __ __ __ __ month / day / year
M0906	(M0906) Discharge/Transfer/Death Date: Enter the date of the discharge, transfer, or death (at home) of the patient. __ __ /__ __ / __ __ __ __ 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

Table G.2: OASIS-B1 and OASIS-C – Items Unchanged, Items Modified, Items Dropped, and New Items Added.

OASIS-B1 Items UNCHANGED on OASIS-C

OASIS-C Item #	OASIS-B1 Item # & Description
M0014	(M0014) Branch State
M0016	(M0016) Branch I D Number
M0020	(M0020) Patient I D Number
M0030	(M0030) Start of Care Date
M0032	(M0032) Resumption of Care Date
M0040	(M0040) Patient Name
M0050	(M0050) Patient State of Residence
M0060	(M0060) Patient Zip Code
M0063	(M0063) Medicare Number
M0064	(M0064) Social Security Number
M0065	(M0065) Medicaid Number
M0066	(M0066) Birth Date
M0069	(M0069) Gender
M0080	(M0080) Discipline of Person Completing Assessment
M0090	(M0090) Date Assessment Completed
M0100	(M0100) Reason for Assessment
M0110	(M0110) Episode Timing
M0220	(M1018) Conditions Prior to Regimen Change or Inpatient Stay Within Past 14 Days
M1005	(M0180) Inpatient Discharge Date (most recent)
M1030	(M0250) Therapies the patient receives at home
M1200	(M0390) Vision
M1230	(M0410) Speech and Oral (Verbal) Expression of Language
M1324	(M0460) Stage of Most Problematic (Observable) Pressure Ulcer
M1610	(M0520) Urinary Incontinence or Urinary Catheter Presence
M1630	(M0550) Ostomy for Bowel Elimination
M1700	(M0560) Cognitive Functioning
M1750	(M0630) Patient Receiving Psychiatric Nursing Services
M2200	(M0826) Therapy Need
M2440	(M0900) Reason(s) for Admission to a Nursing Home
M0903	(M0903) Date of Last (Most Recent) Home Visit
M0906	(M0906) Discharge/Transfer/Death Date

Note, item numbers are changed for most items. In addition, administration timepoints and skip logic ("go to" instructions) may have changed for items listed here as having no changes in *content.

Table G.2: OASIS-B1 and OASIS-C – Items Unchanged, Items Modified, Items Dropped, and New Items Added. (cont'd)

OASIS-B1 Items MODIFIED on OASIS-C

OASIS-C Item #	OASIS-B1 Item # & Description
M0010	(M0010) Agency Medicare Provider Number
M0018	(M0072) Primary Referring Physician id
M0140	(M0140) Race/Ethnicity (as identified by patient)
M0150	(M0150) Current Payment Sources for Home Care
M1000	(M0175) Inpatient Facility Discharges during the past 14 days?
M1010	(M0190) Inpatient Diagnosis within the last 14 days
M1016	(M0210) Medical Diagnoses requiring changed medical or treatment regimen
M1020/1022/1024	M0230/240/246 Diagnoses, Severity Index, and Payment Diagnoses
M1036	(M0290) High Risk Factors
M1210	(M0400) Hearing and Ability to Understand Spoken Language
M1242	(M0420) Frequency of Pain interfering with patient's activity or movement
M1350	(M0440) Does this patient have a Skin Lesion or an Open Wound?
M1306	(M0445) Does this patient have a Pressure Ulcer?
M1308	(M0450 b-e) Current Number of Pressure Ulcers at Each Stage (2-4)
M1322	(M0450 a) Current Number of Pressure Ulcers at Stage 1
M1320	(M0464) Status of Most Problematic (Observable) Pressure Ulcer
M1330	(M0468) Does this patient have a Stasis Ulcer?
M1332	(M0470) Current Number of Observable Stasis Ulcer(s)
M1334	(M0476) Status of Most Problematic (Observable) Stasis Ulcer
M1340	(M0482) Does this patient have a Surgical Wound?
M1342	(M0488) Status of Most Problematic (Observable) Surgical Wound
M1400	(M0490) When is the patient dyspneic or noticeably Short of Breath?
M1410	(M0500) Respiratory Treatments utilized at home
M1600	(M0510) Patient treated for a Urinary Tract Infection in the past 14 days?
M1615	(M0530) When does Urinary Incontinence occur?
M1620	(M0540) Bowel Incontinence Frequency
M1710	(M0570) When Confused (Reported or Observed)
M1720	(M0580) When Anxious (Reported or Observed)
M1740	(M0610) Behaviors Demonstrated at Least Once a Week (Reported or Observed)
M1745	(M0620) Frequency of Behavior Problems (Reported or Observed)
M1800	(M0640) Grooming
M1810	(M0650) Ability to Dress Upper Body
M1820	(M0660) Ability to Dress Lower Body
M1830	(M0670) Bathing
M1840	(M0680) Toileting
M1850	(M0690) Transferring

Table G.2: OASIS-B1 and OASIS-C – Items Unchanged, Items Modified, Items Dropped, and New Items Added. (cont'd)

OASIS-B1 Items MODIFIED on OASIS-C

OASIS-C Item #	OASIS-B1 Item # & Description
M1860	(M0700) Ambulation/Locomotion
M1870	(M0710) Feeding or Eating
M1880	(M0720) Planning and Preparing Light Meals
M1890	(M0770) Ability to Use Telephone
M2020	(M0780) Management of Oral Medications
M2030	(M0800) Management of Injectable Medications
M2300	(M0830) Emergent Care
M2310	(M0840) Emergent Care Reason
M2410	(M0855) Inpatient Facility Patient Been Admitted
M2420	(M0870) Discharge Disposition
M2430	(M0895) Reason for Hospitalization

Table G.2: OASIS-B1 and OASIS-C – Items Unchanged, Items Modified, Items Dropped, and New Items Added. (cont'd)

OASIS-B1 items DROPPED on OASIS-C

OASIS-B1 Item # & Description
(M0012) Agency Medicaid Provider Number
(M0200) Medical or Treatment Regimen Change Within Past 14 Days
(M0260) Overall Prognosis
(M0270) Rehabilitative Prognosis
(M0280) Life Expectancy
(M0300) Current Residence
(M0340) Patient Lives With:
(M0350) Assisting Person(s) Other than Home Care Agency Staff
(M0360) Primary Caregiver
(M0370) Frequency of assistance from the primary caregiver?
(M0380) Type of Primary Caregiver Assistance
(M0430) Intractable Pain
(M0474) Stasis Ulcer that Cannot be Observed
(M0484) Current Number of (Observable) Surgical Wounds
(M0486) Surgical Wound that Cannot be Observed
(M0590) Depressive Feelings Reported or Observed in Patient
(M0730) Transportation
(M0740) Laundry
(M0750) Housekeeping
(M0760) Shopping
(M0790) Management of Inhalant/Mist Medications
(M0810) Patient Management of Equipment
(M0820) Caregiver Management of Equipment
(M0880) Health, personal, or support Services or Assistance after discharge?
(M0890) Acute care Hospital Admission Reason

Table G.2: OASIS-B1 and OASIS-C – Items Unchanged, Items Modified, Items Dropped, and New Items Added. (cont'd)

New items ADDED to OASIS-C

OASIS-C Item # & Description
M0102) Date of Physician-ordered Start of Care (Resumption of Care)
M0104) Date of Referral
(M1012) Inpatient Procedures
(M1032) Risk for Hospitalization
(M1034) Overall Status
(M1040) Influenza Vaccine
(M1045) Reason Influenza Vaccine Not Received
(M1050) Pneumococcal Vaccine (PPV) Received?
(M1055) Reason PPV Not Received
(M1100) Patient Living Situation
(M1220) Understanding of Verbal Content
(M1240) Patient had a formal Pain Assessment?
(M1300) Patient had a Pressure Ulcer Risk Assessment
(M1302) Risk of Developing Pressure Ulcers
(M1307) Oldest Non-epithelialized Stage II Pressure Ulcer
(M1310) Length Largest Pressure Ulcer
(M1312) Width Largest Pressure Ulcer
(M1314) Depth Largest Pressure Ulcer
(M1500) Symptoms in Heart Failure Patients
(M1510) Heart Failure Symptom Follow-up
(M1730) Depression Screening/PHQ2
(M1845) Toileting Hygiene
(M1900) Prior Functioning ADL/IADL
(M1910) Patient Had Fall Risk Assessment?
(M2000) Patient Had Drug Regimen Review?
(M2002) Medication Follow-up
(M2004) Medication Intervention
(M2010) Patient/Caregiver Had High Risk Drug Education?
(M2015) Patient/Caregiver Drug Education Intervention
(M2040) Prior Medication Management
(M2100) Types and Sources of Assistance
(M2110) Frequency of ADL or IADL Assistance?
(M2250) Plan of Care Synopsis
(M2400) Intervention Synopsis