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The OASIS Integrity Project was originally sponsored by the 3M Corporation and co-sponsored by the National Association for Home Care and Fazzi Associates. In addition to serving as a co-sponsor, Fazzi Associates was responsible for conducting the original research, developing the report and for presenting findings in presentations at national, state and agency levels.

Over the last eight years, Fazzi Associates has continued to be deeply involved in supporting agencies efforts to improve the accuracy and integrity of their OASIS reviews. Through Fazzi’s National Home Care Quality Institute, we have provided training to national and state associations and to agencies in every region of the country. We have conducted more than 5,000 patient audits. We have provided quality improvement and Home Health Compare improvement efforts that have impacted the lives of tens of thousands of patients.

As part of our effort to ensure that agency clinicians receive the very best information possible, senior clinicians from Fazzi’s Home Care Quality Institute continually monitor new developments in the field and new CMS information and updates. We then take this information and provide updates to the OASIS Integrity Project Manual.

The 2008 OASIS Integrity Project Manual includes new updates from CMS along with new insights on best practice assessment strategies that have been generated from our extensive categorization of audits. There is no charge for this manual. It is our hope that through this manual, we can contribute to helping agency clinicians improve the accuracy, reliability and integrity of their OASIS audits.

With Best Wishes,

Dr. Robert Fazzi, President
Fazzi Associates, Inc.
A Note to Agency Directors

Fazzi Associates National Home Care Quality Institute specializes in OASIS audits, OASIS trainings and quality improvement efforts. No national consulting firm does more of this type of work nor publishes more on these subjects than Fazzi Associates.

We have had extensive experience helping agencies improve their OASIS assessments, their case mix weights, and the accuracy of their reimbursements. There are three reasons why agencies seek support from Fazzi Associates:

1. **Low Case Mix Weight:** If your case mix weight is below CMS’s announced national average case mix weight of 1.23, Fazzi’s OASIS Audit and Training services can impact your accuracy and scores immediately. *Most agencies experience a significant change within 30 days.*

2. **Low Home Health Compare Scores:** If your scores are below your state’s average scores, you may have problems with P4P. Fazzi will help you deal with your most problematic scores while providing your staff with skills to deal with future quality challenges.

3. **Low Profitability:** If your profitability is below national averages, 15.4% (MedPAC for freestanding in 2006) or 6.5% (NAHC includes hospital-based), Fazzi’s operational and best practice improvement services will help you address operational problems while improving your agency’s overall profitability.

If you want to address any of these areas and are seeking the support of a consulting firm that is passionate, effective, and experienced (twenty-five years) in helping agencies improve, call our Project/Marketing Coordinator, Lindsay Doak at 800-379-0361. Lindsay can provide you with whatever information you might need.
Medicare Certified Home Health Agencies are required to collect OASIS data for:

- All patients receiving skilled care and Medicare or Medicaid is the payer for any or all services provided
- M0150 Current Payment Source includes 1, 2, 3, or 4
- OASIS data collection is excluded for:
  - Patients under the age of 18
  - Services related to pre or post partum care
  - Services provided are exclusively non-skilled and the personal care, chore or companion type

Effective December 8, 2003 OASIS data collection is temporarily suspended for:

- Non-Medicare/non-Medicaid patients

Note: The Medicare Conditions of Participation (42 CFR sections 484.20 and 484.55) require that agencies provide each patient, regardless of payment source, with 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 the achievement of desired outcomes. The comprehensive assessment must also identify the patient’s continuing need for home care, medical, nursing, rehabilitative, social, and discharge planning needs. This comprehensive assessment does not need to include OASIS data items.

****************************************

From time to time CMS releases updated information on OASIS. This May 2008 revision of the original National OASIS Integrity Project Manual incorporates the additional guidance published by CMS in the form of OASIS Q and A through May 2008 retrieved from www.qtso.com, the OCCB website and Chapter 8 of the OASIS Implementation Manual revised January 2008 retrieved from www.cms.hhs.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp.

The OASIS Implementation Manual is the primary source document for OASIS guidance and instruction for home health providers.

In the future, if this National OASIS Integrity Project Manual document does not coincide with the most current information published by CMS please use the CMS guidelines for clarification regarding OASIS data collection and interpretation of data elements as the primary authority.
M0030 Start of Care Date:

(M0030) ____/____/____
Month  Day  Year

Item Clarification: The date that care begins. The date the first skilled service is delivered.

Recommendations from Expert Design Forum

Optimal Technique: Verify with agency administrative staff.

Tips: The Start of Care date is the date of the first *reimbursable* visit to Medicare. With a billable visit, a service is delivered per physician order after the patient has been accepted for care and it is determined that Medicare coverage criteria are met. (42 CFR 409.46) It is usually but may not always be the date the assessment is completed.

When it is the agency practice and/or policy for nursing services to conduct the comprehensive assessment for a physician ordered rehab only case (this assumes the physician has not approved an order for skilled nursing services and the nursing visit is therefore not billable), the nurse must conduct the comprehensive assessment within the first 5 days of the episode. It must occur either the same date as the therapists SOC or afterward to be eligible and accepted for the episode. (42 CFR 484.55(a)(2)). The nurse can, however, conduct the “initial assessment visit” (42 CFR 484.55(a)) to determine the immediate care and support needs of the patient and determine eligibility for the Medicare home health benefit, including homebound status prior to the first billable therapy visit. This visit would not be considered billable and does not establish the SOC date. Any additional clinical information gathered at the time of this “initial assessment visit” is not eligible to be included in the comprehensive assessment. The data for the comprehensive assessment must be collected on the same day as the first billable visit (SOC) or within five days following the SOC.
M0032  Resumption of Care Date (most recent):

___/___/____
Month  Day   Year

☐ NA - Not Applicable

Item Clarification: The date of the first visit following an inpatient stay by a patient currently service from the home health agency.

Recommendations from Expert Design Forum

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

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

If there is more than one admission to an inpatient facility while the agency is providing services, this date reflects the most recent resumption of care by the agency which may have occurred in the current or a previous episode. Update Patient Tracking Sheet.
# M0040 Patient’s Name

<table>
<thead>
<tr>
<th>(First)</th>
<th>(MI)</th>
<th>(Last)</th>
<th>(Suffix)</th>
</tr>
</thead>
</table>

## Item Clarification:
The full name of the patient: first name, middle initial, last name, and suffix (e.g., Jr., III, etc.).

## Recommendations from Expert Design Forum

**Optimal Question:** Obtain information from interview.

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

**Tips:** Use the same name found on the Medicare card, Private Insurance card or HMO identification card.
M0050  Patient State of Residence

Item Clarification: The state in which the patient is currently residing while receiving home care.

Recommendations from Expert Design Forum

Tips: Identify the state in which the patient is located at the time of the assessment, even if not his/her usual residence.
## M0060 Patient Zip Code

| **Item Clarification:** | The zip code for the address at which the patient is currently residing while receiving home care. |

## Recommendations from Expert Design Forum

**Tips:** Identify the zip code of the patient's location at the time of the assessment. Update on the patient tracking sheet if a change occurs. The zip code identifies the places the agency provides services for Home Health Compare data reporting.
### M0063 Medicare Number

- **(including suffix if any)**

| □ NA – No Medicare |

### Item Clarification:
For Medicare patients only. The patients Medicare number, including any prefixes or suffixes. Use RRB number for railroad retirement program.

### Recommendations from Expert Design Forum

#### Optimal Question:
Obtain information from interview.

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

### Tips:
Record Medicare number regardless of whether Medicare is payer for the episode. M0150 will not include response 1 when Medicare is not the payer.

- Record “claim number” exactly as found on Medicare card or other official Medicare information.
- If the patient belongs to a Medicare HMO, another Medicare Advantage Plan, or Medicare Part C and the Medicare number is not available, the response is “NA.”
- Do not record the HMO Identification number here.
- Do not use social security number here.
<table>
<thead>
<tr>
<th>M0064 Social Security Number <em><strong>-</strong></em>-______</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK – Unknown or Not Available</td>
</tr>
</tbody>
</table>

**Item Clarification:** Refers to the patient's Social Security number only.

**Recommendations from Expert Design Forum**

**Optimal Question:** Obtain information from interview.

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

**Tips:** Mark "unknown" if patient refuses to divulge information.
<table>
<thead>
<tr>
<th>M0065  Medicaid Number</th>
<th>_________</th>
<th>□ NA - No Medicaid</th>
</tr>
</thead>
</table>

**Item Clarification:** The patient’s Medicaid number only.

**Recommendations from Expert Design Forums**

**Optimal Question:** Obtain information from interview.

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

**Tips:** Record Medicaid number assigned by the state regardless of whether Medicaid is a payer for the episode. Record number exactly as found on current (still in effect) Medicaid card.
### M0066 Date of Birth

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>__ __</td>
<td>__ /</td>
<td>__ / __ __ __ __</td>
</tr>
</tbody>
</table>

**Item Clarification:** Birth date of the patient, including day, month, and four digits for the year.

### Recommendations from Expert Design Forum

**Optimal Question:** Obtain information from interview.

**Optimal Technique:** Verify with patient or caregiver.

**Tips:** If patient or caregiver is unable to verify, ask to see a legal document such as a driver’s license or birth certificate or passport.
### M0072 Primary Referring Physician ID:

| — — — — — — — — — — |

- **UK** - Unknown or not available

### Item Clarification:
The six digit UPIN number.

### Recommendations from Expert Design Forum

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

#### Tips:
Record the 10 digit National Provider Identifier (NPI). [http://www.cms.hhs.gov/NationalProvIdentStand](http://www.cms.hhs.gov/NationalProvIdentStand) for physician who will be **signing** the home health plan of care. This may be different from the **referring** physician.

Record the physician’s UPIN if the NPI is not available.
M0080  Discipline of Person Completing Assessment

☐ 1 - RN  ☐ 2 - PT  ☐ 3 – SLP/ST  ☐ 4 - OT

Item Clarification:  LPNs, PTAs, COTAs, MSWs and HHAs do not meet the requirements specified in the comprehensive assessment regulation for disciplines authorized to complete the comprehensive assessment.

Recommendations from Expert Design Forum

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

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

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

At other time points, when there are multiple services involved in care, an RN is not required to conduct the comprehensive assessment and an RN, PT, SLP or OT may conduct and record the assessment.

When more than one service is scheduled to conduct a discharge visit on the same day, the last qualified clinician to see the patient is responsible to perform the discharge comprehensive assessment and document the findings.

In an unplanned discharge situation and the patient is unavailable to be seen face to face (i.e., the patient relocates unexpectedly outside the agency’s geographical boundaries, the physician calls and orders a discharge after an office visit, etc.) the last clinician qualified to conduct the comprehensive assessment completes the discharge assessment based on the patient’s health status at their last visit to the patient. If subsequent visits were made by PTA, COTA, LPN, MSW and HHA, that information, patient health status and progress are not considered in the discharge assessment.
## M0090 Date Assessment Completed

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

### Item Clarification:
The actual date the assessment is completed. If agency allows assessments to be performed over more than one visit date, the last date (when the assessment is finished) is appropriate date to record.

### Recommendations from Expert Design Forum

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

#### Tips:
The SOC, ROC, follow-up and discharge assessments must be completed through a face to face encounter with the patient. If the discharge unexpectedly occurs without opportunity or orders for a final visit refer to the clinical record and documentation of the last visit made by a clinician qualified to complete the comprehensive assessment (RN, PT, SLP, and OT). Complete the discharge assessment reporting the patient’s health status at the time of that visit.

The Medicare Conditions of Participation require the SOC assessment be completed on or within 5 calendar days after the SOC date. Refer to the OASIS Reference Sheet at [www.qtso.com/download/hha/OASIS_Ref_Sheet.07.19.06.pdf](http://www.qtso.com/download/hha/OASIS_Ref_Sheet.07.19.06.pdf) for the number of days allowed for completion of assessment at each time point.

Usually the date the assessment is completed is associated with a visit. However, if the clinician needs to follow-up off site with the patient’s family or physician in order to complete any clinical data items, or confer with agency therapists after they have completed their evaluations to answer M0826, M0090 will reflect the date the missing information is obtained which now completes the assessment.

If the original assessing clinician gathers additional information during the SOC 5 day assessment time frame that would change a M0 item response, the M0090 date would be changed to reflect the date the information was gathered and the change was made.

Agency internal supervisory review of the document for completeness and accuracy, assignment of ICD-9-CM code to the diagnostic statements or an agency policy that allows documentation to be completed on a subsequent day would not affect the date the assessment is completed as the actual assessment and data collection is performed and completed prior to the review and documentation process.

If agency policy allows for more than one visit to complete the assessment, M0090 will reflect the date the same clinician finishes gathering the clinical assessment data.

For a transfer to an inpatient facility or death at home assessments (M0100 RFA 6, 7, and 8) record the date the agency learns of the event. These assessments (M0100 RFA 6, 7, and 8) do not require an actual visit to complete.
**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]

---

**Item Clarification:** Identifies the reason why the assessment data are being collected and reported. Accurate recording of this response is important as the data reporting software will accept or reject certain data according to the specific response that has been selected for this item.

**Recommendations from Expert Design Forum**

**Tips:** Mark only one response.

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

   **Exception:** Select this response anytime an initial HIPPS code is required by any payer whether or not further services are received. If only one visit has been made and the agency will bill Medicare for the visit, the discharge OASIS assessment is not required by regulation.

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

   Note: Update patient tracking sheet.

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

Response 5: This comprehensive assessment is conducted due to a significant change (major decline or improvement) in patient condition not anticipated in the home health plan of care at a time other than during the last five days of the episode. The circumstances defining a major decline or improvement are contained in agency policy. This assessment is done to update the patient's plan of care.*

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

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

Response 8: Report data regarding patient’s death when death occurs at home, during transportation to an inpatient facility or when in any department of the facility prior to treatment and actual inpatient admission.**

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

   **Exception:** A visit is not required when a patient is unexpectedly discharged, such as: the patient refuses, the physician orders a discharge without another visit, patient unexpectedly moves, or safety of the staff is in jeopardy. Complete assessment to best of ability describing the patient’s health status at the time of the most recent visit made by a clinician qualified to complete an assessment (RN, PT, SLP, OT not LPN/LVN, PTA, OTA, HHA).
Discharge patient from agency when a Medicare patient remains in the inpatient facility beyond day 60 of PPS payment episode or if care was not resumed after inpatient facility discharge. OASIS discharge assessment is not required. The OASIS assessment completed at time of transfer to inpatient facility completes the OASIS reporting cycle.


*Requires face to face patient contact on home visit for completion.
**Does not require home visit for completion.
### M0110 Episode Timing

- **1 - Early**
- **2 - Later**
- **UK - Unknown**
- **NA - Not applicable. No Medicare case mix group to be defined by this assessment.**

At follow-up, go to M0230.

### Item Clarification:
Identifies the placement of the current Medicare payment episode in the patient’s current sequence of adjacent Medicare payment episodes. “Early” means the only episode OR the first or second episode in a sequence of adjacent episodes. “Later” means the third or later episode in a sequence of adjacent episodes.

### Recommendations from Expert Design Forums

**Optimal Question:** When was the last time you had home health services?

**Optimal Technique:** Office based staff to check Medicare systems, such as Health Insurance Query for Home Health (HIQH) for this information.

**Tips:**

A "sequence of adjacent Medicare home health payment episodes" is a continuous series of Medicare 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 as an episode.

“Adjacent” means that there was no gap between Medicare-covered episodes of more than 60 days.

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 an adjacent episode sequence and are counted as **gap days.** 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. 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.

Select "Early" if the Medicare payment episode is the only episode OR the first or second episode in a current sequence of adjacent Medicare home health payment episodes.

Select "Later" if the Medicare payment episode is the third or higher in the current sequence of adjacent Medicare home health payment episodes.

Select “UK - Unknown” response if the placement of this payment episode in the sequence of adjacent episodes is unknown. This will have the same effect as selecting the “Early” response when calculating reimbursement.

The Medicare computers will "correct" this item at the time the final bill is submitted, or anytime thereafter additional input to the Medicare system indicates the selection was incorrect. The agency does not need to correct the OASIS assessment.

Enter “NA” for a non Medicare FFS payer unless the payer requires a case mix code for billing purposes (a “HIPPS” code).

At ROC, this response does not usually affect payment and “unknown” could serve as an appropriate response. However, if the ROC also serves as a recertification assessment when the patient is discharged from an inpatient facility in the last five days of the certification period, the response of early or late should describe the upcoming episode in order to obtain accurate payment.
M0140  Race/Ethnicity

☐ 1 – American Indian or Alaskan Native
☐ 2 – Asian
☐ 3 – Black or African American
☐ 4 – Hispanic or Latino
☐ 5 – Native Hawaiian or Pacific Islander
☐ 6 – White
☐ UK – Unknown

Item Clarification: The groups or populations to which the patient is affiliated, as identified by the patient or caregiver.

Recommendations from Expert Design Forum

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

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

Tips: Requires asking patient or caregiver. Mark all groups with whom the patient identifies.
### M0150  Current Payment Sources for Home Care

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None, no change for current services</td>
</tr>
<tr>
<td>1</td>
<td>Medicare (traditional fee-for-service)</td>
</tr>
<tr>
<td>2</td>
<td>Medicare (HMO/managed care)</td>
</tr>
<tr>
<td>3</td>
<td>Medicaid (traditional fee-for-service)</td>
</tr>
<tr>
<td>4</td>
<td>Medicaid (HMO/managed care)</td>
</tr>
<tr>
<td>5</td>
<td>Workers compensation</td>
</tr>
<tr>
<td>6</td>
<td>Title programs (e.g., Title III, V, or XX)</td>
</tr>
<tr>
<td>7</td>
<td>Other government (e.g., CHAMPUS, VA, etc.)</td>
</tr>
<tr>
<td>8</td>
<td>Private insurance</td>
</tr>
<tr>
<td>9</td>
<td>Private HMO/managed care</td>
</tr>
<tr>
<td>10</td>
<td>Self pay</td>
</tr>
<tr>
<td>11</td>
<td>Other (specify): ____________________</td>
</tr>
<tr>
<td>UK</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Item Clarification:** 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 care agency.

### Recommendation from Expert Design Forum

**Optimal Technique:** Agency intake staff to identify potential payers for the home health services provided by the agency. Initial visiting clinician to collaborate with designated agency staff to determine and ensure patient meets eligibility criteria of payer. If injury or trauma apparent, inquire about etiology.

### Tips:

On initial visit, assessing clinician verifies that correct payers have been identified.

Mark **all** payers likely to be billed by the agency for home care services (RN, PT, OT, SLP, MSW, and HHA) at this point in time, whether primary or secondary. Do not consider any equipment, medications or supplies being paid for by the patient in part or in full.

Select Medicare, Response 1 or 2, in order to establish episode and collect associated Medicare required data items when Medicare is a secondary payer.

Select Medicare, Response 2, if the payer is a Medicare HMO, Medicare Advantage Plan or Medicare Part C.

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

Select Response 3 if receiving services as part of a Medicaid waiver or home and community-based waiver (HCBS) program.

When a change in payer requires a new Start of Care date, discharge from previous payer and reassess under new payer.

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 and inpatient facility [If NA, go to M0200]

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

Recommendation from Expert Design Forum

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

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

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

Tips: Determine "past 14 days" by looking at a calendar. Determine the day of the week for SOC. Look back to the same day 2 weeks previous. Discharges occurring on or during these days are "the past 14 days."

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

A skilled nursing facility can have Medicare A beds, beds not paid for by Medicare A and separately licensed rehabilitation beds.

Response 1 Hospital includes:
• Acute care hospitals
• Long term care hospitals.

Response 3: SNF is a Medicare-certified nursing facility where the patient received a skilled level of care under the Medicare Part A benefit.

Response 4 Other nursing home includes:
• Days in SNF or other nursing facility not paid by Medicare A
• Intermediate care facilities for the mentally retarded (ICF/MR)

Failure to mark discharges from "ALL" inpatient stays within the past 14 days will affect the risk adjustment when determining many patient outcomes.

Facility types listed in this item differ from those listed in M0855.
### M0180 Inpatient Discharge Date (most recent):

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

- UK - Unknown

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

---

#### Recommendations from Expert Design Forum

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

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

---

#### Tips:

- Determine "past 14 days" by looking at a calendar. Determine the day of the week for SOC. Look back to the same day 2 weeks previous. Discharges occurring on or during these days are “the past 14 days.”
  
- If patient discharged from more than one inpatient facility in past 14 days, record date of **most recent** discharge.
  
- Avoid using "unknown" when Medicare is the payer.
**M0190 Inpatient Diagnosis:** 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):

<table>
<thead>
<tr>
<th>Inpatient Facility Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. __________________________</td>
<td>(_____•____)</td>
</tr>
<tr>
<td>b. __________________________</td>
<td>(_____•____)</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

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

**Tips:** Assessing clinician to record the most relevant diagnoses actively treated as inpatient. Coding specialist may enter the actual ICD-9-CM codes per agency policies.

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

Determine "past 14 days" by looking at a calendar. Determine the day of the week for SOC. Look back to the same day 2 weeks previous. The dates of or between these days are "the past 14 days."

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

This item will affect risk adjustment when determining many patient outcomes.
### M0200 Medical Treatment Regimen Change Within Past 14 Days:

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

- 0 – No [If No, go to M0220]
- 1 – Yes

### Item Clarification:

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

### Recommendations from Expert Design Forum

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

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

### Tips:

Medication, treatment and service changes as a result from a new diagnosis or an exacerbation/improvement of an existing condition or other change in health status will result in a "yes" answer.

A referral for home health services or a physician appointment does not qualify as a change in treatment regimen within the last 14 days. Treatment changes and orders to initiate rehab services do qualify even if they occur on the same day as the assessment visit. A new diagnosis requiring treatment and monitoring is considered a medical or treatment regimen change.

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

Services, such as physical therapy or any other discipline, that are ordered at SOC and discontinued during the episode, would qualify as a service change for M0200 at ROC or D/C if the change in treatment regimen occurred within the 14 days immediately preceding the resumption of care or discharge date.

Determine "past 14 days" by looking at a calendar. Determine the day of the week for SOC. Look back to the same day 2 weeks previous. The dates of or between these days are “the past 14 days.”
**M0210 Medical Diagnosis:** List each Medical Diagnosis and ICD-9-CM code at the level of highest specificity for those conditions requiring changed medical or treatment regimen (no surgical, E-codes, or V-codes):

<table>
<thead>
<tr>
<th>Changed Medical Regimen Diagnosis</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. _______________________________</td>
<td>(<em><strong>·</strong></em>)</td>
</tr>
<tr>
<td>b. _______________________________</td>
<td>(<em><strong>·</strong></em>)</td>
</tr>
<tr>
<td>c. _______________________________</td>
<td>(<em><strong>·</strong></em>)</td>
</tr>
<tr>
<td>d. _______________________________</td>
<td>(<em><strong>·</strong></em>)</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

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

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

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

ICD-9-CM codes may be applied by other agency staff per agency policy after the assessing clinician has determined the applicable diagnoses/condition.

Determine "past 14 days" by looking at a calendar. Determine the day of the week for SOC. Look back to the same day 2 weeks previous. The dates of or between these days are "the past 14 days."
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Urinary Incontinence</td>
</tr>
<tr>
<td>2</td>
<td>Indwelling/suprapubic catheter</td>
</tr>
<tr>
<td>3</td>
<td>Intractable pain</td>
</tr>
<tr>
<td>4</td>
<td>Impaired decision-making</td>
</tr>
<tr>
<td>5</td>
<td>Disruptive or socially inappropriate behavior</td>
</tr>
<tr>
<td>6</td>
<td>Memory loss to the point that supervision is required</td>
</tr>
<tr>
<td>7</td>
<td>None of the above</td>
</tr>
<tr>
<td>NA</td>
<td>No inpatient facility discharge and no change in medical or treatment regimen in past 14 days.</td>
</tr>
<tr>
<td>UK</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

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

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

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

Select NA if there has been both no inpatient facility discharge and no change in medical or treatment regimen in the past 14 days.
M0230/240/246 Diagnoses, Severity Index and Payment Diagnosis: 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 diagnosis. 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.

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 the 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 ICD-(-CM code) in the same row in Column 3.

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 the 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>
<thead>
<tr>
<th>(M0230) Primary Diagnosis &amp; (M0240) Other Diagnoses</th>
<th>(M0246) Case Mix Diagnoses (OPTIONAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 1</td>
<td>Column 2</td>
</tr>
<tr>
<td>Description</td>
<td>ICD-9-CM and severity rating for each condition</td>
</tr>
<tr>
<td>(M0230) Primary Diagnosis</td>
<td>(V codes are allowed)</td>
</tr>
<tr>
<td>a.</td>
<td>a. (___ • • • •)</td>
</tr>
<tr>
<td></td>
<td>□ 0 □ 1 □ 2 □ 3 □ 4</td>
</tr>
<tr>
<td>(M0240) Other Diagnoses</td>
<td>(V or E codes are allowed)</td>
</tr>
<tr>
<td>b.</td>
<td>b. (___ • • • •)</td>
</tr>
<tr>
<td></td>
<td>□ 0 □ 1 □ 2 □ 3 □ 4</td>
</tr>
<tr>
<td>c.</td>
<td>c. (___ • • • •)</td>
</tr>
<tr>
<td></td>
<td>□ 0 □ 1 □ 2 □ 3 □ 4</td>
</tr>
</tbody>
</table>
**Item Clarification:**
Identifies each diagnosis for which the patient is receiving home care and its ICD-9-CM code. Each diagnosis (other than an E code) is then categorized according to its severity. The primary diagnosis \( \text{(M0230)} \) should be the condition which is the chief reason for providing home care. A case mix diagnosis gives a patient a score for Medicare Home Health PPS case mix assignment.

### Recommendations from Expert Design Forum

**Optimal Question:**
Primary diagnosis: What diagnosis is driving the home health plan of care?

Secondary Diagnoses: What diagnoses are addressed by the home health plan of care or have the potential to affect the plan of care, affect progress and rehabilitation potential or justify the services provided? What diagnosis would I use if I could not use this V-code diagnosis?

**Optimal Technique:**
Determine diagnostic statements after completion of assessment, determining patient’s needs and formulation of home health plan of care.

Develop "coding experts" within the agency for applying the codes and assuring sequencing according to ICD-9-CM rules.

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

**Tips:**
A comprehensive listing of applicable diagnoses describes the patient's current health status and helps to establish the need for skilled services and the medical complexity of the patient. These are also risk factors which may affect the calculation of patient outcome measures.

List/sequence diagnoses to best reflect the seriousness of the patient’s condition and to justify the disciplines and in accordance with ICD-9-CM coding rules.

The diagnoses reported in OASIS items M0230/240, on the Home Health Agency Plan of Care and the Medicare claim must match. For more information refer to Chapter 10, section 40.2 of the Medicare Claims Processing Manual http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf

Other agency staff may record the ICD-9-CM code applicable to the diagnosis statement in accordance with agency policies and procedures so long as the assessing clinician determines the primary and secondary diagnoses and assigns their severity rating.

Recommendations for changes to the primary diagnosis, the addition of other pertinent diagnoses and the need to change their sequence during the agency’s internal review process can only be made after agreement by the assessing clinician and in accordance with the agency’s policy for correcting medical records.

---

<table>
<thead>
<tr>
<th>(M0230) Primary Diagnosis &amp; (M0240) Other Diagnoses</th>
<th>(M0246) Case Mix Diagnoses (OPTIONAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column 1</td>
<td>Column 2</td>
</tr>
<tr>
<td>Description</td>
<td>ICD-9-CM and severity rating for each condition</td>
</tr>
<tr>
<td>d.</td>
<td>d. (______ • ____ •)</td>
</tr>
<tr>
<td>0 □ 1 □ 2 □ 3 □ 4</td>
<td>(______ • ____ •)</td>
</tr>
<tr>
<td>e.</td>
<td>e. (______ • ____ •)</td>
</tr>
<tr>
<td>0 □ 1 □ 2 □ 3 □ 4</td>
<td>(______ • ____ •)</td>
</tr>
<tr>
<td>f.</td>
<td>f. (______ • ____ •)</td>
</tr>
<tr>
<td>0 □ 1 □ 2 □ 3 □ 4</td>
<td>(______ • ____ •)</td>
</tr>
</tbody>
</table>

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Primary Diagnosis:
- Diagnosis most related to the current plan of care developed by the agency
- Condition that represents the most acute condition and most intensive services
- Might not be related to the reason for hospitalization
- May be a V-code

Secondary Diagnoses:
- Conditions addressed by the plan of care
- Conditions that coexist at the time the plan of care is established or develop subsequently (added to the plan of care at the time of recertification
- Comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if not the focus of any home health treatment
- Justify disciplines and services rendered
- May be described as a V or E code

Severity Ratings:
Evaluate to what extent presenting symptoms are controlled by current treatments and frequency of contacts with health care providers.
- 0 - Condition requires no treatment or medication.
- 1 - Current treatment, medications, services for this condition has not required change in recent past.
- 2 - Condition new or in exacerbation. Currently stable treatment regimen but new/changed enough to require observation and assessment.
- 3 - Condition unstable requiring close observation and assessment. Recent history of treatment or medication changes and more changes anticipated.
- 4 - Condition significantly unstable. In spite of treatment or medication changes, history of hospitalizations in past year.

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

Case Mix Diagnoses
Explore all V-codes used in M0230/240 for potential replacement with a Case Mix Diagnosis in Column 3. Complete M0246 with the case mix diagnosis only when the case mix diagnosis has been replaced by a V-code. Only codes designated as case mix codes will appear in this item.

When a V-code replaces a case mix code in the primary diagnosis and the case mix code is a combination etiology and manifestation code as identified in the ICD-9-CM code book, then place the etiology code in M0246 Column 3 and the manifestation code in M0246 Column 4 for correct payment.

Eligible diagnosis codes from M0246 are considered for risk adjustment calculation.


Refer to CMS guidance document, Medicare Home Health Diagnosis Coding, www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp. Click on “Medicare Home Health Diagnosis” in the Downloads section. For a list of case mix diagnoses, click on “HH PPS Grouper Software and Documentation.”
M0250 **Therapies** the patient receives at home: *(Mark all that apply.)*

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

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

---

**Recommendations from Expert Design Forum**

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

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

---

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

Infusion therapy involves a therapeutic drug or solution that is administered via an infusion device, including a needle flush, implanted or external pump, or other infusion device.

Include:

1. Central line, subcutaneous, epidural, intrathecal infusions, insulin pumps and home dialysis.
2. Intermittent medications, fluids or flushes via IV line (e.g., heparin or saline flush).
3. Enteral nutrition.
4. Therapy initiated at SOC or is a result of SOC assessment and physician orders reflect treatment and start date.
5. Discontinuation of these therapies on day of assessment.

Exclude:

1. Presence of feeding tube when there is no prescription for therapy which provides nutrition.
2. Feeding tube used for medication administration only.
3. Feeding tube used for hydration only.
4. Flushing feeding tube to keep patent. *(Flushing of a feeding tube does not provide nutrition and is not considered a therapy.)*
5. IM or SQ injection given over 10 minutes.
7. Infusions or enteral nutrition to be administered when specific parameters are met and the parameters are not met on the day of the assessment.
### M0260 Overall Prognosis:

BEST description of patient’s overall prognosis for recovery from this episode of illness.

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

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

### Recommendations from Expert Design Forum

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

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

**Tips:** Focus on overall condition and expected recovery or improvement in the condition for which home care is being provided given the impact of the patient’s current health status, situation and recent past history.
### M0270  Rehabilitative Prognosis:

**BEST description of patient’s prognosis for functional status.**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Guarded: minimal improvement in functional status is expected; decline is possible</td>
</tr>
<tr>
<td>1</td>
<td>Good: marked improvement in functional status is expected</td>
</tr>
<tr>
<td>UK</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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

### Recommendations from Expert Design Forum

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

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

**Tips:** Consider the patient’s overall condition, the home environment, prior level of function and specific health status at the time of the assessment. Use critical thinking and professional experience to determine the patient’s projected change in ability to perform ADL/IADL tasks during this home care episode.
M0280  Life Expectancy: (Physician documentation is not required.)

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

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

Recommendations from Expert Design Forum

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

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

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

Tips: Careful professional consideration of this response selection will help to reduce the number of adverse events charged to the agency on OBQM reports and will affect the calculation of some quality outcome measures.
<table>
<thead>
<tr>
<th></th>
<th>M0290 High Risk Factors characterizing this patient: (Mark all that apply.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 – Heavy smoking</td>
</tr>
<tr>
<td></td>
<td>2 – Obesity</td>
</tr>
<tr>
<td></td>
<td>3 – Alcohol dependency</td>
</tr>
<tr>
<td></td>
<td>4 – Drug dependency</td>
</tr>
<tr>
<td></td>
<td>5 – None of the above</td>
</tr>
<tr>
<td></td>
<td>UK – Unknown</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

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

**Tips:** Consider past and/or current risk factors. Using critical thinking and professional experience determine which of these past or current behaviors or conditions have an effect on the patient’s current health status, coping ability or ability to follow through with the home health plan of care.
M0300  Current Residence:

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

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

Recommendations from Expert Design Forum

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

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

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

Definitions:

Boarding home/rented room - Fee paid in exchange for a place to live which may include meals but does not come with the provision of any health related services or supervision.

Board and care or assisted living facility - Pertains to licensing of facility. Fee paid in exchange for a place to live and includes some purchased care or health related services or supervision (medication management, assistance with personal care or other supervision, etc.).
**M0340 Patient Lives With:** (Mark all that apply.)

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

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

**Recommendations from Expert Design Forum**

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

**Optimal Technique:** Observe for signs that another person is dwelling in the same location.

**Tips:** Report who the patient is living with on the day of assessment, either permanently or temporarily.

A person living in an assisted living situation does not live alone if they share a room or studio apartment with another.

Includes:
- One family member or other designated caregiver staying 24 hrs/day with the patient even if arrangement is temporary

Excludes:
- Part time or intermittent caregiver
- Several family members or caregivers who make up a 24 hr shift
**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 Clarification:** Identifies the individuals who provide assistance to the patient (EXCLUDING the home care agency).

**Recommendations from Expert Design**

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

**Tips:**  
Paid help includes:
- Services purchased in board and care or assisted living arrangement
- An agency other than the home care agency doing the assessment providing assistance
- Other private or community services paid by patient, family, special program or community funds
- Meals On Wheels

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

**Recommendations from Expert Design Forum**

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

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

Select "0 - No one person" if:
- The primary caregiver is the patient himself
- There are multiple caregivers and each provides varying amounts of assistance and no one of them is "in charge"

Paid help excludes:
- Agency doing the assessment
M0370  How often does the patient receive assistance from the primary caregiver?

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

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

Recommendations from Expert Design Forum

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

Optimal Technique: Obtain information from interview and observation.

Tips: This item refers to the amount of help received from the primary caregiver identified in M0360 and not the amount of help the patient receives from all people who assist.
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)</td>
</tr>
<tr>
<td>2</td>
<td>IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances)</td>
</tr>
<tr>
<td>3</td>
<td>Environmental support (housing, home maintenance)</td>
</tr>
<tr>
<td>4</td>
<td>Psychosocial support (socialization, companionship, recreation)</td>
</tr>
<tr>
<td>5</td>
<td>Advocates or facilitates patient’s participation in appropriate medical care</td>
</tr>
<tr>
<td>6</td>
<td>Financial agent, power of attorney, or conservator of finance</td>
</tr>
<tr>
<td>7</td>
<td>Health care agent, conservator of person, or medical power of attorney</td>
</tr>
<tr>
<td>UK</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

**Optimal Technique:** Give patient examples from choices listed.

**Tips:** Response 5 includes picking up prescriptions and rides to physician appointments.

This item refers to the type of help received from the primary caregiver identified in M0360 and *not* the type of help the patient receives from *all* people who help.
M0390  Vision with corrective lenses if the patient usually wears them:

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

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

Recommendations from Expert Design Forum

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

Optimal Technique: Ask patient to read medication label words or numbers. Notice if prescriptive glasses or reading glasses are routinely used to accomplish task.

Can patient see and pick up a small object in front of them?

With impaired cognition, interview caregiver. Observe patient movement/response during assessment visit and determine if there is an ability to see.

Tips: Focus is on functional vision, ability to see and safely function, and not visual acuity, literacy or the ability to read.

Do not limit assessment to patient’s ability to see medication labels and small print.

Determine if the patient’s ability to respond to or function in his environment is altered. If yes, determine if it is due to an impairment of sight or other physical impairment that limits ability to use their vision in a functional way (i.e. neck injury, orbital swelling, etc.) not compensated for by routine use of prescription or reading glasses.

Does a lack of uncorrected vision jeopardize safety, health and well being? Able to see objects in path, read gauges/measures on medical equipment, see telephone numbers, see changes in walking surfaces?

Corrective lenses include:
- Prescription glasses
- Reading glasses, including those purchased in the grocery store

A person is considered:
- Partially or severely impaired if:
  - Magnifying glass is used to see small print or medication labels
  - Does not regularly use glasses when he has them
  - Needs a different prescription for accurate viewing
  - Limited field of vision creates safety risk with mobility, etc.

- Severely impaired if:
  - There is lack of sight (blindness)
  - Is nonresponsive (unable to voluntarily respond) or unconscious

If patient cannot read, observe ability to see large and small objects, pick up a dime, find the line to sign on a consent form, identify numbers.
M0400 Hearing and ability to Understand Spoken Language in patient’s own language (with hearing aids if the patient usually uses them).

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

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

**Recommendation From Expert Design Forum**

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

**Tips:** Focus is on receptive communication, the hearing and understanding of spoken language. Response will be affected by ability to hear and process information (cognitive status).

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

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

Impairment in either hearing or processing of the spoken word will result in a deficit in this item.

"Nonresponsive" means the patient is unable to respond (i.e., vegetative state, etc.).
### M0410 Speech and Oral (Verbal) Expression of Language (In patient’s own language):

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

### Item Clarification:

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

### Recommendations from Expert Design Forum

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

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

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

Select Response 5 when there is:
- Inability to speak and communication is by sign language
- Inability to respond (i.e., vegetative state, etc).
### M0420  Frequency of Pain interfering with patient’s activity or movement:

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

**Item Clarification:**
Identifies how often pain interferes with patient’s activities and movements, with consideration of treatment if prescribed. This does not report the presence of pain.

### Recommendations from Expert Design Forum

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

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

**Tips:**
In spite of pain medication and other relief measures, acute or chronic pain can interfere with activity or movement. Determine if and how often it does.

Interfering pain will cause a person to restrict an activity to be or remain pain free.

A patient may not be able to afford or choose not to use pain relief measures and the pain may interfere with movement and activity. Determine if and how often it does.

Pain that interferes will:
- Cause activity to take longer to complete or movement to slow, be modified or postponed, or
- Require additional assistance of another person or device, or
- Result in activity being performed less often than desired by the patient.

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

If patient is nonverbal, evaluate facial expressions or physiologic responses to pain during activity or movement.
### 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?

<table>
<thead>
<tr>
<th></th>
<th>0 – No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 – Yes</td>
</tr>
</tbody>
</table>

**Item Clarification:** Identifies the presence of intractable pain; a reflection of the patient’s current pain and its impact on his life considering their current effort or lack of to treat and manage the pain.

**Recommendations from Expert Design Forum**

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

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

**Tips:** Select “yes” when all three characteristics are present.

- Characteristics of intractable pain:
  - Not easily relieved
  - Occurs at least daily (need not be constant)
  - Affects sleep, appetite, physical or emotional energy, concentration, personal relationships or ability or desire to perform activity (quality of life)

Intractable pain affects the quality of life and activities and the effort to manage it is “ever present.”

Pain that is constant or occurs daily can interfere with activities and the quality of life. Determine if and how it does. How effective are current pain management strategies?
**M0440**  Does this patient have a **Skin Lesion** or an **Open Wound**? This excludes "OSTOMIES."

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

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

**Recommendations from Expert Design Forum**

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

**Optimal Technique:** Visually inspect skin.

**Tips:** Focus is on assessment of the integument (skin) system.

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

Includes but not limited to:
- Wounds, ulcers, rashes, crusts, bruises, sores
- Skin tears
- Burn
- Surgical incisions, pin sites, wounds with staples or sutures
- Central lines, PICC lines
- Portacath, mediport, implanted infusion devices, venous access devices
- Current surgical wound or healed scar of pacemaker insertion
- Scars
- Peristomal skin breakdown
- Exit site in the abdominal wall for a peritoneal dialysis catheter

Excludes:
- Lesions ending in "ostomy" such as suprapubic catheter site (cystostomy), PEG site (gastrostomy), new colostomy, chest tube site (thoracostomy), tracheostomy, etc.
- Peripheral IV sites
- Cataract surgery and gynecological surgical procedure by a vaginal approach

A diabetic ulcer describes any ulcer occurring on the skin of a diabetic patient. The root cause of the ulcer must be determined. It could be a pressure ulcer, a stasis ulcer, an arterial ulcer or the result of a neuropathic process.
CMS Q&A 08/07: “CMS references, not clinical training programs should be used to guide OASIS scoring decisions. While CMS utilizes the expert resources of organizations like the Wound Ostomy Continence Nurses Society and the National Pressure Ulcer Advisory Panel to help suggest assessment strategies to support scoring of the integumentary items, in some cases, the OASIS scoring instructions are unique to OASIS and may not always coincide or be supported by general clinical references or standards.” See OASIS Q and A found at https://www.qtso.com/hhadownload.html.
M0445  Does this patient have a **Pressure Ulcer**?

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

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

**Recommendations from Expert Design Forum**

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

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

**Tips:**  Pressure ulcers include:
- All current and active lesions that are a result of unrelieved pressure
- Previously healed Stage III and Stage IV pressure ulcers

Support selection of this wound type with documentation of etiology and history in the clinical record.

Support determination of previously healed Stage III and Stage IV pressure ulcers with evidence and documentation in the clinical record.

**Exclude:**
- Previously healed Stage I and Stage II pressure ulcers
- Lesions not caused by pressure
- Pressure ulcer closed with a muscle flap

**Select YES:**
- For a Suspected Deep Tissue Injury, a pressure ulcer stage found in 2/2007 NPUAP *Pressure Ulcer Definitions and Stages*.  [www.npuap.org](http://www.npuap.org)
### M0450 Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.)

<table>
<thead>
<tr>
<th>Pressure Ulcer Stages</th>
<th>Number of Pressure Ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration.</td>
<td></td>
</tr>
<tr>
<td>In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.</td>
<td></td>
</tr>
<tr>
<td>b) Stage 2: Partial thickness skin loss involving epidermis and/or dermis.</td>
<td></td>
</tr>
<tr>
<td>The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.)</td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td>![Yes/No]</td>
</tr>
</tbody>
</table>

#### Item Clarification:
Identifies the presence of a pressure ulcer at each stage present at the time of assessment. Definitions of pressure ulcer stages are derived from the National Pressure Ulcer Advisory Panel, [www.npuap.org](http://www.npuap.org).

#### Recommendations from Expert Design Forum

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

#### Tips:
- Pressure ulcer:
  - Lesion caused by unrelieved pressure resulting in tissue hypoxia and damage of underlying tissue
  - Remains when treated with a skin graft
  - Remains when surgically debrided
  - Occurs on foot of a person with diabetes when the root cause is pressure
  - Partially granulated to the skin surface, leaving the ulcer open in more than one area is only 1 ulcer

Excludes:
- Pressure ulcer closed with a muscle flap
- Previously healed Stage I and II pressure ulcers

**Staging:**
- Identify by worst stage achieved
- Do not reverse stage
- Can be determined when some eschar or slough present in wound bed as long as the deepest viable tissue is visible; the slough does not obscure the depth of the tissue loss

**Nonobservable (M0450e):**
- Eschar or slough covers the wound bed obscuring the depth of tissue loss, even if previously identified and classified
- Dressing cannot be removed by a written physician order
- Cast is covering
Previously healed Stage III or IV pressure ulcer:

- Continues to be regarded as a pressure ulcer at its worst stage
- If breaks down again should be staged at its worst stage

Carry some kind of pocket guide reference tool.

Delay answering M0450 if non observable ulcer will be visualized by the same clinician within 5 days of SOC/ROC. (e.g., Patient with a pressure ulcer has a dressing covering with a doctor’s order to change in 3 days from SOC/ROC and will be visualized.) M0090 would then reflect the date the ulcer is visualized and the assessment is completed.

Contact physician for clarification of wound type if clinician conducting assessment is unsure.

A pressure ulcer closed with a muscle flap is a surgical wound. If the flap completely heals and breaks down due to pressure, it is considered a new pressure ulcer. If pressure causes the flap to break down before it completely heals, the wound is considered a non healing surgical wound.

Suspected Deep Tissue Injury:

Suspected Deep Tissue Injury is a pressure ulcer stage found in 2/2007 NPUAP Pressure Ulcer Definitions and Stages. This new stage is not represented in the OASIS B-1 data set. Document the wound characteristics of a suspected deep tissue injury in the clinical documentation unless the description matches the definition of a stage identified in M0450.

M0460 Stage of Most Problematic (Observable) Pressure Ulcer:

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

Item Clarification: Identifies the most problematic pressure ulcer of those noted in M0450. "Most problematic" may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.

Recommendations from Expert Design Forum


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

If the patient has only one pressure ulcer, that is the most problematic one.

If there are multiple pressure ulcers, clearly identify in documentation which ulcer is referenced in the OASIS response selection.

Exclude:
- Ulcer to which “e” in M0450 is applied (No observable pressure ulcer)

Nonobservable:
- Eschar or slough covers the wound bed obscuring the depth of tissue loss
- Dressing cannot be removed by physician order
- Cast is covering

Delay answering M0460 if non observable ulcer will be visualized by same clinician within 5 days of SOC/ROC (e.g., patient with a pressure ulcer has a dressing covering with a doctor’s order to change in 3 days from SOC/ROC and will be visualized.) M0090 would then reflect the date the ulcer is visualized and the assessment is completed.
M0464 Status of Most Problematic (Observable) Pressure Ulcer:

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

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

Recommendations from Expert Design Forum

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

Tips: Document complete wound description in clinical record; location, size, depth, drainage, appearance of wound bed and surrounding skin using terms found in the descriptions of non healing, early partial and fully granulating wound status by the WOCN.

Select Response 1 fully granulating when:
- A previous Stage III or IV pressure ulcer is healed with intact skin

Select Response 2 early/partial granulation if:
- Part of the ulcer (< 25% of the wound bed) is covered with avascular tissue (eschar and/or slough)

Select Response 3 “not healing” if the pressure ulcer is:
- Stage I
- Infected
- Partially covered (≥ 25% of the wound bed) with avascular tissue (eschar and/or slough)
- Wholly covered by necrotic/avascular tissue, scab

The criteria for “no observable” in this data item is different from M0450 and 464. Select “N/A” no observable pressure ulcer if:
- Presence of non removable dressing by physician order
- Presence of cast

Refer to WOCN OASIS Guidance Document revised July 2006 (www.wocn.org) for additional guidance.

Definitions:
- Fully granulating (Response 1):
  - Wound bed with granulation tissue to the level of surrounding skin or new epithelium
  - No dead space
  - No avascular tissue (eschar and/or slough)
  - No signs or symptoms of infection
  - Wound edges are open
Early/partial (Response 2):
- ≥ 25% of the wound bed is covered with granulation tissue
- Minimal avascular tissue (eschar and/or slough) (i.e., < 25% of the wound bed is covered with avascular tissue)
- May have dead space
- No signs or symptoms of infection
- Wound edges open

Not healing (Response 3):
- Wound with > 25% avascular tissue (eschar and/or slough) OR
- Signs/symptoms of infection OR
- Clean but not granulating wound bed OR
- Closed hyperkeratotic wound edges OR
- Persistent failure to improve despite appropriate comprehensive wound management
<table>
<thead>
<tr>
<th>M0468</th>
<th>Does this patient have a Stasis Ulcer?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No [If No, go to M0482]</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

**Optimal Question:** How did you get this wound?

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

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

- Describe wound in clinical record; location, size, drainage, wound bed and surrounding skin, presence of pain. Support selection of this wound type with documentation of etiology and history.

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

**Exclude:**
- Arterial Ulcers
- Previous fully healed venous stasis ulcer

Contact physician for clarification of wound type if clinician conducting assessment is unsure.
### M0470  Current Number of Observable Stasis Ulcer(s):

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

**Item Clarification:** Identifies the number of visible stasis ulcers.

### Recommendations from Expert Design Forum

**Optimal Technique:** Visually inspect skin.

**Tips:** "Counted" even if it has a scab, crust or necrotic tissue.

"Non observable" stasis ulcers:
- Only those that are covered by a non removable dressing

Exclude:
- Ulcers of arterial origin
<table>
<thead>
<tr>
<th>M0474</th>
<th>Does this patient have at least one <strong>Stasis Ulcer that Cannot be Observed</strong> due to the presence of a nonremovable dressing?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ 0 – No</td>
</tr>
<tr>
<td></td>
<td>□ 1 – Yes</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

**Tips:** "Nonremoveable" dressing:
- Evidenced by physician order

Delay answering this item if dressing will be removed and visualized by the same clinician within 5 days of SOC/ROC. M0090 would then reflect the date the ulcer is visualized and the assessment is completed.
### M0476 Status of Most Problematic (Observable) Stasis Ulcer:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Full granulating</td>
</tr>
<tr>
<td>2</td>
<td>Early/partial granulation</td>
</tr>
<tr>
<td>3</td>
<td>Not healing</td>
</tr>
<tr>
<td>NA</td>
<td>No observable stasis ulcer</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

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

Document complete wound description in record; location, size, depth, drainage, appearance of wound bed and surrounding skin using terms found in the descriptions of non healing, early partial and fully granulating wound status by the WOCN.

If the only stasis ulcer is non observable, delay assessment if the wound will be visualized by the same clinician within 5 days of SOC/ROC. M0090 would then reflect the date the ulcer is visualized and the assessment is completed.

If there are multiple stasis ulcers, clearly identify in documentation which ulcer is reflected in the response selection.


Persistent failure to improve despite appropriate comprehensive wound management.

**Definitions:**

- **Fully granulating (Response 1):**
  - Wound bed with granulation tissue to the level of surrounding skin or new epithelium
  - No dead space
  - No avascular tissue (eschar and/or slough)
  - No signs or symptoms of infection
  - Wound edges are open

- **Early/partial (Response 2):**
  - ≥ 25% of the wound bed is covered with granulation tissue
  - Minimal avascular tissue (eschar and/or slough) (i.e., < 25% of the wound bed is covered with avascular tissue)
  - May have dead space
  - No signs or symptoms of infection
  - Wound edges open

- **Not healing (Response 3):**
  - Wound with ≥ 25% avascular tissue (eschar and/or slough) OR
  - Signs/symptoms of infection OR
  - Clean but not granulating wound bed OR
  - Closed hyperkeratotic wound edges OR
  - Persistent failure to improve despite appropriate comprehensive wound management
M0482  Does this patient have a **Surgical Wound**?

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

**Item Clarification:** Identifies the presence of any wound resulting from a surgical procedure. A wound that has completely healed (thus becoming a scar) is no longer identified as a surgical wound.

**Recommendations from Expert Design Forum**

**Optimal Question:** How did you get this wound?

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

**Tips:** Surgical wound:
- Result of a surgical procedure
- Orthopedic pin sites, central line sites, stapled or sutured incisions
- Mediport site and other implanted infusion device or vascular access device when initially implanted and as long as it is in place. Device does not need to be functional or accessed at a particular frequency. These are central lines placed by a surgical procedure.
- Peritoneal dialysis catheter, AV shunt
- Wounds with drains
- Wound created by a surgical procedure in which a drain is placed and after the drain is pulled until it heals and becomes a scar
- Surgical incision with well approximated edges and a scab (i.e., crust) from dried blood or tissue fluid
- Muscle flap to surgically replace pressure ulcer
- Gastrostomy closed by a surgical "take down" procedure
- A shave, punch or excisional biopsy to remove and/or diagnose skin lesions
- Abscess **treated** by incision and drainage with placement of a drain
- Surgical repair of a traumatic injury
- Arthrocentesis site when a surgical procedure is performed by arthroscopy

**Excludes:**
- Surgical wounds resulting in scar or keloid formation
- Debridement or the placement of skin graft
- PICC lines (peripherally inserted)
- Gastrostomy allowed to close on its own without surgical intervention
- Pressure ulcers **treated** by surgical debridement
- Pressure ulcers treated with a skin graft
- Recent healed surgical wounds with well approximated edges, complete epithelialization, no drainage, edema or signs of infection and evidence of scar/keloid formation
- Suturing of a traumatic laceration
- Abscess **treated** by incision and drainage **without** placement of a drain
- Cataract surgery or a gynecological surgical procedure via a vaginal approach (wound is not of the integument)
- Aspiration of fluid by needle without placement of a drain
- Cardiac catheterization performed by needle puncture
**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.)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>0 – Zero</td>
</tr>
<tr>
<td>□</td>
<td>1 – One</td>
</tr>
<tr>
<td>□</td>
<td>2 – Two</td>
</tr>
<tr>
<td>□</td>
<td>3 – Three</td>
</tr>
<tr>
<td>□</td>
<td>4 – Four or more</td>
</tr>
</tbody>
</table>

**Item Clarification:** Identifies the number of observable surgical wounds.

**Recommendations from Expert Design Forum**

**Optimal Technique:** Inspect skin.

**Tips**

- Count as separate wounds:
  - Number of visible wounds
  - Each non-epithelialized opening in a single surgical wound that has areas of complete epithelialization
  - Orthopedic pin sites

- Do not count as separate wounds:
  - Each suture or staple insertion site
  - Areas of complete epithelialization in a single wound that also contain areas of partial healing evidenced by non-epithelialization

- Exclude:
  - Surgical wound covered by a dressing not to be removed by physician’s order
<table>
<thead>
<tr>
<th>M0486</th>
<th>Does this patient have at least one <strong>Surgical Wound that Cannot be Observed</strong> due to the presence of a nonremovable dressing?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□  0 – No</td>
</tr>
<tr>
<td></td>
<td>□  1 – Yes</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

**Optimal Technique:** Inspect skin. Count visible openings.

**Tips:** Select “Yes” if:
- Wound is covered by a dressing not to be removed by physician’s order

Delay answering this item if dressing will be removed and visualized by the same clinician within 5 days of SOC/ROC. M0090 would then reflect the date the ulcer is visualized and the assessment is completed.
[At follow-up, skip this item if patient has no surgical wounds] **Status of Most Problematic (Observable) Surgical Wound:**

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

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

**Recommendations from Expert Design Forum**

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

**Tips:** After assessment, in the clinician’s professional opinion, this is the surgical wound that provides the greatest challenge to care and treatment for any reason.

If the patient has only one surgical wound, that is the most problematic one.

Select Response 3 non-healing for:
- A venous access puncture site which is covered by a scab (avascular tissue)

"No observable" surgical wound includes only those:
- Covered by a dressing not to be removed by physician’s order
- Covered by a cast

Delay answering this item if dressing will be removed and visualized by the same clinician within 5 days of SOC/ROC. M0090 would then reflect the date the ulcer is visualized and the assessment is completed.

Refer to WOCN OASIS Guidance Document revised July 2006 (www.wocn.org) for additional guidance.

**Definitions:**

Healing by **Primary Intention** (i.e. approximated incisions).

- Fully granulating/healing (Response 1):
  - Incision well approximated with complete epithelialization
  - No signs or symptoms of infection

- Early/partial granulation (Response 2):
  - Incision well approximated but not completely epithelialized
  - No signs or symptoms of infection

- Non-healing (Response 3):
  - Incisional separation OR
  - Incisional necrosis OR
  - Signs or symptoms of infection
Healing by **Secondary Intention** (i.e. healing of dehisced wound by granulation, contraction and epithelialization).

**Fully granulating** (Response 1):
- Wound bed filled with granulation tissue to the level of surrounding skin or new epithelium
- No dead space
- No avascular tissue (eschar and/or slough)
- No signs or symptoms of infection
- Wound edges are open

**Early/partial** (Response 2):
- 25% of the wound bed is covered with granulation tissue
- Minimal avascular tissue (eschar and/or slough) (i.e., 25% of the wound bed is covered with avascular tissue)
- May have dead space
- No signs or symptoms of infection
- Wound edges open

**Not healing** (Response 3):
- Wound with > 25% avascular tissue (eschar and/or slough) OR
- Signs/symptoms of infection OR
- Clean but not granulating wound bed OR
- Closed hyperkeratotic wound edges OR
- Persistent failure to improve despite appropriate comprehensive wound management
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)

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

**Recommendations from Expert Design Forum**

**Optimal Question:** What has caused you to become SOB in the last 24 hrs? Walking? Dressing? Feeling anxious? Talking?

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

**Tips:** Patient must perform some activity and movement in order to evaluate the level of exertion required to produce shortness of breath.

- Report what is true at the time of assessment and in the 24 hr preceding.
- Evaluate the bedbound or chair bound patient while performing ADL and at rest and select corresponding level of exertion which produces shortness of breath.
- If oxygen usually worn continuously, assess patient response while using oxygen.
  If oxygen used intermittently, do **not** assess patient response while using oxygen.
- Emotional states such as anxiety and agitation, illnesses and body types can produce shortness of breath.
- Select Response 1 if shortness of breath occurs:
  - During demanding bed mobility activity for a bedbound patient
  - During physically demanding transfer activities for a chair fast patient
- Select Response 4 if shortness of breath occurs:
  - While supine (orthopnea)
- Excludes:
  - Sleep apnea unless accompanied by an episode of shortness of breath
<table>
<thead>
<tr>
<th></th>
<th>1 – Oxygen (intermittent or continuous)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 – Ventilator (continually or at night)</td>
</tr>
<tr>
<td></td>
<td>3 – Continuous positive airway pressure</td>
</tr>
<tr>
<td></td>
<td>4 – None of the above</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

**Optimal Technique:** Observe environment for evidence of respiratory equipment.

**Tips:** Applies only to the treatments listed in the response items:
- Oxygen
- Ventilator
- C-Pap

**Excludes:**
- Nebulizers
- Inhalers
- Bi-pap, etc.
**M0510**  
Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>NA</td>
<td>Patient on prophylactic treatment</td>
</tr>
<tr>
<td>UK</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

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

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

Select YES if:
- Has symptoms or positive culture and treatment prescribed
- A patient is on prophylactic treatment and develops a UTI.

Select NO if:
- Has symptoms or positive culture and no prescribed treatment
- Treatment ended more than 14 days ago
M0520  Urinary Tract Incontinence or Urinary Catheter Presence:

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

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

Recommendations from Expert Design Forum

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

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

Tips: Urinary incontinence may result from multiple causes, including:
- Physiologic reasons
- Cognitive impairments
- Mobility problems

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

Incontinence includes:
- Any reason/situation the patient leaks urine
- Management with a timed voiding program

Incontinence excludes:
- Leaking urinary drainage appliance

For a patient who was previously incontinent, use clinical judgment, current clinical guidelines and assessment findings to determine if the cause of incontinence has been resolved and the patient is no longer incontinent.

Select response 0 if:
- Has an ostomy for urinary drainage (ileal conduit, urostomy, ureterostomy, nephrostomy, etc.)
- Has a urinary diversion, with or without a stoma, pouch for drainage
- Has anuria
- Is continent

Select Response 2 if:
- Requires a urinary catheter (external, indwelling, intermittent, suprapubic, etc.) for any reason
- Requires intermittent catheterization even with a continent urinary diversion
- Has a urinary diversion, with or without a stoma, that has a catheter or “tube” for urinary drainage
- Catheter is not functioning properly and incontinence is evident
<table>
<thead>
<tr>
<th>M0530 When does Urinary Incontinence occur?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0 – Timed voiding defers incontinence</td>
</tr>
<tr>
<td>□ 1 – During the night only</td>
</tr>
<tr>
<td>□ 2 – During the day and night</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

**Optimal Question:** When (what time of day) do you have trouble holding your urine? Do you leak urine at night?

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

**Tips:** Clinical judgment is required to determine if the last urinary accident is in the relevant past or if the patient’s current use of timed-voiding is 100% effective.

Timed voiding defers includes:
- Actively practicing a timed voiding program which results in no episodes of incontinence in the relevant past

“Relevant past” is a discretionary decision of the assessing clinician based on evaluation of the patient’s circumstances.

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

During day and night Response 2 includes:
- Day only
- Day and night

If dependent on a timed voiding program to defer incontinence, then the correct response to M0520 is Response 1, Patient is incontinent.
M0540 Bowel Incontinence Frequency

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

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

Recommendations from Expert Design Forum

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

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

Tips: Bowel incontinence may result from multiple causes, including:

- Physiologic reasons
- Cognitive impairments
- Mobility problems

Includes:
- Episodes of incontinence in spite of bowel regimen
- Any reason the patient may not have control of his bowels at times

Excludes:
- Regimens that effectively control bowel movements without evidence of “accidents”
**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.

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

**Recommendations from Expert Design Forum**

**Optimal Question:** Do you have a colostomy?

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

**Tips:**

- Includes:
  - Any type of ostomy for bowel elimination (i.e., colostomy, ileostomy, etc.)

- Excludes:
  - An ostomy that has been reversed. (It is no longer an ostomy at the time of the assessment.)

Determine if the bowel ostomy necessitated an inpatient stay or a change in the medical or treatment regimen.
**Cognitive Functioning:** (Patient’s current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)

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

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

**Recommendations from Expert Design Forum**

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

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

**Tips:** Assessment includes health status on the day of assessment and the recent past.

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

Observing ADLs provides an opportunity to determine the patient's ability to comprehend and recall task directions and whether cues, reminders or directions for specific tasks are needed in non-stressful situations. Asking a direct question is not the best assessment strategy.

Explore reports of “forgetfulness.” A patient who uses/needs written reminders to remember events or perform tasks might not be accurately described as a Response 0.

Draw a circle. Ask the patient to draw numbers on a clock. Pick a time. Ask the patient to draw hands representing the time. Evaluate ability to perform correctly.

Perform a mini mental status exam if needed.
### M0570  When Confused (Reported or Observed):

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<tbody>
<tr>
<td>□</td>
<td>0 – Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>1 – In new or complex situations only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>2 – On awakening or at night only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>3 – During the day and evening, but not constantly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>4 – Constantly</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>□</td>
<td>NA – Patient nonresponsive</td>
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</tbody>
</table>

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

### Recommendations from Expert Design Forum

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

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

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

- Assessment includes health status on the day of assessment and the recent past.
- Assessment strategies may include interviewing and probing for the patient’s perception of their mood and feelings. Note thought processes and behavior in the patient’s responses. Sleep habits, appetite changes and weight changes are relevant to determining current mental status.
- Note attention span. Probe for evidence of recent memory decline.
- Delirium and dementia are most frequent causes of confusion.

Select N/A non responsive if the patient:
- Is unconscious, or is unable to voluntarily respond
- Only demonstrates reflexive or otherwise involuntary responses
### M0580 When Anxious (Reported or Observed):

<table>
<thead>
<tr>
<th></th>
<th>0 – None of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 – Less often than daily</td>
</tr>
<tr>
<td></td>
<td>2 – Daily, but not constantly</td>
</tr>
<tr>
<td></td>
<td>3 – All of the time</td>
</tr>
<tr>
<td></td>
<td>NA – Patient nonresponsive</td>
</tr>
</tbody>
</table>

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

### Recommendations from Expert Design Forum

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

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

### Tips:

Anxiety can be an apprehension about an uncertain future, real or imagined, situations where there is a threat to personal safety and security or anything that makes life less predictable or causes one to feel less in control over the direction of one’s life. Anxiety often occurs for patients with chronic respiratory disease.

Someone on anti-anxiety medications can still experience anxious feelings. Determine if they do.

Assessment includes health status on the day of assessment and the recent past.

Assessment strategies may include interviewing and probing for the patient’s perception of their mood and feelings. Note thought processes and behavior in the patient’s responses. Sleep habits, appetite changes and weight changes are relevant to determining current neuro/emotional status.

Select N/A non responsive if the patient:
- Is unconscious, or is unable to voluntarily respond
- Only demonstrates reflexive or otherwise involuntary responses
M0590 Depressive Feelings Reported or Observed in the Patient:
(Mark all that apply)

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

Item Clarification: Identifies presence of symptoms of depression.

Recommendations from Expert Design Forum

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

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

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

Someone on antidepressants can still experience depressive feelings. Determine if they do.

Assessment strategies may include interviewing and probing for the patient’s perception of their mood and feelings. Observe order and amount of light in the environment. Observe type and condition of clothing. Note thought processes and behavior in the patient’s responses. Sleep habits, appetite changes and weight changes are relevant to determining current neuro/emotional status.

If depressive symptoms are present, inquire about the presence of suicidal thoughts. If suicidal thoughts are present, inquire whether these have evolved into a plan for self-harm.
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

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

Recommendations from Expert Design Forum

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

Optimal Technique: Observe for behaviors that are of concern for his/her safety or social environment during assessment or that may have occurred in the recent past. Look at medications.

Determine if patient is on any medication to control any behaviors.

Tips: When evaluating, key in on the first two words used prior to the colon in items 1 thru 4 (i.e. memory deficit, impaired decision making, etc.) to identify behaviors/actions of concern for the patient’s safety or social environment with serious implications for care and care planning that occur at least weekly.

Include for consideration in response 1 those with memory deficits who:
- Require supervision of ADL/IADL for safe performance or completion of task
- Require supervision or assistance with medication or equipment

Include for consideration in response “2” those who:
- Demonstrate poor safety awareness (leave walker on other side of room and use furniture and walls for balance because “I don’t need it,” etc.)

Assessment includes health status on the day of assessment and the recent past.

At discharge, evaluate whether these behaviors which may have been present at SOC, are still present. Assess the effectiveness of the interventions from the POC implemented during episode of care to reduce and manage these behaviors. Consider the plan for ongoing support post discharge. Determine if any of these behaviors continue to have serious implications for care and care planning and select the corresponding response.
## M0620 Frequency of Behavior Problems (Reported or Observed)
(e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Never</td>
</tr>
<tr>
<td>1</td>
<td>Less than once a month</td>
</tr>
<tr>
<td>2</td>
<td>Once a month</td>
</tr>
<tr>
<td>3</td>
<td>Several times each month</td>
</tr>
<tr>
<td>4</td>
<td>Several times a week</td>
</tr>
<tr>
<td>5</td>
<td>At least daily</td>
</tr>
</tbody>
</table>

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

### Recommendations from Expert Design Forum

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

### Tips:
This item reports the frequency of any behaviors that would jeopardize the patient's safety, disrupt his social environment, impact caregivers, or create barriers to achieving care plan goals and includes:
- Examples given in this question
- May include behaviors identified in M0610
- Any other behavior not listed but fitting the criteria

Provide supporting documentation in the record.

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

Assessment includes health status on the day of assessment and the recent past.
<table>
<thead>
<tr>
<th>M0630</th>
<th>Is patient receiving <strong>Psychiatric Nursing Services</strong> at home provided by a qualified psychiatric nurse?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 – No</td>
</tr>
<tr>
<td></td>
<td>1 – Yes</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

**Tips:** Includes only psychiatric nursing services provided at home by a qualified psychiatric nurse with an order on the Plan of Care for mental health nursing.

- At discharge:
  - Select “yes” if psychiatric nursing services is performing discharge assessment
  - Select “no” if psychiatric nursing services were discontinued prior to the discharging clinician’s comprehensive OASIS assessment
OASIS Items M0640-820

Complete OASIS items reporting the patient’s "ability" which may not be how they actually perform the activity on a routine basis. To determine "ability" requires interview strategies combined with patient demonstration of task and then making a clinical judgment to factor out patient “willingness” or "compliance."

In addition, if the patient has varying levels of ability within a day (includes the 24 hours preceding time of assessment), the clinician must decide which response reflects the patient’s ability to perform the task more than 50% of the time on the day of assessment. If there are multiple tasks within an item and the patient demonstrates varying ability with the tasks, consider the frequency of each separate task and select the response that describes the patient’s ability for the majority of the tasks.

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

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

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

Shortness of breath resulting in ADL/IADL tasks performed in stages is not considered when selecting a response for these data items. That observation is correctly scored in M0490. Weakness, cognitive and safety issues accompanying shortness of breath should be considered in the ADL/IADL assessment.

After evaluating all these factors, choose the response that reflects what the patient is "ABLE" to do on the day of the assessment, regardless of what he is or is not actually doing.
**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). In selecting the response, ask yourself the question, "What kind and how much assistance is required for the patient to perform this task safely and effectively?"

<table>
<thead>
<tr>
<th>Prior</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.</td>
</tr>
<tr>
<td></td>
<td>1 - Grooming utensils must be placed within reach before able to complete grooming activities.</td>
</tr>
<tr>
<td></td>
<td>2 - Someone must assist the patient to groom self.</td>
</tr>
<tr>
<td></td>
<td>3 - Patient depends entirely upon someone else for grooming needs.</td>
</tr>
<tr>
<td>UK</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

**Tips:** Assessment includes gathering equipment and performing grooming activities. Consider the frequency with which the selected tasks are necessary. Ability to do more frequently performed activities and inability to perform less frequently performed activities should be considered as having more grooming ability. Consider location and accessibility of grooming items.

Grooming (personal hygiene) includes:
- Washing face and hands
- Hair care (combing, brushing, styling)
- Shaving or makeup
- Teeth or denture care
- Fingernail care, etc

Excludes:
- Shampooing hair
- Toileting hygiene

Assessment of "ability" includes consideration of:
- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc.)
- Physical function (ROM, balance, strength, dexterity, ambulation, endurance, etc.)
- Safe completion of tasks (presence of safety/adaptive equipment, level of function, etc.)
- Medical restrictions (sling and swath to immobilize arm, shoulder, etc.)
- Activity limitations (bed rest, joint replacement patient with inability to climb multiple stairs to second floor where grooming items located, etc)
- Current clinical condition (limited ROM shoulder, elbow, edema, pain, paresis, paralysis, impaired balance, fall risk, etc.)
- Location of bathroom (restricted access for any reason, narrow doorways, etc.)

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

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

**Assistance:**
- Touching
- Contact guarding
- Participation in task
M0640  Continued

Considering physical and cognitive limitations and safety select:

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

Prior:
Report ability to perform grooming tasks on day #14 before this assessment day.
### M0650  
**Ability to Dress Upper Body** (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

<table>
<thead>
<tr>
<th>Prior</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
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<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>UK</td>
<td></td>
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</tbody>
</table>

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

#### Recommendations from Expert Design Forum

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

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

#### Tips:
Determine physical and cognitive ability to safely retrieve, dress and undress upper body in clothing routinely worn by obtaining patient demonstration. Protective and supportive devices such upper extremity prosthesis, immobilizer, splint, cervical collar, etc, are also included as routinely worn clothing items. Consider the storage location of clothing items and the skills necessary to manage buttons, zippers, snaps, etc. if articles of clothing routinely worn include buttons, zippers and snaps.

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

Excludes consideration of:
- Dressing in stages when due to shortness of breath

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

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

**Assistance:**
- Touching
- Contact guarding
- Participation in task
Considering physical and cognitive limitations and safety select:

0    Independent, no human intervention required for completion of a majority of dressing tasks. May use dressing aids and have adapted environment.
1    Dependent on another person for set up, to obtain items for dressing.
2    Dependent on another person for at least minimal assistance (standby) or supervision (cueing, reminders).
3    Totally dependent on another person to accomplish upper body dressing.

Prior:
Report ability to perform dressing tasks on day #14 before this assessment day.
### M0660 Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

<table>
<thead>
<tr>
<th>Prior</th>
<th>Current</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>- Able to obtain, put on, and remove clothing and shoes without assistance.</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>- Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>- Someone must help the patient put on under garments, slacks, socks or nylons, and shoes.</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>- Patient depends entirely upon another person to dress lower body.</td>
</tr>
<tr>
<td></td>
<td>UK</td>
</tr>
<tr>
<td></td>
<td>- Unknown</td>
</tr>
</tbody>
</table>

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

### Recommendations from Expert Design Forum

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

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

**Tips:** Determine physical and cognitive ability to safely retrieve, dress and undress lower body in clothing routinely worn by obtaining patient demonstration. Protective and supportive devices such as lower extremity prosthesis, immobilizer, splint, elastic compression stockings, etc, are also included as routinely worn clothing items. Consider the skills necessary to manage buttons, zippers, snaps, etc if routinely worn items include these and the location of clothing items.

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

Excludes consideration of:
- Dressing in stages when due to shortness of breath

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

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

**Assistance:**
- Touching
- Contact guarding
- Participation in task
Continued

Considering physical, cognitive limitations, and safety select:

0  Independent, no human intervention required for completion of a majority of tasks. May use dressing aids or have adapted environment.
1  Dependent on another person for set up, to obtain items for dressing.
2  Dependent on another person for at least minimal assistance (standby) or supervision (cueing, reminders).
3  Totally dependent on another person to accomplish dressing of lower body.

Prior:
Report ability to perform dressing tasks on day #14 before this assessment day.
**M0670  Bathing:** Ability to wash entire body. *Excludes* grooming (washing face and hands only).

<table>
<thead>
<tr>
<th>Prior</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - Able to bathe self in shower or tub independently.</td>
</tr>
<tr>
<td></td>
<td>1 - With the use of devices, is able to bathe self in shower or tub independently.</td>
</tr>
<tr>
<td></td>
<td>2 - Able to bathe in shower or tub with the assistance of another person:</td>
</tr>
<tr>
<td></td>
<td>(a) for intermittent supervision or encouragement or reminders, OR</td>
</tr>
<tr>
<td></td>
<td>(b) to get in and out of the shower or tub, OR</td>
</tr>
<tr>
<td></td>
<td>(c) for washing difficult to reach areas.</td>
</tr>
<tr>
<td></td>
<td>3 - Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.</td>
</tr>
<tr>
<td></td>
<td>4 - Unable to use the shower or tub and is bathed in bed or bedside chair.</td>
</tr>
<tr>
<td></td>
<td>5 - Unable to effectively participate in bathing and is totally bathed by another person.</td>
</tr>
</tbody>
</table>

UK  Unknown

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

**Recommendations from Expert Design Forum**

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

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

**Tips:** Determine physical and cognitive ability to safely wash their body in the shower or tub, regardless of where or how the patient chooses to bathe, by obtaining patient demonstration. Determine location and ability to access tub/shower and what assistance is necessary for bathing safely.

- **Excludes:**
  - Grooming tasks
  - Shampooing hair
  - Gathering supplies
  - Drying self
  - Transfer in and out of the tub/shower
  - Willingness, compliance and patient preference

**Select Responses 0-3 if:**
- Able to get into and out of the tub/shower by any safe means with the current bathroom and equipment setup regardless of whether they routinely do it.
- Ignore item 2(b) from the item wording as the transfer is not considered when scoring this item.

**Select Response 4 if:**
- Able to safely bathe self or participate in bathing at any location but not in the shower/tub
- Tub/shower not functioning or not safe
- Unable to get to the tub/shower location
- Medical restrictions keep patient from using the tub/shower

**Select Response 5 if:**
- Unable to effectively participate in washing their body regardless of the location.
Assessment of "ability" includes consideration of:

- Cognition, emotional and behavioral state (alertness, comprehension, fear of falling, anxiety, etc.)
- Physical function (ROM, strength, dexterity, ambulation, endurance, etc.)
- Safe completion of tasks (presence of safety/adaptive equipment, level of function, etc.)
- Medical restrictions (no showering till staples removed, keep dressing dry, etc.)
- Activity limitations (joint replacement patient with inability to climb multiple stairs to second floor where shower/tub located, bed rest, joint immobilization, etc.)
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc.)

Location of bathroom, tub/shower facilities (restricted access for any reason, narrow doorways, lack of grab bars, etc.)

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

Supervision:
- Verbal cues
- Prompting
- Reminders
- Standby

Assistance:
- Touching
- Contact guarding
- Participation in task

Considering physical and cognitive limitations and safety and if able to get in/out of the tub/shower by any safe means, select responses 0-3, 5

0 Independent. Does not require human intervention or adaptive or safety equipment.
1 Does not require human intervention but requires use of safety or adaptive equipment.
2 Dependent, requires intermittent assistance or supervision of another person for washing their body in tub or shower.
3 Dependent—requires constant supervision or assistance of another for bathing in shower or tub.
4 Totally Dependent—unable to effectively participate in bathing task.

If unable to get in/out of the tub/shower by any safe means, select responses 4-5

4 Unable to safely bathe in tub or shower with or without human intervention or safety equipment. Can safely bathe at another location, alone or with human intervention.
5 Totally Dependent—unable to effectively participate in bathing task.

Prior:

Report ability to perform bathing tasks on day #14 before this assessment day.
# Toileting: Ability to get to and from the toilet or bedside commode.

<table>
<thead>
<tr>
<th>Prior</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0 - Able to get to and from the toilet independently with or without a device.</td>
</tr>
<tr>
<td></td>
<td>1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet.</td>
</tr>
<tr>
<td></td>
<td>2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).</td>
</tr>
<tr>
<td></td>
<td>3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.</td>
</tr>
<tr>
<td></td>
<td>4 - Is totally dependent in toileting.</td>
</tr>
<tr>
<td></td>
<td>UK Unknown</td>
</tr>
</tbody>
</table>

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

### Recommendations from Expert Design Forum

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

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

### Tips:
Determine physical and cognitive ability to get to and from (mobility/access) the bathroom toilet or bedside commode safely. Notice location of bathroom.

This is an access question. Note ability to safely walk or use wheelchair to the bathroom toilet or bedside commode.

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

Assessment *excludes*:
- Personal hygiene
- Management of clothing

A bedside commode is a free standing device placed in a room other than the bathroom and is not a “raised” or “3 in 1” toilet in the bathroom.

Select Response 0-1 if:
- Able to safely get to the bathroom toilet the majority of the 24 hr time period

Select Response 2 if:
- Unable to get to the bathroom toilet but able to safely get to the bedside commode a majority of the 24 hr time period
Assessment of "ability" includes consideration of:
- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc.)
- Physical function (ROM, strength, dexterity, ambulation, endurance, coordination, etc.)
- Safe completion of tasks (presence of safety/adaptive equipment, level of function, etc.)
- Medical restrictions (hip precautions, etc.)

Activity limitations (joint replacement patient with inability to climb multiple stairs to second floor where toilet is located, bed rest, etc.):
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc.)
- Location of bathroom, (restricted access for any reason, narrow doorways, etc.)

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

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

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

Considering physical and cognitive limitations, location of toilet and safety select:
- 0 - Independent, does not need any human intervention to get to the bathroom toilet safely. May or may not use a device.
- 1 - Dependent, requires human intervention for at least minimal assistance (standby) or supervision (cueing, guarding, etc) to get to the bathroom toilet safely.
- 2 - Cannot get to the bathroom toilet safely but can get to bedside commode safely with or without human intervention.
- 3 - Can use urinal and get on/off bedpan **without** human intervention
- 4 - Cannot effectively perform any of the above activities to toilet self.

**Prior:**
Report ability to ambulate or use wheelchair to get to the bathroom toilet or bedside commode, or use a urinal and get on/off a bedpan on day #14 before this assessment day.
**M0690** Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

<table>
<thead>
<tr>
<th>Prior</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 0</td>
<td>Able to independently transfer.</td>
</tr>
<tr>
<td>□ 1</td>
<td>Transfers with minimal human assistance or with use of an assistive device.</td>
</tr>
<tr>
<td>□ 2</td>
<td>Unable to transfer self but is able to bear weight and pivot during the transfer process.</td>
</tr>
<tr>
<td>□ 3</td>
<td>Unable to transfer self and is unable to bear weight or pivot when transferred by another person.</td>
</tr>
<tr>
<td>□ 4</td>
<td>Bedfast, unable to transfer but is able to turn and position self in bed.</td>
</tr>
<tr>
<td>□ 5</td>
<td>Bedfast, unable to transfer and is unable to turn and position self.</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

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

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

Assistive device includes:
- Equipment items (e.g., walker, cane, grab bars, hydraulic lift, slide board, etc.) that the patient requires in order to safely perform the transfers

Assistive device excludes:
- Chair arms or other furniture items

Select Response 1 if safe transfers require:
- Minimal human intervention (verbal cueing, stand by assist, contact guard) but no assistive device **OR**
- Assistive device but no human intervention

Select Response 2 if transfers require:
- **Both** human intervention **AND** an assistive device (i.e., not safe with just one intervention) **AND**
- Patient can both bear weight **and** pivot

Able to bear weight refers to ability to support the majority of his/her body weight through any combination of weight bearing extremities.

Select Response 3 if safe transfers require:
- Human intervention **AND**
- Patient can either bear weight **OR** pivot (can only do one), **OR** do neither (is lifted by another or by a mechanical lift device)

Select Response 4-5 if:
Confined to the bed, is not able to leave the bed for any of these transfers.
Assessment of "ability" includes:

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

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

Supervision:
- Verbal cues
- Prompting
- Reminders
- Standby

Assistance:
- Touching
- Contact guarding
- Participation in task

If at the time of the assessment and in the 24 hr period preceding the visit, ability varies among the 3 transfers, consider amount of assistance required and the frequency the transfer is performed. Report the level of ability applicable to any or all of the 3 transfers.

Consider physical and cognitive limitations and safety.

If able to leave the bed for one or more transfers, select response 0-3.
- 0 - Able to perform the transfer(s) safely without human intervention or assistive device.
- 1 - Able to perform the transfer(s) when using assistive device OR with minimal human intervention.
- 2 - Able to participate safely with another in the transfer(s) by weight bearing and pivoting.
- 3 - Unable to bear weight and/or pivot when transferred by another person.

If not able to leave the bed for one or more of these 3 transfers, select response 4-5.
- 4 - Confined to bed and can turn and position self in bed.
- 5 - Confined to bed and cannot turn and position self in bed.

Prior:
- Report ability to perform these 3 transfers on day #14 before this assessment day.
**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.

<table>
<thead>
<tr>
<th>Prior</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>- 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).</td>
</tr>
<tr>
<td>1</td>
<td>- 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.</td>
</tr>
<tr>
<td>2</td>
<td>- Able to walk only with the supervision or assistance of another person at all times.</td>
</tr>
<tr>
<td>3</td>
<td>- Chairfast, unable to ambulate but is able to wheel self independently.</td>
</tr>
<tr>
<td>4</td>
<td>- Chairfast, unable to ambulate and is unable to wheel self.</td>
</tr>
<tr>
<td>5</td>
<td>- Bedfast, unable to ambulate or be up in a chair.</td>
</tr>
<tr>
<td>UK</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

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

**Tips:** Determine physical and cognitive ability to safely walk on the typical variety of even and uneven surfaces found in the patient’s indoor and outdoor environment including stairs. If unable to walk, determine physical and cognitive ability to safely propel a wheelchair (manual or powered by any means) on the variety of surfaces in the patient’s environment.

Patient’s who have the ability to walk safely with or without human intervention and also use a wheelchair are scored on their ability to ambulate regardless of how much they use the wheelchair.

Ambulation includes:
- Ability to take more than the 2-3 steps to complete a transfer

Excludes:
- Transfer to standing position or transfer to a wheelchair

Patients who have some ability to walk and also use the wheelchair are scored on their ability to walk.
- Confined to the bed

Assessment of "ability" includes:
- Cognition, emotional and behavioral state (alertness, comprehension, fear, anxiety, etc.)
- Physical function (ROM, strength, dexterity, ambulation, endurance, etc.)
- Safe completion of tasks (presence of safety/adaptive equipment, level of function, etc.)
- Medical restrictions (joint immobilization, etc.)
- Activity limitations (joint replacement patient with inability to climb multiple stairs, bed rest, hip precautions, etc.)
- Current clinical condition (edema, pain, paresis, paralysis, impaired balance, fall risk, etc.)
- Floor plan of home and access to areas routinely used
Assessment of "ability" may be in conflict with reporting how the patient actually performs the task on a routine basis. Document differences in clinical record.

Supervision:
- Verbal cues
- Prompting
- Reminders
- Standby

Assistance:
- Touching
- Contact guarding
- Participation in task

Consider physical and cognitive limitations and safety. If able to walk at all at the time of the assessment or in the 24 hrs preceding the assessment, select responses 0-2 even if the patient uses the wheelchair most of the time.

0 - Able to safely walk on all surfaces in their environment without human intervention and without assistive device.
1 - Requires human intervention or assistive device for some of the surfaces some of the time.
2 - Requires at least minimal human intervention for safety at all times.

If unable to walk at all, select responses 3-5.
3 - Able to propel own wheelchair without human intervention. No functional ambulation.
4 - Requires human intervention to propel wheelchair. No functional ambulation.
5 - Confined to bed and also unable to be up in chair.

Prior:
Report ability to ambulate or use wheelchair on day #14 before this assessment day.
Feeding or Eating: Ability to feed self meals and snacks. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

Prior | Current
--- | ---
0 | Able to independently feed self.
1 | Able to feed self independently, but requires:
   (a) meal set-up; OR
   (b) intermittent assistance or supervision from another person; OR
   (c) a liquid, pureed or ground meat diet.
2 | Unable to feed self and must be assisted or supervised throughout the meal/snack.
3 | Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
4 | Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
5 | Unable to take in nutrients orally or by tube feeding.
UK | Unknown

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

Recommendations from Expert Design Forum

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

Optimal Technique: Observe patient eat.

Tips: Determine physical and cognitive ability to safely perform activities associated with eating once food is placed in front of patient.

Select Response 1 if:
- Requires special adaptations (meal set up) like mashing a potato, cutting up meat and vegetables, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, arranging food on plate for ease of access, etc.

Chopping or cutting of food is not considered meal set-up in homes where the culture dictates that the food be chopped or cut before being served, such as in some Asian cultures.

Select Response 3-4 if:
- Feeding tube is providing any or all nutrients the day of the assessment

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

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

Supervision:
- Verbal cues
- Prompting
- Reminders
- Standby

Assistance:
- Touching
- Contact guarding
- Participation in task
Considering physical and cognitive limitations and safety:

0 - Feeds self without adaptive devices or human intervention.
1 - Feeds self but requires a setup, intermittent assistance or supervision or special food preparation.
2 - Unable to feed self. Requires constant human intervention throughout the meal.
3 - Takes food orally and uses NG tube or gastrostomy for nutrition.
4 - Uses NG or gastrostomy and has no oral intake.
5 - Receives no nutrients by mouth or tube feeding.

Prior:

Report ability to perform feeding/eating tasks on day #14 before this assessment day.
### M0720 Planning and Preparing Light Meals (e.g., cereal, sandwich) or reheat delivered meals:

<table>
<thead>
<tr>
<th>Prior</th>
<th>Current</th>
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<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>(a)</td>
</tr>
<tr>
<td></td>
<td>Able to independently plan and prepare all light meals for self or reheat delivered meals; OR</td>
</tr>
<tr>
<td></td>
<td>(b)</td>
</tr>
<tr>
<td></td>
<td>Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has</td>
</tr>
<tr>
<td></td>
<td>not routinely performed light meal preparation in the past (i.e., prior to this home care admission).</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Unable</td>
</tr>
<tr>
<td></td>
<td>to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Unable</td>
</tr>
<tr>
<td></td>
<td>to prepare any light meals or reheat any delivered meals.</td>
</tr>
<tr>
<td></td>
<td>UK</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
</tr>
</tbody>
</table>

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

#### Recommendations from Expert Design Forum

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

**Optimal Technique:** Observe patient make a sandwich.

#### Tips:
Determine physical and cognitive ability to safely perform all activities associated with planning and preparing a light meal considering medically prescribed diet requirements; consider ability to select, retrieve, carry, prepare, and get items to table or cooking area for reheating a prepared meal. Willingness to adhere to and compliance with therapeutic diet are not considered in this assessment.

For a patient entirely on enteral feedings, consider ability to prepare prescribed feeding, know amount and type of feeding.

Select Response 1 if:
- Unable to physically or cognitively plan and prepare a simple meal
- Able to prepare a simple meal and lacks the knowledge to comply with a medically prescribed diet.

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

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

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

#### Assistance:
- Touching
- Contact guarding
- Participation in task
M0720  Continued

Considering physical and cognitive limitations and safety:

0 - Able to reheat meals or plan and prepare meals according to limitations of a medically prescribed diet. Although able, may or may not routinely have responsibility for doing so.

1 - Has a physical, cognitive or mental limitation and cannot plan and prepare meals on a regular basis and according to medical diet prescription when applicable.

2 - Cannot prepare any light meals or reheat delivered meals.

Prior:

Report ability to plan and prepare light meals on day #14 before this assessment day.
**M0730 Transportation:** Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway).

<table>
<thead>
<tr>
<th>Prior</th>
<th>Current</th>
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<tr>
<td>□</td>
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<tr>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>UK</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

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

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

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

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

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

Considering physical and cognitive limitations and safety:
- 0 - Can drive OR able to use bus without human intervention. Vehicle may be adapted.
- 1 - Cannot drive (includes physician ordered medical restriction) and requires at least minimal human intervention for transportation.
- 2 - Can only be transported by ambulance.

**Prior:** Report ability to use transportation on day #14 before this assessment day.
### 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) Is physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this home care admission).

**Current**
- 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

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

### Recommendations from Expert Design Forum

**Optimal Question:** Describe how you would do laundry today.

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

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

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

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

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

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

Considering physical and cognitive limitations and safety:
- 0 - Able to do all laundry without human intervention. Although able, another person may do routinely.
- 1 - Independent performing minor laundry tasks only. Needs human intervention for larger loads or carrying items.
- 2 - Unable to do any laundry for physical reasons or requires constant human intervention for cognitive reasons.

**Prior:**
Report ability to perform laundry tasks on day #14 before this assessment day.
### M0750 Housekeeping: Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.

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

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

### Recommendations from Expert Design Forum

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

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

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

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

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

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

**Assistance:**
- Touching
- Contact guarding
- Participation in task
Considering physical and cognitive limitations and safety:

0 - Independent - no human intervention required. Although able, may or may not have responsibility to do routinely.
1 - Does not require human intervention for light housekeeping tasks.
2 - Requires at least minimal human intervention for any housekeeping tasks.
3 - Requires constant human intervention to accomplish housekeeping tasks.
4 - Cannot perform housekeeping tasks.

Prior:
Report ability to perform housekeeping tasks on day #14 before this assessment day.
**M0760  Shopping:** Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.

<table>
<thead>
<tr>
<th>Prior</th>
<th>Current</th>
</tr>
</thead>
</table>
| 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       |
|       | (a) Able to go shopping, but needs some assistance:
|       | (a) By self is able to do only light shopping or carry small packages, but needs someone to do occasional major shopping; **OR**
|       | (b) Unable to go shopping alone, but can go with someone to assist.
|       | 2       |
|       | Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery.
|       | 3       |
|       | Needs someone to do all shopping and errands.
|       | UK      |
|       | Unknown |

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

**Recommendations from Expert Design Forum**

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

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

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

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

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

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

**Assistance:**
- Touching
- Contact guarding
- Participation in task
M0760  Continued

Considering physical and cognitive limitations and safety:
0 - Independent- no human intervention required for any shopping task. Although able, may or may not have responsibility to do routinely.
1 - Does not require human intervention for light shopping. May or may not need help with larger shopping. OR Cannot go shopping alone.
2 - Cannot go shopping at all but can develop list and get items into home.
3 - Dependent on another for all aspects of shopping.

Prior:
Report ability to perform shopping tasks on day #14 before this assessment day.
M0770 Ability to Use Telephone: Ability to answer the phone, dial numbers, and effectively use the telephone to communicate.

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

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

Recommendations from Expert Design Forum

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

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

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

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

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

Considering physical and cognitive limitations and safety:
- 0 - Independent. Requires no human intervention and no phone adaptations for making or receiving calls.
- 1 - Able to make essential calls with phone adaptations.
- 2 - Cannot place calls but can answer phone and converse.
- 3 - Intermittently able to answer phone or conversation is limited.
- 4 - Cannot answer phone but can listen with special equipment.
- 5 - Cannot make or receive phone calls.

Prior:
Report ability to communicate by telephone on day #14 before this assessment day.
M0780 Management of Oral Medications: Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

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

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

Recommendations from Expert Design Forum

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

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

Tips: Consider the patient's physical and cognitive ability to safely complete all tasks associated with taking oral medications; getting it from where it is stored, reading and interpreting label instructions, preparing it (opening bottles, pouring, breaking tablets, etc.), and reliably taking correct dose at proper time.

Includes:
- Prescribed medications
- Over the counter medications

Excludes:
- Knowledge about medications; effects and side effects, etc.
- Filling, reordering and obtaining

Alert! The emphasis of the word "all" preceding "prescribed medications" in the item wording refers to the inclusion of both prescribed and over the counter medications when making this assessment. In scoring this item however, select the response that represents what the patient can safely do on the day of assessment. If ability varies from medication to medication, consider the total number of daily doses and report what the patient is able to do for the majority of doses.

Assisted living environments (or hospitals, SNF, Rehab facilities when determining health status 14 days prior) may require facility staff to administer medications. Determine the patient's ability to safely and reliably take his/her own medications despite the policies and restrictions of the facility.
M0780  Continued

Considering physical and cognitive limitations and safety:

0  Takes the majority of the doses of medications safely and reliably without human intervention. May use reminder system(s) or prompts he/she creates independently.

1  Cannot take most doses reliably or safely without human intervention for some part of the task. Requires either a set up OR reminders to take.

2  Totally dependent on another for effectively taking the majority of doses of oral medications reliably and safely. Requires both a set up AND prompts for taking.

Prior:
Report ability to take oral medications on day #14 before this assessment day despite the facility's policies and restrictions.
**M0790 Management of Inhalant/Mist Medications:** Patient’s ability to prepare and take all prescribed inhalant/mist medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes all other forms of medication (oral tablets, injectable and IV medications).**

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

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

**Recommendations from Expert Design Forum**

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

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

**Tips:** Consider the patient’s physical and cognitive ability to safely complete all tasks associated with taking inhalant/mist medication; getting it from where it is stored, reading and interpreting the directions, preparing it (opening bottles, pouring), setting up the equipment, reliably taking correct dose at proper time.

Includes:
- Oxygen
- Nebulizers
- Metered dose devices

Considering physical and cognitive limitations and safety:
- 0 Requires no human intervention for any aspect of taking inhalant/mist medications. May use own reminder system.
- 1 Cannot take most doses reliably or safely without human intervention for some part of the task. Requires either a set up OR reminders to take.
- 2 Dependent on another for taking most doses of inhalant/mist medications safely and reliably.

**Prior:** Report ability to take inhaled medications on day #14 before this assessment day despite the facility policies and restrictions.
M0800  Management of Injectable Medications: Patient's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of the correct dosage at the appropriate times/ intervals. 

**Excludes IV medications.**

<table>
<thead>
<tr>
<th>Prior</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
|       | 1       | Able to take injectable medication at the correct times if:  
  (a) individual dosages are prepared in advance by another person;  
  (b) given daily reminders. |
|       | 2       | Unable to take injectable medication unless administered by someone else. |
|       | NA      | No injectable medications prescribed. |
|       | UK      | Unknown |

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

**Recommendations from Expert Design Forum**

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

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

**Tips:** Consider the patient’s physical and cognitive ability to safely complete all tasks associated with taking injectable medication (by needle and syringe, subcutaneously or intramuscularly); getting it from where it is stored, preparing it (opening bottles, drawing up), selecting correct site, disposing of supplies, reliably taking correct dose at proper time.

**Includes:**
- Medications received or to be received by needle and syringe subcutaneously or intramuscularly in the home during the time covered by the plan of care even if not received on the day of assessment

**Excludes:**
- Medications administered intravenously
- Medications infusing via an implanted pump or external infusion device even if a medication is injected into the infusion device via a needle and syringe
- Physician orders for nurse to administer, not for convenience, but because the patient is unable or it be unsafe to self inject (select Response 2)

Considering physical and cognitive limitations and safety
- 0 Requires no human intervention for any aspect of taking injectable medications. May use own reminder system.
- 1 Cannot take most doses reliably or safely without human intervention for some part of the task. Requires either a set up OR reminders to take.
- 2 Dependent on another for taking most doses of injectable medications safely and reliably.

**Prior:** Report ability to take injectable medications on day #14 before this assessment day despite the facility policies and restrictions.
### M0810 Patient Management of Equipment (includes ONLY oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies):

Patient’s ability to set up, monitor, and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique.  
*(NOTE: This refers to ability, not compliance or willingness.)*

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Patient manages all tasks related to equipment completely independently.</td>
</tr>
<tr>
<td>1</td>
<td>If someone else sets up equipment, patient is able to manage all other aspects of equipment.</td>
</tr>
<tr>
<td>2</td>
<td>Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task.</td>
</tr>
<tr>
<td>3</td>
<td>Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.</td>
</tr>
<tr>
<td>4</td>
<td>Patient is completely dependent on someone else to manage all the equipment.</td>
</tr>
<tr>
<td>NA</td>
<td>No equipment of this type used in care.</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

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

**Tips:** Consider the patient’s physical *and* cognitive ability to safely complete all tasks associated with managing the equipment used to perform certain therapies identified in M0250 and M0500.

Include equipment types related to only the following therapies:
- Subcutaneous, epidural, intrathecal infusions, and insulin pumps
- Intermittent medications, fluids or flushes via VAD intravenously
- Enteral/parenteral nutrition
- Intermittent or continuous oxygen
- Ventilators
- Dialysis through a central line occurring in the home

Exclude equipment related to the following:
- Continuous positive airway pressure (C-PAP) without oxygen
- Nebulizers, inhalers, bi-pap
- IM or SQ injections
- Other equipment for treatments not listed above

Equipment management by the patient includes:
- Set up and monitoring equipment
- Adding fluids and medications
- Cleaning
- Storing
- Disposing of equipment and supplies
M0820  Caregiver Management of Equipment (includes ONLY oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies):  Caregiver's ability to set up, monitor, and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique.  (NOTE:  This refers to ability, not compliance or willingness.)

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

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

Recommendations from Expert Design Forum

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

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

Tips:  Consider the caregiver's physical and cognitive ability to safely complete all tasks associated with managing the equipment used to perform certain therapies identified in M0250 and M0500.

Include equipment types related to only the following therapies:
- Subcutaneous, epidural, intrathecal infusions, and insulin pumps
- Intermittent medications, fluids or flushes via VAD intravenously
- Enteral/parenteral nutrition
- Intermittent or continuous oxygen
- Ventilators
- Dialysis through a central line occurring in the home

Exclude equipment related to the following:
- Continuous positive airway pressure (C-PAP) without oxygen
- Nebulizers, inhalers, bi-pap
- IM or SQ injections
- Other equipment for treatments not listed above

Equipment management by the caregiver includes:
- Set up and monitoring equipment
- Adding fluids and medications
- Cleaning
- Storing
- Disposing of equipment and supplies
**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.

**Item Clarification:** 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. 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.

**Recommendations from Expert Design Forum**

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

**Tips:** For greatest accuracy, collaborate with rehab services to determine their plan and the physician's orders for their services after rehab evaluation is performed. Complete this item on or within 5 days of M0030 SOC. If collaboration is not possible, an estimation of the projected therapy visits based on the need identified and supported by the comprehensive assessment is acceptable.

Complete this item with 3 digits (zero filled and right justified, i.e. 004, etc.) when:

- Medicare traditional fee for service is a payer (M0150 includes 1)
- A HIPPS code (case mix code) is needed by a non Medicare fee for service payer for billing purposes

Choose N/A for:

- All payers not listed above

Completion of M0826 at ROC will generally not affect reimbursement for the episode. Select N/A when appropriate UNLESS a SCIC/ROC occurs after an intervening hospital stay and there is a return home during the last 5 days of an episode. Complete ROC assessment. For M0826 select response based on therapy need for the subsequent certification period. See OASIS Considerations for Medicare PPS Patients, revised October 2007 for more information. [http://www.cms.hhs.gov/OASIS/Downloads/OASISConsiderationsforPPS.pdf](http://www.cms.hhs.gov/OASIS/Downloads/OASISConsiderationsforPPS.pdf)

At recertification consider:

- The number of therapy visits that will be made in the next episode

**Note:** The final claim will be paid based on the actual number of therapy visits made to the patient. When the actual number does not match the projected number at SOC or ROC, the computers at the RHHI will automatically adjust the predicted number up or down and there is no action required by the agency to correct M0826 on the original document.
M0830  **Emergent Care**: Since the last time OASIS data were collected, has the patient utilized any of the following services for emergent care (other than home care agency services)? (Mark all that apply)

- □ 0 - No emergent care services [If no emergent care, go to M0 855]
- □ 1 - Hospital emergency room (includes 23 hour holding).
- □ 2 - Doctor’s office emergency visit/house call.
- □ 3 - Outpatient department/clinic emergency (includes urgicenter sites).
- □ UK - Unknown [If UK, go to M0855]

**Item Clarification:** Identifies whether the patient received an unscheduled visit to any (emergent) medical services other than home care services. Emergent care services include all unscheduled visits occurring within 24 hours of the time the patient has contacted the medical services. A "pm" agency visit is not considered emergent care.

**Recommendations from Expert Design Forum**

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

**Optimal Technique:** Read medical record.

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

Emergent care is determined by timing of the visit, the provider of service and not the reason for the visit.

Emergent care includes:
- Any and all treatment and services received within 24 hrs of the time patient made initial contact with the hospital emergency department, the physician’s office or the outpatient clinic/urgicenter AND
- Treatment and services were received since the last OASIS assessment was completed SUCH AS
- ER visits that result in a hospitalization OR
- ER visits that do not result in a hospitalization
- Visits to the home from the doctor or nurse practitioner
- ER visits that result in a “hold” or observation status for any length of time without admission to the inpatient facility
- Visits to a physician’s office who does not make appointments and requires patients to show up and are served on a first come basis

Emergent care excludes:
- PRN visits by the home health agency
- Direct admit to the hospital
- Outpatient visits for scheduled diagnostic testing
- Emergent care received prior to the last time OASIS data was collected
- Emergency services summoned to the patient’s home AND not transported to the hospital emergency department, the physician’s office or the outpatient clinic/urgicenter

**Note:** The definition of emergent care (scheduled/unscheduled visits occurring within 24 hours of the patient contact with the hospital emergency room, doctor’s office/house call or outpatient department/emergency clinic) in this item is different from the definition for emergent in M0890 (unscheduled; typically occurring immediately subsequent to a doctor’s office, outpatient clinic or ER visit).
M0840  **Emergent Care Reason:** For what reason(s) did the patient/family seek emergent care? *(Mark all that apply.)*

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

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

**Recommendations from Expert Design Forum**

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

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

**Tips:** Multiple reasons may apply. All reasons must be marked.

Select Response 3 if:
- Injury sustained as a result of a fall or accident occurring at home (either indoor or outdoor)

Select Response 9:
- Injury sustained as a result of a fall or accident occurring in a location other than at home
M0855  To which Inpatient Facility has the patient been admitted?

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

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

Recommendations from Expert Design Forum

Optimal Technique: Contact family or physician office for information.

Tips: The list of Inpatient facility types differs in this item from those found in M0175.

If in doubt as to facility type, contact facility to inquire how it is licensed. Confirm that patient had a qualifying inpatient stay (Medicare Part A is payer).

Hospitals can have "swing beds," separately licensed skilled nursing facility beds and separately licensed rehabilitation beds within their walls. They may also have freestanding SNF and rehabilitation facilities on or off campus. Determine where the patient was confined and "type" of bed the patient occupied.

Inpatient Facility excludes:
- Outpatient visit or "held for observation" for any length of time and did not result in an inpatient admission (Medicare B is payer)

Response 1 - Hospital includes:
- Acute care hospital
- Long term care hospital

Response 2 - Rehabilitative facility includes:
- Freestanding rehabilitation hospital
- Distinct part unit of a general acute hospital

Response 3 - Nursing home includes:
- Skilled nursing facility (SNF)
- Intermediate care facility for the mentally retarded (ICF/MR)
- Nursing facility
M0870  Discharge Disposition:  Where is the patient after discharge from your agency? (Choose only one answer)

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

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

Recommendations from Expert Design Forum

Optimal Question: Where will you be staying after we discharge you?

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

Tips:

Response 1 - Remained in community includes:
- Assisted living facilities
- Board and care homes
- Patient discharge from agency and readmitted to agency due to change in payer source

Response 2 – Non-institutional hospice includes hospice care:
- At home
- In a caregiver’s home
- In a Hospice house
### M0880

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

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>☐ 1</td>
<td>No assistance or services received</td>
</tr>
<tr>
<td>☐ 2</td>
<td>Yes, assistance or services provided by family or friends</td>
</tr>
<tr>
<td>☐ 3</td>
<td>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)</td>
</tr>
</tbody>
</table>

[Go to M0903]

### Item Clarification:

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

### Recommendations from Expert Design Forum


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

### Tips:

Assistance or services may be paid or unpaid.

- Response 3 - Assistance provided by other community resources also includes:
  - Outpatient therapy
  - The home health agency when discharge and readmission to the agency occurs due to change in payer source
If the patient was admitted to an acute care Hospital, for what reason was he/she admitted?

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

Item Clarification: Identifies the urgency of the hospitalization.

Recommendations from Expert Design Forum

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

Tips: Reason for acute care hospitalization is defined by the amount of time between the medical event and the hospitalization and not circumstance causing the hospitalization.

Definitions:
- Emergent: Admission to hospital is unscheduled and occurs immediately and subsequent to a medical event (i.e., “Go now,” etc.)
- Urgent: Admission to hospital is scheduled to occur within 24 hours of medical event
- Elective: Admission to hospital is scheduled to occur more than 24 hours after medical event

Note: Definition of emergent, (unscheduled) in this item differs from the definition for emergent care (scheduled/unscheduled visits occurring within 24 hours of the patient contact with the hospital emergency room, doctor’s office/house call or outpatient department/emergency clinic) in M0830.
### M0895  Reason for Hospitalization: (Mark all that apply)

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

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

**Recommendations from Expert Design Forum**

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

**Tips:** Multiple reasons may exist. All reasons must be marked.

- Select response 2:
  - Injury sustained as a result of a fall or accident occurring at home (either indoor or outdoor)

- Select Response 16:
  - Injury sustained as a result of a fall or accident occurring in a location other than at home
M0900  For what **Reason(s)** was the patient **admitted** to a **Nursing Home**?  
(Mark all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Therapy services</td>
</tr>
<tr>
<td>2</td>
<td>Respite care</td>
</tr>
<tr>
<td>3</td>
<td>Hospice care</td>
</tr>
<tr>
<td>4</td>
<td>Permanent placement</td>
</tr>
<tr>
<td>5</td>
<td>Unsafe for care at home</td>
</tr>
<tr>
<td>6</td>
<td>Other</td>
</tr>
<tr>
<td>UK</td>
<td>Unknown reason</td>
</tr>
</tbody>
</table>

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

**Recommendations from Expert Design Forum**

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

**Tips:** Multiple reasons may exist. **All** reasons must be marked.

If nursing home placement was planned – medical record documentation should reflect the plan.
M0903 Date of Last (Most Recent) Home Visit:

[ ] [ ] [ ]
Month  day  year

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

Recommendations from Expert Design Forum

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

Tips: Collaborate with designated office based staff to determine when the last visit (billable or non billable) was made by any agency provider under the plan of care. Consider both skilled (SN, PT, SLP, OT) and unskilled (HHA) services.

The date of the last home visit M0903 will likely be the same as M0090, date of the assessment except:

- With a transfer to an inpatient facility
- Patient death at home
- In the case of an "unexpected discharge"

In these situations, M0090 is the date the agency learns of the event.
M0906 Discharge/Transfer/Death Date:

Month / day / year

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

Recommendations from Expert Design Forum

Tips: Date of discharge is determined by agency policy or physician order.

Record actual date of the occurrence for:
- Transfer to inpatient facility
- Death occurring at home

"Death at home" includes:
- Death which occurs while being transported to an inpatient facility and before being admitted to the facility or treated in the emergency room (i.e. DOA)

"Death at home" excludes:
- Death occurring in an inpatient facility

If the agency policy requires the discharge date to be the date of a physician’s order for discharge, the discharge assessment must be completed on that date or within 48 hours after that date.

Note: Medicare regulation does not require a physician’s order to discharge a patient, but does require the physician be notified of the discharge. Provide evidence and document notification of the physician in the patient’s record.